PERCEIVED PARENTING AND SOMATIZATION: THE MEDIATING ROLE OF EMOTIONAL EXPRESSION AND SELF-COMPASSION

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ETHICAL DECLARATION

I hereby declare that I am the sole author of this thesis and that I have conducted my work in accordance with academic rules and ethical behaviour at every stage from the planning of the thesis to its defence. I confirm that I have cited all ideas, information and findings that are not specific to my study, as required by the code of ethical behaviour, and that all statements not cited are my own.

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ABSTRACT

PERCEIVED PARENTING AND SOMATIZATON: THE MEDIATING ROLE OF EMOTIONAL EXPRESSION AND SELF-COMPASSION

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The objective of the study was to examine how emotional expression and self-compassion mediate the relationship between perceived parenting attitudes and somatization. Three hundred and three people between the ages of 18-69 participated the study. Sociodemographic Information Form, Somatization Subscale of the MMPI (Minnesota Multiphasic Personality Inventory), Young Parenting Inventory, Emotional Expression Questionnaire and Self-Compassion Scale were conducted online via Google Forms. Simple mediation analyses were performed to analyze the mediating role of emotional expression and self-compassion on the relationship between perceived parenting attitudes and somatization. To test the mediating role of 3 subdimensions of emotional expression and 6 subdimensions of self-compassion, multiple mediation analysis was used. While it was found that self-compassion, the negative emotional expression and closeness expression subdimensions of emotional expression and self-kindness, isolation, and over-identification subdimensions of

self-compassion had a mediating role in the relationship between perceived parenting attitudes and somatization, the mediating role of emotional expression, positive emotional expression subdimension from emotional expression and self-judgement, common humanity, and mindfulness subdimensions from self-compassion were not observed. This study contributed to the importance of studying the effects of the mediator role for future studies on the relationship between perceived parenting attitudes and somatization. The findings of the present study provide a better understating of the relationship between perceived parenting attitudes and somatization. Furthermore, it can be concluded that Schema Therapy, emotional expression and third wave approaches includes the development of self-compassion could be an effective treatment for somatization.

Keywords: Somatization, Perceived Parenting, Emotional Expression, Self-Compassion.

ÖZET

ALGILANAN EBEVEYNLİK VE SOMATİZASYON: DUYGULARI İFADE ETME VE ÖZ-ŞEFKATİN ARACI ROLÜ

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Bu çalışmanın amacı, algılanan ebeveynlik tutumları ile somatizasyon arasındaki ilişkide duygu ifadesi ve öz-şefkatin aracı rolünü incelemektir. Çalışmaya 18-69 yaş arasındaki üç yüz üç kişi katılmıştır. Sosyodemografik Bilgi Formu, MMPI (Minnesota Çok Yönlü Kişilik Envanteri) Ölçeğinin Somatizasyon Alt Ölçeği, Young Ebeveynlik Ölçeği, Duygu İfade Etme Ölçeği ve Öz-Şefkat Ölçeği çevrimiçi olarak Google Forms aracılığıyla uygulandı. Algılanan ebeveynlik tutumları ile somatizasyon arasındaki ilişkide duygu ifadesi ve öz-şefkatin aracı rolünü analiz etmek için basit aracılık analizleri yapılmıştır. Duygu ifadesinin 3 alt boyutunun ve öz-şefkatin 6 alt boyutunun aracı rolünü test etmek için çoklu aracılık analizi kullanılmıştır. Algılanan ebeveynlik tutumları ile somatizasyon arasındaki ilişkide duyguları ifade etme ile, negatif duygu ifadesi ve yakınlık ifadesi alt boyutlarının öz-şefkat ile öz-sevecenlik, yabancılaşma ve aşırı özdeşleşme alt boyutlarının aracı rolü olduğu bulunmuştur. Duyguları ifade etmenin, pozitif duygu ifade etmenin ve öz-şefkatin öz-yargılama, paylaşımların bilincinde olma ve bilinçlilik alt boyutlarından aracılık rolü gözlenmemiştir. Bu çalışma, algılanan ebeveynlik tutumları ile

somatizasyon arasındaki ilişki üzerinde gelecekteki çalışmalar için aracı rolün etkilerini incelemenin önemini vurgulamıştır. Bu çalışmanın bulguları, algılanan ebeveynlik tutumları ile somatizasyon arasındaki ilişkinin daha iyi anlaşılmasını sağlamaktadır. Ayrıca, Şema Terapisi, duygu ifadesi ve öz-şefkat gelişimi gibi yaklaşımların somatizasyon için etkili bir tedavi olabileceği önemi vurgulanmaktadır.

Anahtar Kelimeler: Somatizasyon, Algılanan Ebeveynlik, Duygu İfadesi, Öz-şefkat

Dedicated to my grandmother, Sevim…

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CHAPTER 1: INTRODUCTION

Somatization is the disorder characterized with the presence of recurring and often fluctuating physical symptoms that cannot be attributed to any identified medical condition (APA, 1994). Common symptoms of somatization consist of musculoskeletal pains, gastrointestinal complaints, cardiopulmonary symptoms, pseudo-neurological symptoms (e.g., numbness, paresthesia, loss of vision), menstrual problems, and sexual symptoms (Kirmayer and Robbins, 1991). In addition to them, dermatological symptoms (atopic dermatitis, pruritus, urticaria, pityriasis, psoriasis etc.) are also linked with somatization (Millington et al., 2022). Somatization, is a highly prevalent issue across different medical fields. It poses a significant public health concern as functional symptoms contribute to significant work and social impairment. Patients experiencing recurrent unexplained somatic symptoms often undergo extensive medical investigations, hospitalizations, invasive procedures, and costly treatments. Moreover, individuals with heightened concerns about their health may misuse healthcare services (Ford 1983; Kellner 1986; Lipowski 1988).

For communication, we frequently use language and our body. We begin with instinctual cries in infancy and gradually, through signs, social signals, and our narrative repertoire, we produce messages (Ünal, 2002). The language we speak shapes our perceptions and thoughts about the world (Whorf, 1956). Also, it is argued that invididual's templates about themselves and the world are shaped by recurrent parenting attitudes and behaviors during early stages of life (Bowlby, 1973; Safran, 1990; Young, 2017). The attitudes of parents are regarded as important factor for the development of children (Holden and Buck, 2002). Positive and supportive attitudes from parents contribute to the child's development, while negative and restrictive attitudes can lead to the emergence of certain mental problems (Seven, 2008). It has been shown that there is a significant relationship between psychosomatic symptoms and intrafamily conflicts in children and adolescents. It has also been demonstrated that impaired family functioning is one of the factors contributing to somatization disorder (Bouman, 2002). Also, the consistent and regular behavioral patterns exhibited by parents towards their children play a

decisive role in their emotional well-being and development of self-compassion (Thompson and Meyer, 2007; Hall, 2015; Pepping, et al, 2015). Characteristics such as receiving support from one's mother, experiencing a harmonious family environment, and developing a secure attachment during childhood have been associated with increased levels of self-compassion whereas "poor parenting" like showing low parental warmth, being overprotective and high rejection have been linked to decreased levels of self-compassion (Hall, 2015; Pepping et al., 2015).

Studies have indicated a correlation between somatization and a limited capacity to consciously perceive and acknowledge emotions, as well as effectively communicate and express them (Waller and Scheidt, 2006). Even it is founded that the suppression of the expression of emotions includes intense feelings is the primary cause of somatization (Koh, 2013). Additional to emotional expression, self-compassion could serve as a buffer effect for somatization since the aim is to adapt mindful, friendly and accepting approach toward suffering rather than experiencing emotional and physical harm (Lind et al., 2014; Huang et al., 2016; MacBeth and Gumley, 2012; Muris and Petrocchi, 2017). In summary, there is a growing significance in uncovering the mechanisms that underlie the connection between perceived parenting and somatization. Also, the mediating role of emotional expression and self-compassion would be meaningful since the studies showed that there are significant relationships between them (Koh, 2013; Huang et al., 2016; MacBeth and Gumley, 2012; Muris and Petrocchi, 2017).

Literature focused on the different relationships between perceived parenting, somatization, emotional expression and self-compassion separately (Bouman, 2002; Eray, Vural and Çetinkaya, 2015; Neff and McGehee, 2010; Ahmed and Bhutto, 2016). There are studies revealed relationship between emotional expression and somatization (Traue and Deighton, 2016; Güleç et al., 2004; Classen et al., 1996). Also, literature showed an association between self-compassion and somatization (Lind et al., 2014; Huang et al., 2016; Muris and Petrocchi, 2017). In addition to existing research, it is believed that providing a detailed explanation of the relationship between perceived parenting attitudes and somatization, considering the mediating roles of emotional expression and self-compassion, would be a novel contribution to the existing literature.

In the next paragraph, firstly, the definition and explanation of somatization will be discussed from different points of views. After that, the etiology, epidemiology of

somatization and psychodermatology will be detailed.

1.1. Somatization

The concept of somatization was first used by a psychoanalyst named Stekel who was a student of Freud in 1924. He explained the term somatization as the bodily expression of a neurosis that is hidden deep within (Lipowski, 1990). Stekel's concept of somatization corresponds to Freud's concept of conversion.

Lipowski (1988) defined somatization as the tendency to seek medical help based on the belief that a physical discomfort experienced without pathological evidence may be due to a bodily disturbance.

Menninger (1947) defined "somatization reactions" as the manifestation of anxiety through physical symptoms, serving as a means to prevent the anxiety from becoming conscious.

On the other hand, Kesebir (2004) said that “There is no well-defined diagnostic category for somatization; it is a clinical phenomenon that requires a multidimensional approach.” Simply, somatization can be described as the inclination to manifest psychological distress through physical symptoms, even when no identifiable pathological causes can be found (Gupta, 2006; Gureje, Simon, Ustun and Goldberg; Kirmayer, 1984; Kirmayer, 1984; Lipowski,1998; Kirmayer and Young, 1998). In conventional mental health, symptoms that cannot be medically explained are often categorized as “somatoform disorders” or, more lattery, "somatic symptom disorders". Another widely used term to describe these symptoms is "medically unexplained symptoms." (APA, 2013).

The present study uses the term “somatization”.

Three key factors are essential to differentiate somatization. Firstly, there should be a persistent presence of medically unexplained physical symptoms that significantly diminish the individual's quality of life. Secondly, individuals experiencing somatization tend to display an increased sensitivity to body’s sensations, being excessively alert or responsive to them. Lastly, the person tends to frequently seek medical assistance rather than addressing underlying emotional issues (Suen and Tusaie, 2004).

In medical literature, somatization is categorized according to the specific organ where damage in tissue occurs (Karslı, 2008).

1. **Dermatological symptoms:** Urticaria, eczema, psoriasis.
2. **Musculoskeletal symptoms:** Pain in joints, rheumatoid arthritis, spasmodic torticollis.
3. **Respiratory symptoms:** Hyperventilation syndrome, bronchial asthma, allergic rhinitis.
4. **Cardiovascular symptoms:** Coronary heart disease, migraine, essential hypertension.
5. **Gastrointestinal symptoms:** Ulcerative colitis, ulcer, gastric ulcer, cardiospasmus, dyspepsia, spastic colon (irritable bowel syndrome)
6. **Endocrine symptoms:** Diabetes mellitus, disorders of thyroid
7. **Reproduction and Urinary symptoms:** Disorders of menstruation, sexual dysfunctions, pseudopregnancy, enuresis, encopresis, infertility.
8. **Sensory organ and other system symptoms:** Atrophicae rhinitis, allergic reactions, tics.
9. **Pseudo-Neurological symptoms:** Numbness, paresthesia, loss of vision

Within the field of general medicine, somatic symptoms are commonly referred to as "functional somatic syndromes." Examples of such syndromes include "irritable bowel syndrome," characterized by abdominal pain and bowel problems, and "fibromyalgia," characterized by musculoskeletal pain, joint pain, and fatigue. (Brown, 2007). Most common symptoms are fatigue, pain and aches, chest pain, abdominal pain, back pain, dizziness, headaches, and palpitations (Creed and Barsky, 2004; Patel and Sumathipala, 2006).

1.1.1. History of Somatization

It is estimated that the earliest views on unexplained physical symptoms focused on disorders in the body and organ systems, dating back as far as 4000 years ago (Fischer-Homberger, 1972). In the 1900s BC, the Egyptians described unexplained physical symptoms as the "displacement of the uterus and its replacement with other organs." Therefore, the Greek term for uterus, "hysteria" was used for a long time to describe unexplained physical symptoms (Ford and Folks, 1985). During the Middle Ages, spiritual and physical illnesses were attributed to magical causes, and the belief that hysteria patients sold their souls to the devil prevailed (as cited in Çetin and Sözeri Varma, 2021).

Until the late 18th century, physicians have been aware of somatizing patients for centuries and these individuals have been labeled with various terms such as "hysteria," "hypochondriasis," and "melancholia." (Fischer-Homberger, 1972). Thomas Willis, who is considered the father of neurology, viewed hysteria in women and hypochondriasis in men as disorders of the brain. Thomas Sydenham, made significant contributions to the idea that hysteria and hypochondriasis are disorders of the mind rather than the body. George Cheyne used the term "English Disease" and wrote about hysteria and hypochondriasis as diseases of the brain and/or mind. The term "neurosis" was initially introduced by William Cullen, making him the first individual to employ this term. Jean-Martin Charcot, who practiced medicine at the Salpêtrière Hospital in Paris, used hypnosis in the diagnosis and treatment of hysteria. (Çetin and Sözeri Varma, 2021). Charcot and his students made significant contributions to the understanding of the mechanisms and treatment of hysteria (Ünal 2002). Paul Briquet was the first to describe the clinical presentation that forms the basis of the current definitions of somatization, initially referred to as "Briquet's Syndrome." Later, the term "somatization" was first used by the German psychoanalyst Wilhelm Stekel to describe this condition (Öztürk and Uluşahin, 2016). The clinical presentation that Briquet emphasized as hysteria was later attempted to be defined by Freud. Freud claimed that the origin of hysteria lies in early sexual experiences of patients and that individuals develop physical symptoms as a way to cope with these experiences. Later, Freud modified his stance and suggested that these mentioned sexual experiences are based on the patients' fantasies in their minds (Freud, 1916).

1.1.2 Somatization in Diagnostic Manual of Mental Disorders

The classification systems first introduced the term "hysteria" in 1980 with DSM III (APA, 1980). This disorder was defined as recurrent and varying physical complaints without an organic cause. In the later edition, DSM-IV, this diagnosis was defined as a disorder characterized by four pain symptoms, two gastrointestinal symptoms, one sexual symptom, and one pseudo-neurological symptom, with an onset prior to the age of 30. In the DSM-V, a modification has been made in the nomenclature, replacing "Somatization Disorder" with "Somatic Symptom Disorder," which falls under the category of somatic symptom and related disorders. Unlike previous

versions, DSM-V no longer includes the phrase "without an organic origin." Instead, it now requires the presence of intense thoughts, emotions, or behaviors related to somatic symptoms. To summarize, the diagnosis of Somatic Symptom Disorder involves individuals who exhibit disproportionate and persistent thoughts about the significance of their symptoms for a minimum duration of six months. They consistently experience heightened anxiety related to their health or symptoms and dedicate excessive time and energy to their concerns, alongside other associated thoughts, emotions, or behaviors. (APA, 2013). The diagnostic criteria for Somatic Symptom Disorder is given in the Table 1.

Table 1. The Diagnostic Criteria for Somatic Symptom Disorder (APA, 2013).

The Diagnostic Criteria for Somatic Symptom Disorder
A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.
C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).
Specify if:
Persistent: A persistent course is characterized by severe symptoms, marked impairment and long duration (more than 6 months).
Specify current severity:
Mild: Only one of the symptoms specified in Criterion B is fulfilled.
Moderate: Two or more of the symptoms specified in Criterion B are fulfilled
Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

1.1.3. Epidemiology of Somatization

According to Lipowski (1988), somatization is a pervasive and unresolved issue in psychiatry and patients with somatization utilize healthcare services extensively.

Also, diagnosing and managing their conditions can be challenging, as they may or may not have underlying psychiatric disorders. Based on the APA's 2013 studies, it was found that the estimated prevalence of Somatic Symptom Disorder in the general population falls within the range of 5-7%, while it ranges from 4-15% in the medical population (APA, 2013). Somatization occur at varying frequencies across different age groups within the general population. In young groups, the prevalence ranges from 11% to 21%, while in middle-aged individuals, it falls between 10% and 20%. In the older age group, the frequency ranges from 1.5% to 13% (Van Driel et al., 2018). Somatization is common in early adulthood, typically in the 20s and symptoms generally decrease after the age of 65 (Hilderink et al., 2013). In older adults, certain somatic symptoms like fatigue and pain may be perceived as normal aspects of aging, leading to their normalization (APA, 2013b).

A study conducted on 628 women who were not seeking clinical treatment aimed to investigate the occurrence of conversion symptoms, which are a particular type of somatization, throughout their lifetime. The results revealed an alarmingly high rate, with 48.7% of the women exhibiting conversion symptoms (Sar, Akyüz, Dogan and Öztü, 2009).

In a study comparing university students to the general population, it was found that the prevalence of somatization disorder was higher among university students (7.7%) than in epidemiological studies of the general population (1.5%) (Özenli et al., 2009). When examining the distribution by age, it was observed that a significant proportion of children experience somatic symptoms. For instance, 20% to 55% of children were reported to suffer from headaches, while persistent abdominal pain accounted for 5% of pediatric office visits. During adolescence, approximately 10% of youths reported experiencing frequent headaches, nausea, fatigue, and chest pain (Silber and Pao, 2003).

In the population, the most common somatic symptoms are back pain and headaches (Hiller, Rief and Brahler, 2006). The most frequently reported symptoms in the Turkish society were dizziness (22.9%) and fainting (22.1%).

Research findings indicate that among psychological disorders, major depressive disorder is the most commonly associated with somatization (Gureje et al., 1997; Russo et al., 1994; Simms, Prisciandaro, Krueger, and Goldberg, 2012). Additionally, somatic symptoms were commonly found to coexist with both depressive and anxiety disorders (Bekhuis, Boschloo, Rosmalen and Schoevers,

2015; Sayar, Kirmayer, and Taillefer, 2005). Individuals diagnosed with Generalized Anxiety Disorder (GAD) were found to experience a higher frequency of somatic symptoms compared to those without generalized anxiety disorder (Groen, et al., 2020). Additionally, panic disorder was identified as a risk factor to have somatic symptoms (Brown, Golding, and Smith, 1990). Somatic symptoms are frequently observed in not only depressive disorders, panic disorder, and generalized anxiety disorder but also in conjunction with phobic disorders and obsessive-compulsive disorder (Brown et al., 1990).

It has been found that somatization disorder is observed 5 to 20 times more frequently in women compared to men (Işık et al., 2008).

The risk factors for somatization include being female, low socioeconomic status, low education level, family history of somatization, belonging to a minority group, certain personality traits, various social stressors, childhood traumas, and mood disorders (De Gucht and Fischler, 2002; Ünal and Coşar, 2021).

1.1.4 Etiology of Somatization

During the initial emergence of the term "somatization," the psychodynamic perspective played a dominant role in explaining its predictors. According to this view, somatization was believed to be a manifestation of psychological distress, where certain physical symptoms served as a psychogenic defense mechanism (Kirmayer and Young, 1998; Waitzkin and Magana, 1997). Psychosocial conflicts were thought to be transformed into bodily distress as a means of protecting individuals from confronting the underlying psychological conflicts (Kirmayer, 1984; Lipowski, 1988).

According to Lipowski (1987), somatization is not a disorder; it is a cluster of experiential, cognitive, and behavioral components. The experiential component refers to the bodily symptoms that a person perceives, such as pain. The cognitive component involves attributing these sensations to a physical illness. The behavioral component includes seeking medical help or engaging in other behaviors in response to the distressing symptoms.

In the historical process, various definitions have focused on either biological or psychological processes. Research on family history has shown that somatic symptoms tend to occur within families (Nolen-Hoeksema, 2011). Even though the

information on the genetics of somatoform disorders is limited, research conducted with twins has provided support for a link between genetic predisposition and the occurrence of somatization disorders (Silber, 2011). Furthermore, considering a behavioral standpoint, it has been proposed that parents who experience somatic symptoms may have a higher likelihood of neglecting their children. As a consequence, children may acquire the belief that the sole means of receiving care and attention is by manifesting illness (Nolen-Hoeksema, 2011). Also, somatization has a cultural dimension. The idea of having a physical illness, manifested through bodily symptoms, is often perceived as more legitimate than a mental illness, which allows individuals to receive more support from their surroundings (Baskak and Çevik, 2007).

Certain personality traits can influence the development of somatization. According to a study, dependent, histrionic, and aggressive traits are twice as prevalent in somatization patients compared to anxiety and depression patients (Stern, Murphy and Bass, 1993). The frequency of somatization is higher in individuals with borderline personality disorder (Mai, 2004). There are also studies suggesting a link between somatization and antisocial personality traits (Dülgerler, 2000). Factors such as a family history of alcoholism, early traumatic life events, having an antisocial parent, and a history of sexual abuse contribute to the manifestation of somatization (Çetin and Sözeri Varma, 2021).

In the following part, somatization will be discussed from various perspectives such as psychoanalytical, cognitive and behavioral.

1.1.5. Psychoanalytical Perspective

Psychoanalysts used the term “somatization” to describe unconscious defense mechanism. Freud made a distinction between the bodily symptoms of "psychoneurosis," which are symbolic and arise from internal conflicts often rooted in early trauma, and the "actual neuroses," which refer to intense physical experiences such as overwhelming anxiety that can coexist with or conceal fear (Freud, 1894). He proposed that in the case of actual neuroses, these experiences arise from physical sensations that are unable to penetrate the conscious mind. He contrasted them with the physical symptoms of hysterical conversions. In this process, repressed internal conflicts generate psychological stimulation, but since

they are kept out of conscious awareness, they manifest as physical symptoms. Conversions regarded as more symbolic which originates from internal conflicts; contrarily, somatic symptoms don’t have symbolic meanings but occurs with the tissue damage (Gubb, 2013; İkiz, 2012).

Gubb (2013) referred to two contemporary schools of thought in psychosomatic theory known as the "Paris School of Psychosomatics" and the "Attachment Approach.". The Paris School viewed psychosomatic illness as the speechless mind, while the Attachment approach conceptualized it as the speaking body. According to the Paris School's perspective, somatization can occur through two pathways: In one of these pathways, the process begins in individuals who exhibit neurotic or normal psychological functioning. Following an experience that overwhelms the ego's ability to manage emotions, such as a traumatic event, there is a disruption in mental functioning. As a result, individuals regress and direct excessive libidinal energy towards bodily processes, leading to either overactivity or underactivity of the physical systems. This regression serves as a temporary relief for the overwhelmed psyche. The second pathway of somatization involves the inability of expression of drives, resulting in typically progressive and severe illnesses such as autoimmune diseases or cancer, which can even be life-threatening. In individuals who have experienced psychological trauma, this uncontrolled release of drives is particularly severe, as it reopens early and profound narcissistic wounds. The Paris School argued that the level of individuals' mentalization determines which somatization process takes place and ultimately influences the outcome of the symptoms. According to the Attachment Approach, the quality of the initial symbiotic attachment between an infant and their mother or primary caregiver significantly influences the postnatal development of the brain. This approach suggests that if there are issues with attachment and the mother is unable to regulate the child's experiences, the infant may struggle to effectively modulate their own arousal and emotional states. Psychosomatic patients often report having mothers who are either excessively possessive and overwhelming or mothers who are unresponsive to the child's needs (Gubb, 2013).

Rubin (1959) observed the occurrence and different manifestations of somatic symptoms during psychoanalysis. In exploring the factors contributing to somatization, he particularly highlighted changes in the dynamics of the neurotic process. According to Rubin's theory, somatization is understood as a symbolized

way of experiencing inner psychological events, primarily through the use of projection (externalizing or internalizing) and specialization, as a mode of self-presentation.

1.1.6. Cognitive and Behavioral Perspective

Barsky (1992) introduced the concept of "somatosensory amplification." This concept refers to an elevated tendency to perceive unpleasant bodily sensations and visceral experiences, as well as a propensity to misinterpret existing bodily symptoms as pathological rather than perceiving them as normal. Furthermore, it is believed that psychological and emotional distress contribute to the heightened perception of somatic sensations due to faulty information processing. Kirmayer and Robbins (1991) similarly examined the role of symptom attribution style as a contributing factor to somatization and psychological distress. They proposed that the way individuals attribute symptoms can lead to the conversion of psychological or emotional issues into physical complaints, which in turn is associated with the experience of somatic symptoms.

Behavioral theory suggests that somatic symptoms are learned and reinforced through rewards. Somatization is believed to be a maladaptive behavior developed by individuals to fulfill their social needs. During childhood, an individual may observe and learn the sick role by witnessing a sick parent or sibling. This plays a significant role in the manifestation of somatization (Mai, 2004). The learning theory places importance on the behavioral reinforcement system, social influences, and the secondary benefits of assuming the sick role in the process of somatization. The learned sick role can be attributed to two reasons. Firstly, during childhood, an individual may have experienced neglect and learned that they receive attention from their parents only when they are sick, thus reinforcing this behavior. Secondly, the individual may have observed or experienced certain privileges or secondary gains associated with illness, such as resting or avoiding responsibilities (Çetin and Sözeri Varma, 2021). It is suggested that somatization is a maladaptive strategy employed to fulfill social needs and compensate for deficiencies in an individual's adaptive behavioral repertoire. The prior experience of illness is considered a crucial factor in the development of somatization (Mai, 2004).

1.1.7. Psychodermatology

Psychosomatic factors are believed to have significant involvement in disturbances related to the skin although it has long been underestimated (Gupta and Gupta, 1996; Jafferany, 2006).

The skin is widely acknowledged as the largest organ of the human body (Koblenzer, 1997). Furthermore, the skin is one of the earliest organs to develop during embryonic development, and according to biological principles, organs that form earlier are more likely to have greater significance and importance (Anzieu, 1989). The skin and the central nervous system have their origins in the embryonic ectoderm (Anzieu, 1989; Osman et al., 2011; Koblenzer, 1997). This shared embryonic origin can be seen as a metaphorical representation that stimulates contemplation about the interconnectedness of the skin and psyche (Osman et al., 2014). Skin-to-skin contact plays a crucial role in regulating the physiological functions of newborn infants, including blood pressure, heart rate, and respiratory functions. This contact is responsible for maintaining homeostatic organization in infants who are entirely dependent and helpless (Koblenzer, 1997). Placing the infant on the mother's body at birth has a calming effect on the nervous and agitated infant through the contact between their skins (Levine and Stanton, 1984). The pleasurable experience of being held facilitates the mutual exchange of sensory stimuli, including smells, touches, tastes, and warmth, between the caregiver and infant. Consequently, the skin serves as a means for nonverbal communication. Even from birth, emotions that are non-verbal in nature are experienced somatically through the skin (Weiss, 1999). As a result of this contact, the mother has the ability to convey various emotions through the skin. The range of emotions in this context can span from feelings of love, acceptance, and pride to emotions of non-acceptance, rage and even disgust (Koblenzer, 1997). According to the theories proposed by Didier Anzieu (1989) and Esther Bick (1968), the formation of the psychic apparatus is intricately linked to and dependent on the functions of the skin as well as the early tactile experiences within the mother-infant relationship. Put simply, tactile experiences on the somatic level gradually transition into the realm of the mind, incorporating representations that involve the ego and its functions (Anzieu, 1989). Therefore, when the mother provides appropriate care to the infant, including meeting their physical needs and offering nurturing through touch, it functions as a mechanism for

regulating not only biological processes but also the development of emotions and behaviors. Additionally, this kind of care contributes to the infant's susceptibility to skin-related diseases (Hofer, 1978). Disturbances or disruptions in maternal care can lead to immediate emotional and physical consequences, which can be observed in the form of infantile psychodermatology. Also, these maternal disturbances can also have long-lasting impacts in adulthood, leading to emotional difficulties and specifically, disturbances related to the skin, as if the skin is unable to provide the necessary sense of containment or support (Howlett, 1999). According to Conor (2004), the skin has the ability to express emotions and inner states in a manner that individuals have limited control over, as if they are overwhelmed by them. This can be observed, for instance, when someone blushes in an embarrassing situation. Psychoanalytic theory expands on this concept by proposing that the skin not only reflects conscious emotions and states in an uncontrolled manner but also has the ability to express emotions and states that individuals may not be consciously aware of. Hence, occurrences of dermatological complaints can be interpreted as outward expressions of unconscious internal states (Conor, 2004). The skin can serve as a direct reflection of an individual's mental world, where its expressiveness can be regarded as a representation or metaphorical depiction of their mental states (Conor, 2004). Importantly, it is essential to highlight that becoming fixated on emotions during early stages of development can serve as a mediator in the emergence of specific skin-related ailments in later years (Koblenzer, 1983). Within psychoanalytic theory, psychodermatology is often linked to a regression to earlier stages of psychological development. These conditions can be the outcome of psychological disarray caused by either conscious or unconscious stress, disturbances in the mutually beneficial bond with the mother, struggles in the initial stages of self-identification, insufficient or prolonged dependency, limited ability to symbolize, challenges in separating and forming an individual identity, and conflicts pertaining to intimacy and distance within relationship (Ulnik, 2013).

Somatization is a prevalent condition that impacts a considerable segment of the population and is influenced by multiple factors, manifesting in diverse manners. Also, it can be explained by various perspectives theoretically. It has been found that somatization particularly affects young adults and women. Common symptoms are fatigue, pain and aches, chest pain, abdominal pain, back pain, dizziness, headaches, and palpitations. Additionally, symptoms manifested on the skin are also explained

within the concept of somatization.

In the next paragraph, perceived parenting attitudes, parenting styles, schema perspective of parenting styles, studies on parenting and lastly, relationship between parenting styles and somatization will be mentioned.

1.2. Perceived Parenting Attitudes

Parenting is a reflection between parent and child relationship that plays a crucial role. It involves a range of specific attitudes and behaviors that work together to influence child development and establish an emotional connection. Parental behaviors serve as a means of expression through which the parent-child bond is formed (Darling and Steinberg, 1993). The attitudes of parents are considered important for the development of children (Holden and Buck, 2002). It is believed that caregivers' facial expressions, tone of voice, labeling of emotions, and linking them with behavior and representations is important for psychological awareness development as a prerequisite for understanding one's inner world and others (Greenspan, 1997). Children's development is positively influenced by parental responsiveness, warmth, and providing appropriate levels of stimulation (Field, 1978; Goldberg, 1977; Gratton, 2001; Sable, 2008) On the other hand, being overly directive, providing high levels of stimulation, and responding without considering the child's needs have a detrimental impact on child development (Field, 1980; Murray, Waller, and Legg, 2000).

During the normal development of children, a range of cognitive, emotional, and social differences can be observed based on their parents' behaviors (Wake et al., 2007). Parent-child relationship and personality development have been addressed in this context by various psychological theorists from the past to the present (Winnicott, 1986; Klein, 1957; Kernberg, 1980; Kohut, 1998; Bowlby, 1973; Young, Klosko and Weishaar, 2003).

Winnicott (1986), an object relations theorists emphasized the concepts of the "good-enough mother" and the "holding environment" as crucial for a child's healthy personality development. He highlighted the importance of a caregiver who can fulfill the child's requirements and provide a nurturing environment without causing fixations or disruptions during the transition from omnipotence to objective reality (Winnicott, 1986). Other object relations theorists also propose that the formation of

self and other representations occurs in early caregiver-infant/child relationships, and these cognitive representations play a central role in personality development (Klein, 1957; Kernberg, 1980).

According to self-psychology, empathic mirroring in parent-child interactions is essential for the development of a cohesive self and personality. Kohut (1998) emphasized that the absence of empathic mirroring in parental caregiving is a significant risk factor for the development of narcissistic personality disorders. In this context, empathic mirroring refers to the parent's capacity to accurately mirror and acknowledge the child's experiences, emotions, and needs, thereby fostering the child's self-esteem, identity formation, and overall psychological welfare (Kohut, 1998).

Attachment theory is another widely accepted theory that suggests that parent-child interactions influence an individual's personality and interpersonal behavior in adulthood. Bowlby (1973) proposed that a strong attachment between the mother and child is a lifelong process that enhances the child's chances of survival in the face of danger, and the mental processes influenced by this attachment persist in a primitive form in adult interpersonal relationships. Put simply, the nature of early attachment experiences molds a person's internal working models of relationships, which subsequently impact their ability to regulate emotions, engage in social interactions, and develop their overall personality during adulthood (Bowlby, 1973).

The Schema Model is another model that suggests that the early parent-child relationship forms the structure of the core beliefs children develop about themselves and others in their interpersonal relationships (Young, Klosko, and Weishaar, 2003). In schema therapy, it is believed that consistent failures to meet a child's fundamental emotional needs result in the formation of negative schemas. These negative schemas are thought to be connected to problematic behavioral tendencies that manifest during adolescence and continued into adulthood (Louis, 2021). Young (1990) not only emphasizes the significance of unmet needs in parent-child relationships but also introduces the Schema Therapy model and techniques, which have been demonstrated significant efficacy in the therapeutic management of persistent personality disorders. (Young, Klosko, and Weishaar, 2003; Young, 1990). Schema therapy is an integrative and multi-modal approach that incorporates key elements from various therapeutic modalities, such as Cognitive Behavioral Therapy, Object Relations Theory, Gestalt Therapy, Transactional Analysis, Mentalization-Based

Therapy, Dialectical Behavior Therapy, and Positive Psychology (Chard et al., 2005; Lockwood and Shaw, 2012).

Based on these theories, it can be concluded that parenting attitudes play a significant and influential role in a person's life. Parenting attitudes, which can be explained from various perspectives by different theories, have the potential to impact individuals from childhood to adulthood in diverse ways. Further sections will discuss this topic in detail.

1.2.1. Parenting Styles

Initial studies in developmental psychology investigated parenting styles by employing a dimensional framework. These dimensions included detachment/involvement (Baldwin, 1948), emotional warmth/hostility, autonomy/control (Schaefer, 1959), and warmth and indulgence (Sears, Macoby, and Levin, 1957). Nonetheless, Baumrind (1966) acknowledged that the dimensional approach had its shortcomings in capturing the combined impacts of various parenting dimensions. As a result, typological approach is started to better study and understand parenting styles. Baumrind (1966, 1978) introduced three distinct prototypes of parental practice: permissive, authoritarian, and authoritative.

Permissive parents demonstrate a tolerant and accepting attitude towards their children's impulses, interests, and actions. They do not impose demands or exert control over their children. Instead, they aim to liberate their children from external social standards as much as possible. Permissive parents do not try to shape an ideal image for their children to achieve in adulthood; rather, they position themselves as a resource that their children can utilize as they see fit. Consequently, they allow their children a significant degree of self-regulation (Baumrind, 1966; 1978).

Authoritarian parents exercise strict control over their children and aim to mold their behaviors. They prioritize obedience to both parental and societal standards and rules. Authoritarian parents strive to present themselves as ideal role models for their children and consequently dictate the direction of their children's behaviors, limiting their autonomy. They do not encourage their children to regulate their own activities (Baumrind, 1966; 1978).

Authoritative parents also exert a level of control over their children. However, authoritative parents value the autonomy of their children within the boundaries of

acceptable parental discipline. They establish reasonable standards for the future and make an effort to guide their children's behaviors in a rational manner, taking into account the children's own capabilities and interests. Authoritative parents establish reasonable and rational standards for their children's future. They strive to guide their children's behaviors in a rational manner, considering the unique capabilities and interests of each child. Authoritative parenting practices blend elements of both authoritarian parenting, which emphasizes children taking on responsibilities akin to adults, and permissive parenting, which emphasizes children having rights akin to adults. Authoritative parents comprehend the significance of striking a balance between parental responsibilities and children's rights. They acknowledge that the parent-child relationship evolves across various developmental stages and adapt their approach accordingly (Baumrind, 1966; 1978).

Later, Maccoby and Martin developed a fourfold parenting typology based on Baumrind's framework (Kurdek and Fine, 1994; Steinberg, et al., 1991; Steinberg, Elmen, and Mounts, 1989). Their typology suggests that the parenting styles can be characterized by two underlying dimensions: responsiveness (warmth) and demandingness (control). Responsiveness dimension is related with affection, care and acceptance (Brobhy-Herb et al.,2012). The dimension of demandingness is associated with restriction, intrusion, control and discipline (Rohner, 1986). The combination of these two dimensions results in the formation of four parenting styles: authoritative parenting style (high in both demandingness and responsiveness), authoritarian parenting style (high in demandingness but low in responsiveness), permissive/indulgent parenting style (high in responsiveness but low in demandingness), and neglectful parenting style (low in both responsiveness and demandingness) (Kurdek and Fine, 1994; Steinberg et al., 1991; Steinberg et al., 1989). These parenting styles are shown in the Table 2.

Table 2. Parenting Styles Model of Maccoby and Martin

Permissive	**Authoritative**
"Whatever you want!"	*"Let's discuss this"*
Low expectations	High expectations
Few rules	Clear standards
Indulgent	Assertive
Accepting	Democratic
Lenient	Flexible
Avoids confrontation	Responsive
Warm	Warm
Uninvolved	**Authoritarian**
"I really don't care"	*"Because I said so!"*
No expectations	High expectations
Few rules	Clear rules
Absent	Forceful
Passive	Autocratic
Neglectful	Rigid
Uninterested	Punishment
Competing priorities	Limited warm

1.2.2. Schema Therapy Model

Schema Therapy is a comprehensive treatment model developed by Jeffrey Young (1990, 1999) for addressing personality disorders and significant characterological problems that have not been effectively treated using traditional therapy methods. The Schema Therapy Model is a structured and systematic model that integrates various elements from cognitive-behavioral, psychodynamic, Gestalt, constructivist, object relations, and attachment theories in terms of conceptualization and therapeutic approaches (Young et al., 2003). Schema therapy focuses not only on psychological symptoms but also on the underlying personality traits that contribute to these symptoms (Young, Klosko and Weishaar, 2003). The theory stated that secure attachment to others (which involves feelings of safety, stability, care, and acceptance), autonomy, competence, self-perception, the freedom to express needs and emotions, spontaneity and play, realistic boundaries, and self-control are fundamental universal needs that form the foundation of psychological well-being.

Whether these needs are adequately met or not is determined by the child's temperament, early environment, and relationship with caregivers (Young et al., 2003). In the Schema Therapy Model, three key concepts play a central role: Early maladaptive schemas, maladaptive coping styles and schema modes. Early maladaptive schemas are dysfunctional patterns of thinking that develop about oneself and others in relationships. These maladaptive schemas develop during childhood within the context of critical parent-child interactions and unmet needs and play a significant role in subsequent life experiences (Lobbestael, van Vreeswijk and Arntz, 2007).

Young and colleagues (2003) argue that there are two primary schema processes: schema healing and schema maintenance. The main goal of Schema Therapy is to facilitate schema healing. The mechanism that leads to schema maintenance is the maladaptive coping styles developed to accommodate maladaptive schemas (Young et al., 2003). The second concept emphasized by Jeffrey Young (2017) is maladaptive coping styles. According to this concept, individuals maintain their schemas in three ways: surrender (acquiescing to the schema), avoidance (avoiding the activation of the schema), and overcompensation (fighting against the schema as if it were untrue) (Young et al., 2003; Lobbestael and Arntz, 2007). In addition to early maladaptive schemas and coping styles, the third fundamental concept of the Schema Therapy Model is schema modes (Young et al., 2003). Schema modes refer to the emotional states and accompanying adaptive or maladaptive coping responses that we experience in the present moment. Young (2003) defines early maladaptive schemas as lifelong recurring patterns of self-destructive emotions and cognitions that begin in childhood or adolescence. He argues that individuals' behaviors are influenced by the schemas they possess, but he emphasizes that behavior is not a part of the schema itself. In other words, he believes that behaviors are driven by schemas or emerge as a response to schemas (Young et al., 2003).

Young et al., (2003) have identified 18 schemas that represent emotional needs within five schema domains. These five schema domains are: Disconnection and Rejection/Abandonment, Impaired Autonomy and Performance, Impaired Limits, Orientation to Other, Hypervigilance and Inhibition. The basic emotional needs, schema domain and early maladaptive schemas are shown in the Table 3.

Table 3. The Basic Emotional Needs, Schema Domains and Early Maladaptive Schemas

Basic Emotional Need	Schema Domain	Early Maladaptive Schemas
1. Secure attachment	Disconnection and rejection	1. Abandonment/instability 2. Mistrust/abuse 3. Emotional deprivation 4. Defectiveness/shame 5. Social isolation/alienation
2. Autonomy, competence and sense of identity	Impaired autonomy and performance	6.Dependence/incompetence 7. Vulnerability to harm or illness 8. Enmeshment/undeveloped self 9. Failure
3. Realistic limits and self-control	Impaired limits	10. Entitlement/grandiosity 11. Insufficient self-control/self-discipline
4. Freedom to express valid needs and emotions	Other - directedness	12. Subjugation 13. Self-sacrifice 14. Approval-seeking/recognition seeking
5. Spontaneity and play	Over-vigilance and inhibition	15. Negativity/pessimism 16. Emotional inhibition 17. Unrelenting standards 18. Punitiveness

1.2.3. Perceived Parenting and Early Maladaptive Schemas According to Schema Perspective

When fundamental universal needs are not properly met, maladaptive schemas referred to as early maladaptive schemas emerge (Rafaeli et al., 2013). These schemas are rooted in describing parent-child interactions, and parenting styles have been identified to characterize how individuals perceive and remember their parents. Due to their focus on thoughts about how individuals perceive and remember their parents, these parenting styles are referred to as "perceived parenting styles" (Soygüt, Çakır, and Karaosmanoğlu, 2008).

According to schema-focused approaches, the core of individuals' evolving cognitive patterns regarding themselves and the world is believed to be rooted in early repetitive parental attitudes (Bowlby, 1973; Safran, 1990; Young, et al., 2003). Schema Therapy Model developed by Young and colleagues (2003), stated that there are certain core emotional needs that individuals need to have met during childhood in order to be psychologically healthy and adaptive. These needs, believed to be universal, include secure attachment to others, autonomy, competence and identity, expression of needs and emotions, spontaneity, and play (Soygüt, Çakır and Karaosmanoğlu, 2008). When the core emotional needs are met by parents, it contributes to the development of a healthy perspective in the individual. Nonetheless, when these fundamental needs are insufficiently fulfilled, it can result in the formation of maladaptive schemas in the child (Young et al., 2003). As argued in attachment theory and many other approaches, "the child's representations of the family form the basis for the child's representations of the entire world, making early interactions with parents of great importance." The experiences the child has in later periods, such as friendships, school, and social environment, can also contribute to the development of schemas. However, these schemas developed through later experiences are not as strong and resilient as schemas developed through family representations. In a study done by Soygüt and Çakır (2009), it is founded that perceived parenting styles have predictive power over interpersonal schemas.

1.2.4. Parenting Styles According to Schema Therapy Model

According to schema-focused approaches, individuals' evolving mental templates about themselves and the world are shaped by repeated early parental attitudes and behaviors (Bowlby, 1973; Safran, 1990; Young, 2017). The parenting styles, originally developed and conceptualized by Young (1990), have been studied in Turkish literature with 10 sub-dimensions (Soygüt, Çakır, and Karaosmanoğlu, 2008). These parenting styles play a central role in the development of dysfunctional beliefs in individuals (Young, 1994).

Emotionally Depriving Parenting: Parents who adopt this parenting style deprive their children of emotional nurturing.

Overprotective/Anxious Parenting: This is a parenting style characterized by being overly protective, excessively anxious, and hindering the development of children's independence and individuation.

Belittling/ Criticizing Parenting: If this is an aspect of parenting styles, it represents parental behaviors that belittle their children through their words and actions, making them feel flawed and inadequate.

Conditional/Achievement Focused Parenting: The parenting model that implies that having a positive outlook towards their children is dependent on the child's achievements.

Pessimistic/Worried Parenting: It is the anxious and fearful parenting style. It reflects angry parents who have a pessimistic outlook on life.

Punitive Parenting: It reflects the parenting model that responds to children's mistakes with punishments.

Restricted/Emotionally Inhibited Parenting: It is the parenting style that reflects the ability of parents to share their emotions with their children.

Normative Parenting: It reflects the parenting model that controls or hinders the independence of their children. Parents who adopt this parenting style do not view their children making their own decisions positively and act in a way that limits the development of the child's sense of self.

Exploitative/Abusive Parenting: It reflects the parenting style that adopts exploitative and abusive behavior in parent-child relationships.

Over-permissive/ Boundless Parenting: It is the parenting style characterized by a lack of discipline and rules.

(Sheffiled et al., 2005; Soygüt et al., 2008)

Bo et al., (2017) conducted a study investigating the associations among parenting styles, schemas, and the wounded child mode. According to their finding, emotionally depriving parenting was primarily associated with emotional deprivation, social isolation, and incompetence schemas. Overprotective parenting was mainly related to the enmeshment schema. Belittling parenting was primarily linked to emotional deprivation, social isolation, incompetence, pessimism, and mistrust/abuse schemas. Normative parenting was primarily connected to the subjugation, enmeshment, emotional deprivation, social isolation, and pessimism schemas. Emotionally inhibited parenting was mainly related to emotional deprivation, emotional inhibition, and social isolation schemas. Punitive parenting was primarily associated with emotional deprivation, social isolation, mistrust/abuse, incompetence, and punitiveness schemas. Conditional parenting was primarily associated with the approval-seeking schema. The wounded child mode was found to be most strongly associated (showing a moderate level of relationship) with belittling, emotionally neglectful, controlling, punitive, pessimistic, and emotionally inhibited parenting styles.

1.2.5. Studies on Parenting Attitudes

Extensive literature exists that delves into the impact of perceived parental attitudes on the well-being and psychological well-being of individuals (LeMoyne and Buchanan, 2011; Perris, Arrindell, and Eisemann, 1994; Schnuck and Handal, 2011). In a study conducted by Lavasani, Borhanzadeh, Afzali, and Hejazi (2011), it was discovered that individuals who perceived their parents as more authoritative or permissive had lower levels of psychological well-being. Multiple studies in the literature have consistently revealed that parental authoritarianism has a detrimental effect on self-esteem and increases the risk of experiencing depression (Chapman, 2012; Heppner and Lee, 2002; Patock-Peckham and Morgan-Lopez, 2007; Wolfradt, Hempel, and Miles, 2003). On the other hand, parental nurturance and emotional warmth has been found to have a positive effect on self-esteem, resilience depression (Chapman, 2012; Wolfradt et al., 2003; Brennan, Le Brocque and Hammen, 2003). Likewise, elevated levels of perceived social support have been linked to enhanced psychological well-being in various studies (Lavasani et al., 2011). Also, it is found

that parental acceptance has a positive correlation with various adjustment variables, including self-reliance, psychosocial competence, school engagement, and academic success. Conversely, strict control has been shown to have a negative correlation with these same variables (Kurdek and Fine, 1994; Steinberg, et al., 1991; Steinberg, Elmen, and Mounts, 1989). Another study conducted by Bourne et al., (2014), significant positive associations were found between psychological awareness and maternal warmth, while a significant association was found between psychological awareness and paternal overprotection (Bourne et al., 2014). The association was found to be negative.

Kapçı and Hamamcı (2010) examined the relationship between family functioning and psychological symptoms, it was found that the prediction of psychological symptoms by negative family functioning stems from the Emotional Deprivation schema (Kapçı and Hamamcı, 2010). There are other studies that demonstrate the mediating role of the Emotional Deprivation schema domain. For instance, a study conducted with individuals diagnosed with eating disorders discovered that the Social Isolation schema, evaluated within the Emotional Deprivation schema domain, acted as a mediating factor in the connection between eating disorders and negative parental attitudes (Jones, Harris and Leung 2005). There are also studies indicating significant relationships between early maladaptive schemas and experiences of neglect and abuse in childhood (Cecero et al., 2004). Specifically, perceptions of parents as cold, rejecting, and excessively controlling (Murris, 2006; Harris and Curtin, 2002; Leung et al., 2000), as well as experiences of neglect and abusive events (Hartt and Waller, 2001; Waller et al., 2001), have been found to be associated with early maladaptive schemas. Lastly, similar to various aspects of human life, gender has been identified as a significant factor in determining perceived parenting styles, results showed that females were found to be more likely to expect paternal disapproval than males (Hampton et al., 2005).

1.2.6. Somatization and Parenting

It has been observed that individuals with somatization disorder often grew up in unhealthy family environments during their childhood, experiencing physical and sexual violence (Kinzl et al., 1995; Kırpınar, 2014; Kesebir, 2004), and having a history of alcohol and substance abuse by their parents (Dülgerler, 2000), and

various traumatic experiences (Katon et al., 2001; Imbierowicz and Egle, 2003; Spitzer et al., 2008). Also, researches showed that individuals who attached insecurely to their caregivers report higher levels of somatic symptoms (Ciechanowski et al., 2002; Wearden et al., 2005).

From a learning perspective, it is proposed that the association between somatization and parenting attitudes can be elucidated through mechanisms of operant conditioning, such as reinforcement, punishment, or the act of ignoring reactions (Fordyce, 1978). Positive or negative reinforcement, such as parental attention or omission of negative affairs can strengthen somatization. Conversely, negative reactions or minimizing responses to somatic complaints may decrease their prevalence. These reactions from parents are likely to be associated with adolescents' functional impairment. Similarly, punishment from parents was associated with higher somatization (Bergstrom et al., 2001; Turk and Rudy, 1990). Contrarily, ignoring the somatic symptoms of children was found to be a factor to minimize somatization. Additionally, encouraging/monitoring behaviors of parents seems to be protective for somatization (Walker et al., 2006).

Minuchin and his colleagues (1975) presented a ‘psychosomatogenic family model’ and described certain family interaction patterns for the development of psychosomatic problems. They identified four essential interaction characteristics necessary for a particular context. These characteristics include enmeshment, which refers to a strong sense of responsiveness and involvement between individuals; over-protectiveness, indicating a high level of concern for each other's well-being; rigidity, indicating a strong commitment to maintaining the existing state or structure; and lack of conflict resolution, suggesting a lack of explicit negotiation or resolution of differences between individuals (Minuchin et al., 1975). Parental overprotection may be preventive of developing coping mechanism strategies for somatization since active coping mechanism strategies have been found to be important for dealing with somatization (Sanders et al., 1994).

Another study revealed that adolescents experienced more psychosomatic symptoms in families characterized by a lack of emotional support, high levels of intrusiveness, and irritability (Eray, Vural and Çetinkaya, 2015). It is also noted that parents of children with chronic abdominal pain exhibit more psychological symptoms, and the presence of a chronic physical illness in family members is associated with somatic symptoms in children (Wasserman, Whitington and Rivara, 1988). A significant

number of individuals with somatization disorder have been brought up in emotionally distant and unsupportive family environments, frequently marked by instances of emotional or physical abuse (Brown et al., 2005; Feldman et al., 2010; Rhee et al., 2005). In a study conducted by Güleç et al., (2013), it was found that physical abuse and emotional neglect in family have predictive effects on somatization. Furthermore, insufficient or disrupted mother-child relationships were found to independently predict somatization (Luminet, 1994). Also, it is revealed that higher parental over-protection is significantly related to higher physical complaints (Fisher and Chalder, 2003).

In the next paragraph, emotional expression firstly will be discussed with theoretically such as evolutionary perspective, then the inhibition model, development of emotional expression and studies about it will be detailed, lastly, its relations with somatization and perceived parenting will be explained.

1.3. Emotional Expression

Emotions are considered as relatively transient intentional states that impact cognitive processes, physiological responses, and alterations in motor behavior (Hess and Thibault, 2009). Also, emotions can be described as automatic responses that are universally shared, culturally specific, and individual-specific reactions to events and situations (Ekman and Cordaro, 2011). According to Darwin, emotions are linked to the survival functions of all species; William James states that they cannot be explained without changes occurring in the body. Canon and Waler also explain emotions in terms of biology, the nervous system, and the body, similar to James and Darwin (Öksüz, 2012). Damasio presents a more sophisticated theory, he argued that emotions are not only a product of experienced processes but can also arise from unexperienced processes (Damasio, 1999).

Emotion is completement of intense feelings directed towards an object or a person. It prepares the individual for action, shapes their future behaviors, and assists in regulating their social interactions (Çakar and Arbak, 2004). Simply, emotions are the messengers of our mood that accompany our thoughts and behaviors in human life. They arise automatically and rapidly as a result of making sense of situations and events, providing us with an understanding of our emotional state (Kuzucu, 2008).

William James (1884, 1894) proposed that emotions are adaptive behavioral and physiological responses that are elicited directly by situations that have significant evolutionary relevance. While individuals frequently exhibit these emotional responses, they are not always obligatory. Illustrated in Figure 1, James's viewpoint on emotions as response tendencies acknowledges that individuals possess the capacity to regulate or alter their emotional response tendencies. For example, instead of fleeing in fear, they may choose to whistle, demonstrating a modulation of their emotional response.

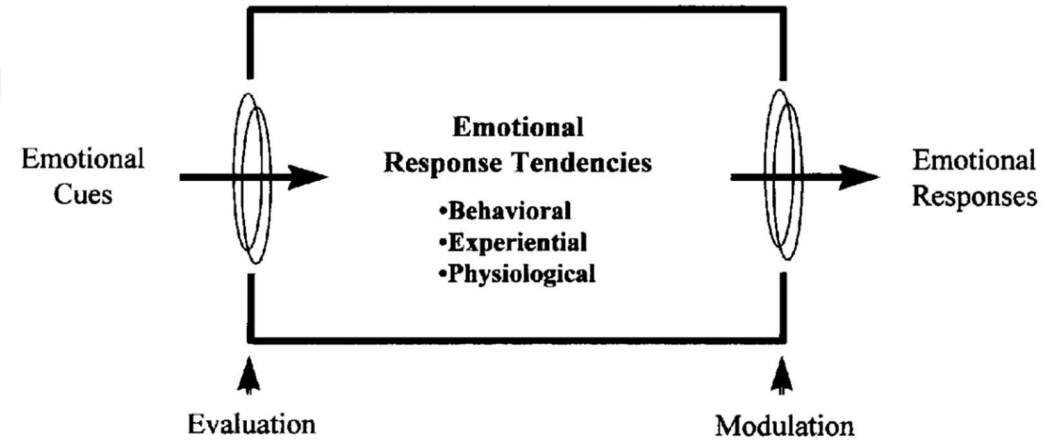


Figure 1. A consensual process model of emotion generation.

Happiness, sadness, anger, fear, surprise, and disgust are universally acknowledged as fundamental or basic emotions (Ekman and Cordaro, 2011). When the literature is examined, it can be observed that emotions are classified in various ways, such as primary and secondary emotions, positive and negative emotions (Weisfeld and Goetz, 2013). In Greenberg's (2008) Emotion-Focused Therapy theory, he discusses primary and secondary emotions. The emotions that an individual initially and instinctively displays are referred to as primary emotions, while the emotions that arise in response to primary emotions are defined as secondary emotions. Positive emotion refers to the feelings that give the individual pleasure and enjoyment in life, such as joy, interest, desire, and trust. On the other hand, negative emotion is defined as unpleasant feelings such as stress, anger, and fear (Watson, 1988; Watson and Pennebaker, 1989).

Psychologist Robert Plutchik proposed a conceptualization of emotions that includes 32 different emotions in 1980. This conceptualization is expressed as the "wheel of

emotions," consisting of "eight primary emotions" with two polarities each. The wheel of emotions is shown in the Figure 2. Plutchik, based on his research, discusses how emotions can be divided into primary and secondary emotions, similar to colors. There are four positive emotions paired with four negative emotions, and it is stated that these emotions located at opposite ends cannot be felt simultaneously. When constructing the wheel of emotions, he arranges opposing emotions far apart from each other and places similar emotions closer together. Moreover, just as different colors can be obtained by mixing colors, the combination of two emotions can give rise to another emotion. In the wheel of emotions, the outermost emotions between the primary emotions represent the secondary emotions that arise from the combination of two emotions (Plutchik, 2011).

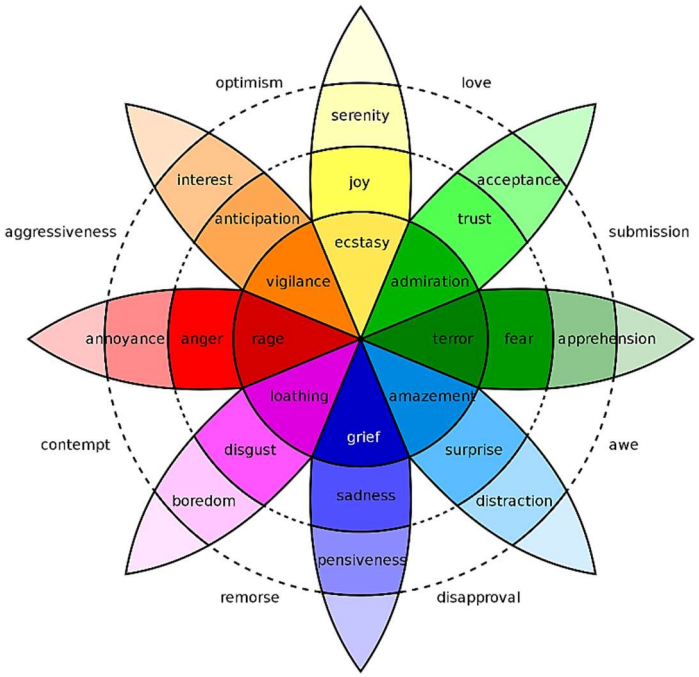


Figure 2. The Wheel of Emotions

Emotional expression refers to the outward display of emotions through facial expressions, vocal cues, and body postures, serving the purpose of communicating or concealing internal emotional states to others (Chaplin, 2015). From Freud to the present, “bottled up emotions” related to physiological and physical symptomatology (Freud, 1977). Also, Charles Darwin’s (1872/1965) work, The Expression of the Emotions in Man and Animals is a highly influential source on emotions. The fundamental idea concerning the expression of emotions is that it has evolved and serves an adaptive purpose (Hess and Thibault, 2009). According to Traue and

Deighton (2016), emotions play a vital role in the interactions between individuals and their social environments. They attribute personal significance to both external and internal stimuli and communicate meaning from the individual to others. From a perspective of system regulation, emotional expression serves two crucial functions. Firstly, it serves a communicative function by facilitating the regulation of person-environment processes. Second, behavioral expressions have feedback functions which controls the intraindividual emotion regulation. Expressive behavior can function as an integral aspect of both the emotional process and coping response (Traue and Deighton, 2016). For example, experiences such as rape, molestation, serious crimes, or acts of deception, individuals may find themselves unable to talk about these events with anyone. Surprisingly, the act of withholding or refraining from discussing and confiding in others about such experiences can potentially inflict more harm than the events themselves (Pennebaker, 1985).

The paradox of distress expression arises when the outward expression of negative emotions can serve as both an indication of distress and a mechanism for coping with that distress. Furthermore, chronic expression of distress is a symptom commonly observed in various mood disorders. However, such expression can hinder active coping efforts and amplify distress, as noted by Ebbesen, Duncan, and Konecni (1975), and it can have detrimental effects on interpersonal relationships, as highlighted by Tavris (1984).

However, expression also can be a means of alleviating distress (Kennedy-Moore and Watson, 2001). Expression can help alleviate distress through three main mechanisms: (a) by reducing distress related to the experience of distress itself; (b) by facilitating insight and understanding; and (c) by influencing interpersonal relationships in a positive manner (Kennedy-Moore and Watson, 2001).Breuer and Freud (1966) claimed that the underlying causes of the symptoms experienced by hysterical patients can be traced back to suppressed emotions, known as "strangulated affect," which are connected to repressed memories of past traumas.

1.3.1. Evolutionary Perspective of Emotional Expression

Charles Darwin's (1872/1965) work, The Expression of the Emotions in Man and Animals highlighted the innate, evolved and survivor-related functions of emotion expression. Darwin (1872/1965) stated that emotional expression is not only a part of

an emotion process to protect or prepare the organism for action but also a communicative function. For Darwin, communicative function of emotion expression has an adaptive value and emotion expression is seen as an outward manifestation of an inner state. Darwin (1872) put forth the idea that emotional expressions have evolved to fulfill two main purposes: a) To prepare organisms to respond in a way that is adaptive to stimuli that occur repeatedly in the environment and b) to communicate important social information.

From the functionalist viewpoint, emotions have behavioral, physiological, cognitive, and affective processes that have been naturally selected to facilitate automatic and adaptive responses to recurring environmental circumstances that present challenges to an individual's fitness (Shariff and Tracy, 2011). For instance, in the case of surprise, the act of raising eyebrows serves a practical purpose by expanding the field of vision and enabling easier movement of the eyeballs in various directions (Hess and Thibault, 2009). Another example is fear, it triggers a sequence of reactions that includes increased breathing rate, redistribution of blood flow to prepare for quick movements, and a mobilization of attentional resources to enhance hypervigilance. These responses effectively enable the animal to enhance its capacity to flee from a predator or any other imminent danger (Shariff and Tracy, 2011). Other expressions function in a similar way.

Another principle of Darwin is that some expressions occur because of the need of nervous systems' discharge of excess excitement and serve as a source of information related to internal states or intended actions (Shariff and Tracy, 2011). Darwin gave the laughter example for that. He proposed that laughter serves as a mechanism to release an excess of nervous energy that arises from psychological tension, whether it is induced by physical or psychological factors (Hess and Thibault, 2009).

Evolutionary biologists highlighted a significant difference between cues and signals. A cue refers to information that is obtained incidentally as a result of something else that serves a different adaptive purpose. On the other hand, signals have a purpose of communication. According to the two-stage model, it is proposed that emotion expressions initially emerged as cues, providing insights into internal states without specifically existing for that purpose. However, over time, these expressions underwent transformation, both in terms of their form and their function, eventually becoming signals. In essence, the function of expressions evolved during the course

of evolutionary history (Shariff and Tracy, 2011).

With the increasing importance of social interaction for many species, the adaptive significance of these expressions may have shifted towards communication. In the case of emotion expressions, this transition from being cues to becoming signals can be considered as the second stage of their evolution. As a result, primates have developed two interconnected psychological abilities. The first ability involves the automatic display of ritualized expressions in situations that are prototypical and frequently encountered throughout evolutionary history. The second ability entails the automatic interpretation and response to the underlying meaning conveyed by these expressions when exhibited by others (Shariff and Tracy, 2011).

Expressing emotions holds significant implications in human life, both from an evolutionary perspective and in daily practicality. On the contrary, suppressing emotions yields different outcomes. Just as expressing emotions is crucial, suppressing them is equally meaningful for individuals.

1.3.2. Pennebaker's Inhibition Model

The main premise of the inhibition model posits that the suppression of behaviors, thoughts, and emotions requires physiological effort, and this process culminates in heightened autonomic responses. The act of inhibiting emotional expression is associated with stress, intrusive and rumination thoughts, elevated autonomic activity, and chronic autonomic arousal. These factors have been associated with the emergence of psychosomatic diseases, cardiovascular and dermatological disorders, asthma, cancer, and even pain conditions. This is due to the cumulative effect of inhibition acting as a persistent low-level stressor (Pennebaker, 1985; Traue and Deighton, 2016; Pennebaker and Seagal, 1999). Autonomic arousal can be associated with both the inhibition and expression of emotions, depending on situational factors, individual differences in expressive styles, and the nature of the specific emotion. For instance, negative emotions like aggression, anger, and hostility can pose unique challenges for individuals, as the expression of these emotions can lead to significant consequences. (Roth and Cohen, 1986; Murray, 1985).

Pennebaker and his colleagues have found that individuals who suppress their inclination to share or confide their feelings are at a higher risk of developing physical ailments such as flu, ulcers, and respiratory infections (Emmons and King,

1998). Baumeister and Tice (1987) have proposed that the key element of emotional response is the motivation to express oneself. Pennebaker (1985) suggested that the absence of emotional expression itself may not be pathogenic; rather, it is the combination of inhibiting emotional expression while harboring a desire to express that can lead to negative health outcomes. Pennebaker characterized this situation as "active inhibition," referring to the intentional prevention of oneself from engaging in a desired action. Engaging in active inhibition results in prolonged autonomic arousal and, ultimately, physical deterioration (Pennebaker, 1985). Baumeister and Tice (1987) argued that every emotion carries a motivation to be expressed. Prolonged inhibition of these expressive motives has been associated with a weakened immune system and increased vulnerability to stress-related illnesses (McClelland et al., 1980). Emmons (1986) defined personal striving is “what a person is characteristically trying to do" and he found out that ambivalence about personal striving is identified with low subjective well-being and physical symptomatology. From that perspective, ambivalence emotion expression could be apart from expression itself (King and Emmons, 1990).

1.3.3. Development of Emotional Expression

Freud argued that emotional inhibition played a crucial role in psychological disorders, and the aim of his talk therapy was to facilitate the communication of "strangulated affect" that had been significantly diminished in its expression for various reasons (Breuer and Freud. 1957/1895). The concept that emotional inhibition can give rise to psychological distress continues to be a fundamental principle in psychodynamic psychotherapy (Gross and Levenson, 1997). In psychotherapy, the process of expression plays a crucial role in assisting clients in navigating and processing their emotional experiences (Kennedy-Moore and Watson, 1999). Breuer and Freud (1895/1966) highlighted the significance of "the talking cure" in their development of the cathartic method. They emphasized the importance of encouraging patients to openly discuss all significant aspects of their past traumatic experiences as a means to alleviate hysterical symptoms.

Several studies revealed that laughter as a healthy expression. These studies showed that humor has a buffer effect of stress. Individuals who possess a greater inclination to employ humor as a coping mechanism tend to experience less mood disturbance.

Moreover, laughter has been shown to elevate discomfort thresholds, act as a counteractive force against pain, and be linked to a decrease in subjective stress levels (Martin and Lefcourt, 1983; Labott, Martin, and Eason, 1989).

Pennebaker and colleagues carried on several experiments and stated that self-disclosure (emotions) have an effect on decrease in stress and improvement in physical and psychological health (Pennebaker and Seagal, 1999). Pennebaker, Mayne, and Francis (1997) stated that when thoughts and emotions are expressed, they become organized, structured, and labeled through language. This process of imposing structure on the event enables individuals to better assimilate and comprehend their experiences, ultimately enhancing their coping mechanisms. Mahrer (1980) documented case studies of cancer patients who experienced remission of their diseases after undergoing cathartic and abreactive therapeutic experiences.

The techniques employed in Gestalt Therapy are primarily aimed at encouraging patients to directly confront suppressed emotions and enhance their level of emotional arousal (Beutler, 1983). In addition to therapy, engaging in expressive writing about the emotional aspects of traumatic experiences has been associated with improvements in health (Pennebaker and Beall, 1986). The assertion suggests that if avoiding discussions about traumatic or stressful events leads to adverse physiological effects, it logically follows that disclosing these events could have beneficial outcomes. Recent research indicates that engaging in conversations or writing about significant traumatic experiences can potentially decrease health issues (Pennebaker, Hughes and O'Heeron 1987). The study done by Segal and Coolidge (2009) found out that the act of writing about positive emotions can be equally therapeutic as writing about negative emotions and can increase insight and cognitive reorganization regarding the unpleasant experience. The findings of the study align with Frederickson's (2001) broaden-and-build theory, which suggests that positive emotions broaden individuals' attention and cognitive processes, enabling them to engage in new ways of thinking and behaving. This, in turn, leads to a broader mindset and replenishment of personal resources in social, intellectual, and physical domains.

Besides therapies and techniques, Mindfulness – Based Stress Reduction (MBSR) intervention found by Kabat-Zinn (1982) originally developed for the treat patients who suffer from chronic pain. Although the mechanism underlying MBSR on

psychological symptoms like depression, anxiety, and perceived stress are not fully comprehended, one potential set of mechanisms could be related to shifts in attitudes and behaviors concerning emotion regulation. These changes may involve a decreased fear of experiencing emotions and an increased willingness to confront them rather than trying to suppress them (Robins et al., 2012). Mindfulness is considered to be one of the elements comprising self-compassion as will be discussed in detailed in the next section. It is known as holding balanced experience toward one's suffer instead of exaggerating it just like in the somatization (Neff, Kirkpatrick, and Rude, 2007). Mindfulness is a required concept in self-compassion (Neff et al., 2007).

In many societies, there is an underlying understanding that suppressing emotions can have implications for health. The conflicts arising from the need to regulate emotions and the desire for emotional disclosure or catharsis have led to various cultural phenomena aimed at addressing these consequences. These phenomena encompass universal cultural rituals, such as mourning rituals, as well as religious practices like confessions. An example of a disclosure phenomenon is the Western (Wailing) Wall in Jerusalem, where Jews traditionally deliver written prayers. In contemporary times, online platforms have emerged as an alternative means for submitting prayers, and similar services are provided in relation to the Christian confession ritual. Western societies have incorporated psychotherapy as a means to promote emotional expressiveness. In the context of psychotherapy, individuals are encouraged to openly discuss their emotions, engage in expressive writing, and even enact emotions through role-playing exercises (Traue andd Deighton, 2016).

1.3.4. Studies on Emotional Expression

In Western European countries, women tend to exhibit higher levels of overall emotion expression, with a particular emphasis on positive emotions. However, they also tend to internalize negative emotions, such as sadness and anxiety (Brody and Hall, 1993; Kring and Gordon, 1998; LaFrance, Hecht, and Levy Paluck, 2003; Allen and Haccoun, 1976) however men express more aggression and anger than women (Archer, 2004). Friedman et al., (1985) found out that male who is low-expressive are at risk for heart disease. They are often characterized as being tense, having a tendency to exert active control over their emotions, and actively inhibiting strong

emotional expressions. Also, gender differences in children's emotion expression are very common. Sayings such as "boys don't cry" are highly used in populations. Such expectations like girls show cheeriness or sadness and boys show strongness and calmness are wide (Chaplin and Aldao, 2013). Chaplin and Aldao (2013) conducted a study that revealed girls tend to express more positive emotions and internalize negative emotions such as sadness and anxiety, whereas boys exhibit more externalizing emotions like anger. The study also highlighted that the extent of gender differences varied based on contextual factors such as age, interpersonal context, and the type of task being assessed. Additionally, beginning in adolescence, women exhibit higher rates than men of clinical depression and various types of anxiety disorders. These disorders involve significant degrees of internalizing negative feelings like sadness, guilt, and fear in both its origin and description (Chaplin and Cole, 2005; Keenan and Hipwell, 2005; Zahn-Waxler, Shirtcliff, and Marceau, 2008). In contrast, research has indicated that men exhibit a higher prevalence of antisocial behaviors and alcohol abuse compared to women (Nolen-Hoeksema and Hilt, 2006). This may manifest in outbursts of rage (Chaplin and Cole, 2005) and has been associated with a limited experience with and expression of anxiety and sadness (Chaplin et al., 2008).

Research conducted on the relationship between personality and health has identified that individuals who engage in emotional inhibition are often categorized as alexithymic, exhibit a repressive coping style, possess Type C personality traits, or display high levels of self-control (Leventhal and Patrick-Miller, 2000; Temoshok, 1987; Temoshok 1993). Contrarily, people with Type A behavioral pattern also found to be related to coronary heart disease even though they are emotionally expressive (Friedman, Hall and Harris, 1985). Individuals classified as Type A are characterized by a negative and hostile-competitive behavioral style. Friedman et al., (1985) found out that hostility plays a crucial role in the development of heart disease. It is possible that a combination of a hostile interpersonal outlook and competitive social environments generates a constant state of anger, arousal, and tension, ultimately increasing the risk of heart disease. This predisposition towards illness can be observed through general expressive style and specific nonverbal behaviors.

1.3.5. Emotional Expression and Somatization

It is found that one of the primary causes of somatization is the inhibition of the expression of emotionally intense feelings (Koh, 2013). Somatization is utilized as a means of expression tend to transfer their individual and interpersonal problems through physical symptoms (Uğur, 2015). Individuals who exhibit somatic symptoms often have difficulty identifying and expressing their emotions verbally, commonly referred to as emotional “non-expressiveness” and they are more prone to experience somatization (Akyıldız, 2011; Bozo, Yılmaz and Tathan, 2012; Riggio and Riggio, 2002). Individuals who experience somatization are susceptible to developing a personality trait referred to as "alexithymia." This characteristic comprises three elements: challenges in recognizing emotions, challenges in expressing emotions, and a inclination towards externally focused thinking. (Bagby, Parker and Taylor, 1994).

Emotional expressiveness recently evaluated as a personality trait component (Bozo et al., 2012; Ogden, 2004). As previously discussed, the personality trait known as Type-C is characterized by passive behavior, a calm demeanor, a perceived inability to help oneself, a tendency towards self-sacrifice, and a lack of emotional expression (Bozo et al., 2012; Ogden, 2004). A qualitative study conducted through interviews revealed that individuals with somatoform disorders exhibited a reduced ability to express their emotions (Waller and Scheidt, 2004). Moreover, research has shown that individuals who struggle with expressing their emotions face an increased risk of developing serious health conditions, including breast cancer (Bleiker, van der Ploeg, Hendriks, and Ader, 1996; Bozo et al., 2012). Other studies have also demonstrated a connection between emotional suppression and symptoms experienced by patients with fibromyalgia (Erkic et al., 2018; van Middendorp et al., 2008).

Especially, anger is suppressed to avoid undesirable outcomes. Several studies, have provided evidence supporting the association between the inhibition of anger and somatization (Liu et al., 2011; Okifuji, Turk, and Curran, 1999). Liu et al., (2011) conducted a study to investigate the relationship between anger, attachment, and somatization. The study findings indicated that the relationship between insecure attachment and somatization is influenced by different factors in men and women. In men, this connection is mediated by elevated levels of anger, while in women, it is mediated by the suppression of anger. Okifuji et al., (1999) conducted a study

specifically investigating the relationship between chronic pain and the expression of anger. The findings indicated that the target of anger plays a significant role. It was observed that inwardly directed anger, which is directed towards oneself, is particularly associated with chronic pain (Okifuji et al., 1999).

Existing literature consistently demonstrates that the inhibition of emotions has adverse effects on both physical and mental health (Greenberg and Stone, 1992). Alexander (1950) stated emotional conflict as a core of all psychosomatic illness. Research conducted by Pennebaker has revealed that individuals who engage in emotional disclosure of their reactions to stressful events exhibit improved physical health compared to those who do not engage in such disclosure (Francis and Pennebaker, 1992; Pennebaker and Beall, 1986; Pennebaker, Colder, and Sharp, 1990; Pennebaker, Kiecolt-Glaser, and Glaser, 1988). Suppressed thoughts and feelings are anticipated to cause persistent stress and recurrent inhibition. The active suppression of ongoing behavior has been found to have physiological implications. Temporary inhibition of behavior is linked to temporary changes in autonomic activity, such as increased skin conductance, heart rate, and blood pressure. Conversely, long-term inhibition of behavior is associated with stress-related conditions such as heart disease, cancer, or ulcers (Pennebaker, 1985).

Contrarily, actively confronting prior traumas should therefore reduce physiological stress from inhibition and increase disease resistance (Wegner et al., 1987). Emotional inhibition and individuals classified as “repressers”, “inhibitors” or “suppressors” has been related to several physical illnesses such as cancer (Cox and McCay, 1982; Jensen, 1987; Kissen, 1966), elevated blood pressure levels (Davies, 1970; McClelland, 1979), coronary heart disease (Friedman and Booth-Kewley, 1987), asthma, ulcers, hives (Alexander, 1950) and other physical diseases in general (Beutler et al., 1986; Pelletier, 1985; Udelman and Udelman, 1981; Blackburn, 1965). In a study conducted by Güleç and colleagues (2004), they examined 101 Fibromyalgia patients, 30 Rheumatoid Arthritis patients, and 56 healthy control subjects. The results of the study revealed significantly higher scores on the Toronto Alexithymia Scale's "difficulty identifying feelings" and "difficulty expressing feelings" subscales among Fibromyalgia patients. This suggests that experiencing difficulty in expressing emotions may particularly impact Fibromyalgia symptoms, especially pain symptoms.

Cox and McCay (1982) stated that the strongest psychosocial predictor of cancer is

inability to express negative emotion. It is showed that cancer patients more likely to inhibit emotional displays of anger compared to healthy individuals. Women diagnosed with breast cancer often report difficulties in regulating and expressing their emotions, leading to higher levels of emotional distress, symptoms of depression and anxiety, and lower levels of physical health quality (Classen et al., 1996; Iwamitsu et al., 2005; Low et al., 2006). Also, studies yielded that unexpressed hostility is associated with coronary heart disease (Friedman, Hall, and Harris, 1985). Hollaender and Florin (1983) found that children with asthma exhibited reduced expression and intensity of anger, joy, and fear compared to children without asthma in their study. However, the expression of anger varies across different illnesses. For example, it is believed that the embodiment of anger in depression is related to its outward expression, while the embodiment of anger in anxiety disorders is believed to be associated with its suppression. Particularly in chronic pain patients, a significant and high-level relationship has been found between disability, increased pain severity, and suppressed anger (Güleç et al., 2004). A study done by Romano and Turner (1985) showed that depression and pain are related and later Beutler and his colleagues (1986) proposed that depression and pain share similar processes at psychological level which is inability to express intense, unacceptable feelings. This risk is mediated by the deactivation of the immune system. Suppressing emotional expression can result in an excessive autonomic response, which is closely associated with the causes and persistence of psychosomatic disorders.

Researches revealed that in individuals who suppress emotional expression, measurements showed high physiological activity. People who display limited emotional expression during stressful situations but experience heightened physiological arousal are referred to as "internalizers," while individuals who exhibit extensive emotional expression but have limited psychological distress are known as "externalizers." (Traue and Deighton, 2016). Scheff (1979) stated a catharsis theory to offer an alternative view of the process mediating the health benefits of emotion expression. According to him “verbal recall is neither necessary nor sufficient for therapy but emotional expression is both necessary and sufficient”. According to Scheff, the process of emotional healing involves achieving an "optimum distance" from the expressed stressful emotions. This distance allows individuals to vividly experience their emotions within a context of feeling safe in the present moment, enabling them to end the emotional episode before it becomes overwhelming. A

large literature shows that there is a likelihood for developing psychopathology when a person is limited about the emotion expression or is encouraged to express particular emotions (Chaplin and Cole, 2005; Keenan, 2000; Keenan and Hipwell, 2005; Zahn-Waxler, Shirtcliff, and Marceau, 2008). Suppression of emotion expression is related to lower levels of well-being and several forms of psychopathology in adults (Gross and John, 2003; Aldao, Nolen-Hoeksema, and Schweizer, 2010).

Contrarily, people with Type A behavioral pattern also found to be related to coronary heart disease even though they are emotionally expressive (Friedman, Hall and Harris 1985). Individuals classified as Type A are characterized by a negative and hostile-competitive behavioral style. Friedman et al., (1985) found out that hostility plays a crucial role in the development of heart disease. It is possible that a combination of a hostile interpersonal outlook and competitive social environments generates a constant state of anger, arousal, and tension, ultimately increasing the risk of heart disease. This predisposition towards illness can be observed through general expressive style and specific nonverbal behaviors.

1.3.6. Emotional Expression and Perceived Parenting

One of the best indicators of the emotional atmosphere within a family is emotional expression. A significant portion of family factors believed to influence the course of illness are examined within the concept of emotional expression (Berksun, 1992). For a significant period, developmental psychologists have regarded parental emotional expression as a crucial factor contributing to a child's evolving emotional and social skills (Dix, 1991). The emotional expression of parents holds paramount significance as the primary environment within the family where children initially acquire knowledge about the rules of displaying emotions and develop an understanding of how others express their emotions (Halberstadt et al., 1995). Research findings have demonstrated that the emotional expression of parents within the family setting significantly influences children's beliefs regarding the types of emotional expressions that are considered normal and expected in intimate relationships (Denham, 1998; Dunsmore and Halberstadt, 1997).

In a study conducted by Eray, Vural and Çetinkaya (2015), it has been founded that there are strong associations between perceived expressed emotions, which is one of

the strongest indicators of the emotional atmosphere within the family, and psychosomatic symptoms. During the initial years of life, children undergo the developmental process of acquiring the ability to express their emotions through various means such as facial expressions, vocalizations, and behavioral cues. This progression enables them to effectively communicate and convey their feelings (Malatesta and Wilson, 1988). Especially mothers play a significant role in shaping and modeling emotional behavior for their children. The manner in which mothers handle and express their own emotions presents valuable opportunities for children to observe, mimic, and acquire skills in displaying emotions. By exhibiting their own emotional expressions, mothers effectively convey emotional information to their children and serve as role models for diverse ways of expressing emotions (Hu et al., 2017). Research has yielded evidence indicating a positive association between the emotional expression of mothers and the manner in which children express their own emotions (Crandall et al., 2015). In a similar vein, Sineiro and Paz Míguez (2007) found that children whose mothers reported higher levels of anxiety were more likely to display increased negative emotions when confronted with challenging or frustrating situations (Sineiro and Paz Míguez, 2007).

According to Darling and Steinberg (1993), displaying emotions within the family context contributes to shaping the overall emotional atmosphere or environment. The environment created by parental emotional expression within the family context can play a facilitating role in the relationship between parent emotionality and child emotionality. Multiple aspects of a child's and adolescent's emotional and social development have been found to be associated with the frequency, intensity, and nature of parental emotional expression within the family setting (Eisenberg, Cumberland and Spinrad, 1998). As an example, Fosco and Grych (2007) yielded that the attribution of self-blame was more likely in children aged 8-12 whose parent’s expressed more frequent negative emotions and less frequent positive emotions. Contrarily, in several studies, it was revealed that toddlers and preschool-aged children whose mother expressed frequent positive emotion had exhibited more emotion regulation. (Garner 1995; Garner and Power 1996). Similarly, Pellerone et al., (2017), founded that difficulties in recognizing and expressing emotions are significantly associated with perceived overprotective parenting style towards the mother. Nevertheless, Greenberg et al., (1999) discovered that regardless of whether the emotional expression is positive or negative, communication and emotional

expression within families offer children increased opportunities to observe and regulate their own emotions. These interactions provide valuable exposure to various practices of emotion regulation.

Lastly, the self-compassion concept will be discussed in the next paragraph with the explanation, development of it, studies in the literature about it and it is relation with somatization, perceived parenting and emotional expression.

1.4. Self-Compassion

Compassion is described by Goetz, Keltner, and Simon-Thomas (2010) as a "apparent affective experience with a primary function to facilitate cooperation and protection the weak and who suffer." Witnessing another's suffering constitutes this affective state and creates a motivation about desire to help (MacBeth and Gumley, 2012). Compassion abilities have a foundation in survival as they encompass a range of motivational, emotional, and cognitive-behavioral competencies that drive individuals to care for others, thereby enhancing their own likelihood of survival (Gilbert, 2005). Compassion abilities encompass several essential aspects, including a motivational component related to the desire to promote the well-being of others. It involves the ability to recognize and confront distress rather than avoiding or denying it, as well as demonstrating tolerance for distress and showing sympathy towards others instead of attempting to control or avoid their emotions. Additionally, empathy plays a crucial role by facilitating an understanding of the root causes of distress and determining the necessary steps for providing assistance. Lastly, a non-judgmental attitude towards the situation or behaviors of others is an integral part of compassion abilities. All of them requires the warmth with the emotional tone. Any problem in one of them makes the compassion difficult. This model suggest that compassion provides the motivation and capacity to co-operate, engage in kinship caring, regulate negative affect, express and communicate feeling of warmth and safeness, results in formation of attachment (Gilbert, 2005). Self-compassion involves applying these competencies to oneself. Essentially, self-compassion involves directing compassion towards oneself, characterized by the ability to wholeheartedly embrace one's own feelings of suffering with a genuine sense of warmth, connection, and care (Neff and McGehee, 2010). Being sensitive, sympathetic, and accepting in the face of distress, and cultivating empathy and a non-

judgmental mindset (Gilbert and Procter, 2006).

Self-compassion holds a significant place within Buddhist philosophy, which stands as one of the ancient wisdom traditions in the world (Rahula, 2007). The Buddhist thought put self-compassion as a central concept for well-being (Davidson and Harrington, 2002). On the other side, it is relatively a new concept for Western psychology (Brach, 2003). According to McKay and Fanning (1992), self-compassion can be understood as a synthesis of understanding, acceptance, and forgiveness. Building upon this perspective, Neff (2003a, 2003b), drawing from both social psychology and the Buddhist tradition, has more recently proposed self-compassion as a positive and beneficial form of self-acceptance. Self-compassion is a warm and accepting attitude toward the aspects of oneself and one's life that are disliked and it is a healthy relationship with oneself (Neff, 2003b). Neff (2003b) defines self-compassion as "Being touched by and open to one's own pain, without escaping or disconnecting from it, producing the desire to lessen one's suffering and to cure oneself with love. It is also a nonjudgmental understanding to one's suffering, inadequacies, and mistakes so that one's experience is seen as a part of the wider human experience." According to Gilbert's (1989) conceptualization, self-compassion is described within the framework of social mentality theory, which integrates principles from evolutionary biology, neurobiology, and attachment theory. This involves disengaging the threat system, associated with insecurity, defensiveness, and the limbic system, while engaging the self-soothing system, associated with secure attachment, a sense of safety, and the oxytocin-opiate system. The self-soothing capacity of self-compassion leads to enhanced intimacy, regulation of emotions, exploration, and successful adaptation to one's environment.

Self-compassion is creating a balance between 'observing self' and 'suffering self' (Vatan, 2019). The attention is given from the observing self to the suffering self is self-compassion. Segal and his colleagues (2012) represented the observing self to the sky. Whether the weather is sunny or rainy, the sky is still there. Just as the sky is not consist of the weather, an individual is not consists of their own emotions, thoughts and behaviors. Observing self can make the differentiation of "me" and "mine". A person with an observing self can say "I think that I am a depressive person" instead of "I am depressive". On the other hand, suffering self, experiences the negativity of the current moment. Self-compassion is putting the distance between the observing self and suffering self. With the discrimination of "me" and

“mine”, an individual can experience that they are not their emotions, thoughts and behaviors; as a result, self-criticism, self-blame and feeling shame could be decrease. (Vatan, 2019).

Neff (2003b) outlined three key elements of self-compassion: self-kindness, sense of common humanity, and mindfulness. Self-kindness involves treating oneself with care and understanding, rather than engaging in harsh self-judgment, especially in the face of personal failures. The concept of common humanity involves acknowledging that imperfections are a universal part of being human, rather than feeling alone or isolated in one's personal challenges. Lastly, mindfulness involves maintaining a balanced perspective on one's current experience and being aware of the present moment, rather than exaggerating one's suffering. Additionally, it refers to being conscious of one's emotions and having the capacity to confront painful thoughts and feelings directly, without resorting to avoidance or denial, and without getting caught up in excessive drama or self-pity (Neff, Kirkpatrick, and Rude, 2007). When these components are combined, they form a mindset of self-compassion. These components also have corresponding counterparts. For instance, self-judgment can be likened to engaging in harsh self-criticism, while isolation is similar to experiencing social withdrawal and loneliness. Over-identification aligns with traits such as self-absorption and self-focused rumination. (Muris, 2015; Zuroff et al., 1990; Rubin and Coplan, 2004; Lyubomirsky and Nolen-Hoeksema, 1995).

Mindfulness is another Buddhist construct which is having a current impact in Western psychology. It is characterized as a state of non-judgmental awareness, involving the ability to perceive and accept mental and emotional experiences as they emerge in the present moment, without attempting to avoid or alter them (Neff et al., 2007). Bishop et al., (2004) stated two main elements of mindfulness: paying attention to one’s present experience and having a curious, open, accepting stance towards this experience. Literature shows that mindfulness has several positive psychological effects such as increased subjective wellbeing, reduce negative symptoms, emotional reactivity and improved behavioral regulation (Keng, Smoski, and Robins, 2011). While mindfulness is an essential aspect of self-compassion, it is crucial to emphasize that they are not identical. The mindfulness component of self-compassion entails cultivating a balanced awareness of negative thoughts and emotions. In essence, mindfulness can be defined as the capacity to consciously direct attention to any experience, irrespective of its nature - whether it is positive,

negative, or neutral - and approach it with a sense of acceptance. Another difference is, mindfulness tends to focus on internal experience, rather than being experiencer. Self-compassion emphasizes providing oneself with comfort and understanding when faced with painful experiences, while also recognizing that such experiences are a natural part of the human condition (Neff and Germer, 2012).

Studies indicate that self-compassion yields comparable psychological well-being benefits to self-esteem, but with a few limitations or disadvantages (Neff, 2003a). According to Neff, Kirkpatrick, and Rude (2007) self-compassion is different to self-esteem for many reasons. Self-compassion is not strongly correlated with narcissism, as it involves the capacity to cultivate positive emotions towards oneself without inflating one's self-concept (Neff, Hsieh and Dejitterat, 2005). Self-compassion also differs with self-pity. In self-pity, people become absorbed in their own problems and forget the knowledge that others are experiencing similar problems. Self-pity individuals do over-identification, results to exaggerate the extent of personal suffering and prevent to adopt an objective perspective. Contrarily, the common humanity component of self-compassion breaks the self-absorption cycle and allow the recognition of related experiences of self and other (Neff, 2003b). Self-compassion is intricately connected to reflective wisdom, as highlighted by Neff et al., (2007). Reflective wisdom, as formulated by Ardelt (2003), involves perceiving reality as it truly is and developing self-awareness and insight in alignment with this understanding. Given that self-compassion offers emotional support and a safe space to observe oneself objectively, it has the potential to foster wisdom (Leary et al., 2006).

1.4.1. Development of Self-Compassion

Due to the recognized advantages of self-compassion, psychologists have turned their attention to strategies for enhancing it. One effective method involves cultivating mindfulness. Programs such as Mindfulness-Based Stress Reduction and Mindfulness-Based Cognitive Therapy, developed by Kabat-Zinn (1982), have demonstrated promising outcomes in this regard. Also, evidences showed that these programs are useful for generating self-compassion.

Compassionate Mind Training, developed by Gilbert and Proctor (2006), is a therapeutic approach based on compassion that shows great promise in treating

individuals who struggle with self-criticism. The primary objective is to provide individuals with training that enables them to cultivate compassion and warmth during moments when they feel threatened, experience defensive emotions, or engage in self-criticism. Currently, many therapies are focusing on the development of self-compassion such as Dialectical Behavioral Therapy. Also, in some mindfulness trainings, self-compassion can emerge naturally with practice (Gilbert and Proctor, 2016).

Paul Gilbert and his colleagues have developed a therapeutic approach known as Compassion-Focused Therapy (Gilbert, 2010) as a means to bolster self-compassion. The aim is to help patients develop sense of warmth toward themselves. This is done through variety of exercises (Neff and Germer, 2012). Because Compassion-Focused Therapy is a tool for patients, Neff and Germer (2012) developed Mindful Self-Compassion program for clinical and nonclinical populations. The program primarily concentrates on assisting participants in cultivating self-compassion, employing a diverse range of tools provided to them.

1.4.2. Studies on Self-Compassion

Self-compassion is investigated as a factor that offers protection for adults' mental well-being (Muris, 2015). One of the most powerful and consistent finding about self-compassion in the literature is it is relation with the decline in the depression, anxiety, stress and other psychopathological symptoms (Neff et al., 2007; Neff, Pistsungkagam, and Hseih, 2008; Neff et al., 2007; Raes, 2010; MacBeth and Gumley, 2012; Neff, 2003a; Neff et al., 2005). Promoting self-compassion enhances resilience to stress, and psychological health (MacBeth and Gumley, 2012; Neff, 2003a; Gilbert, 2010; Neff et al., 2005). This discovery could be linked to the observation that self-compassion has a propensity to reduce cortisol levels and increase heart-rate variability (Rockliff et al., 2008). Also, self-compassion is closely linked to psychological wellbeing, including increased happiness, as well as lower levels of neurotic perfectionism, rumination and self-criticism (Neff, 2009; Neff et al., 2005). Individuals with high levels of self-compassion tend to experience reduced negative emotions following a negative event, as they engage in less rumination or even abstain from it altogether (Leary et al., 2007). Compassion can serve as a protective shield against symptoms of mental health disorders (Brown and

Ryan, 2003). According to the findings of Muris and Petrocchi (2017), positive aspects of self-compassion, such as self-kindness, common humanity, and mindfulness, demonstrated a negative correlation with psychopathology. Conversely, negative aspects of self-compassion, including self-judgment, isolation, and over-identification, showed a positive correlation with psychopathology.

Individuals with high self-compassion when recognize that they are suffering, they provide themselves feeling of warmth, kindness and interconnectedness (Neff, 2009). Individuals who possess self-compassion exhibit a tendency to treat themselves with kindness. They possess an understanding that their problems are shared by others as part of the human experience. Consequently, they engage in less rumination and self-judgment when faced with negative or challenging emotions (Neff et al., 2007).

Moreover, individuals who demonstrate higher levels of self-compassion tend to take greater responsibility for their challenges, which enables them to be less overwhelmed by difficulties. They also exhibit a greater inclination to take care of themselves during times of illness or injury. Self-compassion gives ability to approach painful feelings and this is linked to happier, more optimistic mindset, resulting to grow, explore, understand oneself and others (Neff et al., 2007). Furthermore, self-compassion equips individuals with the ability to effectively cope with various life stressors, including academic failure, divorce, childhood maltreatment, or chronic pain. Those with high self-compassion experience improved functioning in their relationships, demonstrating heightened empathetic concern, altruism, and a greater capacity for forgiveness. Also, self-compassion increases health related behaviors like sticking one's diet, reducing smoking, exercising (Neff, Hseih, and Dejitthirat, 2005; Sbarra, Smith, and Mehl, 2012; Vettese et al., 2011; Costa and Pinto-Gouveia, 2011; Neff and Beretvas, 2012; Neff and Pommier, 2012; Adams and Leary, 2007; Kelly et al., 2009; Magnus, Kowalski, and McHugh, 2010).

Lastly, literature about gender differences according to self-compassion suggest that women are often socialized to prioritize the needs of others over their own, which can potentially hinder their ability to show self-compassion (Baker-Miller, 1986; Raffaelli and Ontai, 2004; Ruble and Martin, 1998). In comparison to men, women generally exhibit a higher tendency towards self-criticism and engage in more negative self-talk (DeVore, 2013; Leadbeater et al., 1999). However, there are also indications that the opposite may be true. Self-compassion involves actively providing oneself with soothing and comfort during times of suffering, qualities

traditionally more associated with femininity (Neff, 2009; Baker-Miller, 1986; Raffaelli and Ontai, 2004; Ruble and Martin, 1998). Studies investigating gender differences in self-compassion have produced inconsistent results. Some studies have demonstrated lower levels of self-compassion among females compared to males (Neff, 2003a; Neff, Hseih, Dejitthirat, 2005; Neff and McGehee, 2010; Raes, 2010; Yarnell and Neff, 2012) while others have found no significant differences (Iskender, 2009; Neff, Pisitsungkagarn, and Hseih, 2008; Neff et al., 2007; Neff and Pommier, 2013; Raque-Bogdan et al., 2011). It is worth noting that the current research on gender differences in self-compassion is limited, making it difficult to draw firm conclusions about which gender demonstrates higher levels of self-compassion.

1.4.3. Self-Compassion and Somatization

Self-compassion has a positive impact on both physical and mental health since it reduces negative affect (Neff and Dahm, 2015; MacBeth and Gumley, 2012; Neff et al., 2007; Neff and Germer, 2012). Individuals with high levels of self-compassion shows lower levels of stress (MacBeth and Gumley, 2012). Self-compassion promotes resilience in general and in the context of illness (Neff et al., 2007). Self-compassion has the potential to foster positive health behaviors by mitigating negative affective states that might otherwise hinder or jeopardize individuals' pursuit of health goals (Leary et al., 2007). Self-compassion is linked to the adoption of positive self-talk in response to health threats (Terry et al., 2013). It has a facilitative role on the health behavior regulation with some processes such as setting goals, taking action, attention and evaluation of ongoing behavior and lastly, emotion regulation (Sirois, Kitner, and Hirsch, 2014). In comparison to the general population, individuals diagnosed with somatoform disorder exhibited lower levels of self-compassion. Furthermore, decreased self-compassion was linked to a higher occurrence of physical symptoms and a lower quality of life, observed in both the patient group and the control group. Therefore, insufficient self-compassion is associated with an increased presence of physical symptoms and a reduced health-related quality of life (Dewsaran-van der Ven et al., 2017). Self-compassion could serve as a protective factor against somatization since it is recognized that individuals with somatization may exhibit a persistent inclination to avoid physical and emotional harm rather than adopting a mindful, friendly, and accepting approach

towards their own suffering (Lind et al., 2014; Huang et al., 2016; MacBeth and Gumley, 2012; Muris and Petrocchi, 2017). The literature indicates the importance of cultivating a compassionate and kind relationship with oneself when dealing with medical conditions. There is a suggestion that enhancing self-compassion may have the potential to contribute to more effective management of physical symptoms and an overall improvement in quality of life (Dewsaran-van der Ven et al., 2017).

Overall, literature about the relationship between self-compassion and somatization is limited. In this study, it is aimed to contribute the literature in terms of the relationships of these constructs.

1.4.4. Self-Compassion and Perceived Parenting Attitudes

Self-compassion can be viewed as an internal manifestation or reflection of the parent-child relationship (Neff and McGehee, 2010). Self-compassion emerges within the psychological system of mammals through the development of attachment and caregiving behaviors (Gilbert, 1989; 2005). When given care, individuals experience feelings of connectedness and soothing (Neff and McGehee, 2010). People who experience nurturing and safe environments during their upbringing are more likely to develop the capacity to treat themselves and others with kindness and empathy. On the other hand, individuals who grow up in insecure, stressful, or hostile environments tend to display a lack of warmth and self-criticism in their interactions with themselves (Gilbert and Proctor, 2006).

The way individuals handle difficult times or failures can be influenced by their family background and experiences. Children who have parents exhibiting anger, coldness, or criticism often internalize these negative patterns and tend to display similar behaviors towards themselves. Conversely, children who grow up with warm, caring, and supportive parents tend to internalize these positive qualities and reflect them in their inner dialogue and self-perception (Gilbert and Proctor, 2006). In a study done by Neff and McGehee (2010) results showed that self-compassion found to be significant contributor to well-being when other factors are controlled like family relationship. Research has shown that adults who had experienced maternal support, a harmonious family environment, and secure attachment during childhood tend to exhibit higher levels of self-compassion later in life (Hall, 2015). Gilbert and Irons (2005) state that when a baby receives warmth and care from their primary

caregiver, they are able to establish a relationship with themselves. This self-relationship will be based on their internalization of relationships with others and their family (Ahmed and Bhutto, 2016).

In a study conducted by Pepping et al., (2015) it has been founded that "poor parenting" (low parental warmth, overprotection, and high parental rejection) was associated with lower levels of self-compassion in adults. Based on these findings, high sensitivity can be associated with high parental warmth, while low sensitivity can be associated with high parental rejection. According to Pepping and colleagues' research, low parental sensitivity is associated with low self-compassion, whereas high parental sensitivity is associated with high self-compassion (Pepping, et al., 2015). These findings are encouraging since self-compassion can be enhanced with practice (Gilbert and Procter, 2006).

1.4.5. Self-Compassion and Emotional Expression

Self-compassion can be viewed as an effective strategy for emotional regulation, as it involves acknowledging and holding painful feelings in awareness without avoidance or denial. This approach embraces a compassionate and understanding perspective, fostering a sense of shared humanity (Neff, 2003a). Emotional regulation involves the attempt to influence the individuals' emotions when they have them, and how they are experienced or express them (Gross, 1998). Self-compassion is considered a beneficial attribute because it cultivates emotional resilience, thus acting as a safeguarding element (Neff, 2009). In a well-controlled study, it is found that generating a self-compassionate mindset directly enhancing emotional well-being (Leary et al., 2006). When individuals consciously acknowledge their pain and adopt a self-compassionate approach, they actively avoid suppressing their thoughts and emotions, instead recognizing the broader human context of their experiences. Consequently, self-compassion serves as a powerful strategy for regulating emotions by counteracting negative emotional patterns and fostering positive feelings of kindness and interconnectedness (Neff et al., 2005).

Although the literature provides information about self-compassion and emotional regulation or emotional resilience, there is no enough information related to self-compassion and emotional expression.

1.5. Aim of the Present Study

Somatization pertains to a state where individuals exhibit physical symptoms that cannot be sufficiently accounted for by medical observations or existing health conditions. Also, it involves the tendency to expression of psychological distress with body (APA, 2013). Somatic symptoms manifest as the presence of one or more physical symptoms accompanied by excessively intense cognitive processes, emotions, and behaviors. The symptoms often manifest as pain (in the back, waist, head, chest, etc.) in different parts of the body, disturbances in the functioning of organs (gastrointestinal, respiratory, etc.), fatigue, and exhaustion. Individuals generally experience multiple physical symptoms along with mental and psychosocial disorders (Okur Güney et al., 2019). Also, psychosomatic factors are believed to have significant involvement in disturbances related to the skin (Gupta and Gupta, 1996; Jafferany, 2006). Furthermore, somatic complaints often arise when individual's experiences difficulties in expressing emotional distress verbally (Karkhanis and Winsler, 2016).

In literature, there are many studies claims that there is a relationship between somatization and parenting. According to researches, being in the unhealthy family environment, experiencing or witnessing violence or having traumatic experiences is linked with the somatization (Kinzl et al., 1995; Kırpınar, 2014; Kesebir, 2004; Dülgerler, 2000; Katon et al., 2001; Imbierowicz and Egle, 2003). Together with, abusive, emotionally cold, unsupportive, over-protective parents are also founded to be relative with somatization (Brown et al., 2005; Güleç et al., 2013; Fisher and Chalder, 2003). Regarding dermatological complaints, it has been discovered that these conditions may emerge due to psychological disorganization resulting from conscious or unconscious stress, disruptions in the symbiotic bond with the mother, challenges in early processes of identification, inadequate or prolonged symbiosis, limited ability for symbolization, difficulties in separation-individuation and the development of subjective identity, as well as conflicts related to issues of intimacy and distance in relationships (Ulnik, 2013).

Somatization also was found to be associated with emotional expression since the condition characterized with bodily expression of psychological distress (Lipowski, 1990; Menninger, 1947; Kesebir, 2004). It is claimed that individuals with somatization having trouble about expressing their emotions verbally and non-

expressive people are found to be more prone to having somatization (Akyıldız, 2011; Bozo, Yılmaz and Tathan, 2012). Similarly, self-compassion was related with somatization as a protective factor since it reduces negative effects, stress and promote health behaviors (Neff and Dahm, 2015; MacBeth and Gumley, 2012; Sirois, Kitner, and Hirsch, 2014).

Additionally, the literature has many studies about the investigating the relationship between parenting attitudes, emotional expression, and self-compassion. Parent-child relationship found to be important factor to development of emotional expression and self-compassion (Neff and McGehee, 2010; Neff and McGehee, 2010; Gilbert and Proctor, 2006; Halberstadt et al., 1995; Crandall, et al., 2015). Emotional expression in the families provides children more opportunity to regulate and observe emotion regulation practices and facilitate child's emotionality, this contributes to overall affective environment (Greenberg et al., 1999; Darling and Steinberg, 1993). Self-compassion also associated with the parenting attitudes. If children exposed angry, cold or critical parenting, they may behave in the same way towards themselves, contrarily, if they exposed warm, caring and supportive parenting, they could reflect this to their inner dialogues (Gilbert and Proctor, 2006).

According to gender differences, literature revealed that somatization disorder is significantly more prevalent in women, occurring at a rate ranging from 5 to 20 times higher compared to men (Işık et al., 2008). Similarly, women reported more negative perceptions of their parents, particularly their mothers, in comparison to male participants (Hampton et al., 2005). Regarding the emotional expression, it is founded that in general, women tend to display higher levels of emotional expression, especially when it comes to positive emotions and the internalization of negative emotions such as sadness and anxiety. Conversely, men are more likely to exhibit increased levels of aggression and anger in specific situations (Brody and Hall, 1993; Kring and Gordon, 1998). The existing research on gender differences in self-compassion has produced inconsistent and inconclusive results. Some studies have indicated lower levels of self-compassion among females compared to males, while other studies have found no significant differences between genders in terms of self-compassion (Neff and McGehee, 2010; Raes, 2010; Yarnell and Neff, 2012; Iskender, 2009; Neff, Pisitsungkagarn, and Hseih, 2008; Neff et al., 2007; Neff and Pommier, 2013; Neff, 2003a; Neff, Hseih and Dejitthirat, 2005).

The objective of this study is to examine how emotional expression and self-

compassion mediate the relationship between perceived parenting attitudes and somatization. Although there are many studies about the relationship between perceived parenting, somatization, emotional expression, and self-compassion separately, no study so far investigated all of them together. Additionally, the literature about the relationship between somatization and perceived parenting from the schema perspective is limited. Also, even though there have been numerous studies examining the relationship between somatization and perceived parenting in terms of regulating emotions, there is relatively less research focusing on the expression of emotions. Moreover, as self-compassion is a relatively new construct compared to other concepts, there is a scarcity of studies exploring the relationship between self-compassion and somatization. Additionally, it has been observed that not only these constructs but also their subscales have not been thoroughly examined. It is thought that the results of study will contribute the literature by providing different insights and perspectives regarding the relationship between perceived parenting and somatization. Also, gender differences of constructs will be examined since there are significant findings in the literature. Anticipated results suggest that emotional expression and self-compassion will serve as mediators in the association between perceived parenting attitudes and somatization. The objective is to gain better understanding, knowledge and insight about somatization in order to provide better treatment.

According to the literature, the following research questions and hypotheses were formulated.

1.6. Hypothesis

H1: Women and men significantly differ in terms of somatization, perceived parenting, emotional expression and self-compassion.

H2: There is significant positive relationship between perceived negative parenting and somatization.

H2.1: There is significant positive relationship between subscales of perceived negative parenting and somatization.

H3: There is significant negative relationship between emotional expression and somatization.

H3.1: There is significant negative relationship between positive, negative emotional

expression and closeness expression and somatization.

H4: There is significant negative relationship between self-compassion and somatization.

H4.1: There is significant negative relationship between self-kindness, common humanity, mindfulness, self-judgement (counterpart of self-kindness), isolation (counterpart of common humanity), and over-identification (counterpart of mindfulness) and somatization.

H5: Dermatological complaints found significantly higher in the individuals who perceived their mothers negatively.

H6: Emotional expression significantly mediate the relationship between perceived parenting attitudes and somatization.

H7: Self-Compassion significantly mediate the relationship between perceived parenting attitudes and somatization.

H8: The subscales of emotional expression significantly mediate the relationship between perceived parenting attitudes and somatization.

H9: The subscales of self-compassion significantly mediate the relationship between perceived parenting attitudes and somatization.

CHAPTER 2: METHOD

2.1. Participants

The sample of the current study includes 303 participants, 248 women, 54 men and 1 non-binary (Mean = 34.12 and SD = 9.73). Participants were selected according to convenience sampling. The two inclusion criteria were 1) being voluntary; and 2) being 18 years and above. The age range was between 18-69. Demographic information about participant's, such as age, gender, education and income level, marital status, psychiatric and psychologic diagnoses, dermatological diagnoses are showed in the Table 4.

For the level of education variable, one participant graduated from elementary school (0.3 %); two participants graduated from middle school (0.6 %); thirty participants graduated from high school (8.7 %); one hundred seventy – four participants had associate degree (50.6 %); eighty – two participants had master's degree (23.8 %); fourteen participants had a Ph.D. (4.1 %).

Regarding the income level eighteen participants defined their level as lower (5.2 %); one hundred fifty – one participants defined their level as lower – middle (43.9 %); one hundred twenty – five participants defined their level as middle – upper (36.3 %) and nine participants defined their level as upper (2.6 %).

Fifty – two participants reported to have chronic disorder (15.1 %); fifty-three participants reported psychiatric diagnosis (15.4 %); thirty-nine participants reported that they used psychiatric medicine in the last three months (11.3 %) and lastly, seventy-two participants reported that they got psychological help in the last three months (20.9 %).

Finally, one hundred forty – seven participants had dermatological complaints such as eczema, psora, urticaria, herpes zoster, rosacea etc. (42.7 %); ninety-eight participants had one dermatological complaints (28.5 %); forty-two participants had two dermatological complaints (12.2 %); twelve participants had three dermatological complaints (3.5 %) and three participants had four dermatological complaints (0.9 %).

Table 4. Demographic Characteristics of the Participants

Study Variables		**N**	**%**
Gender	Female	248	72.1
	Male	54	15.7
	Non-binary	1	0.3
Level of Education	Elementary school	1	0.3
	Middle school	2	0.6
	High school	30	8.7
	Associate degree	174	50.6
	Master's degree	82	23.8
	Ph.D degree	14	4.1
Income Level	Lower	18	5.2
	Lower – Middle	151	43.9
	Middle	125	36.3
	Upper	9	2.6
Chronic Disorder	Yes	52	15.1
	No	251	73
Psychiatric Diagnosis	Yes	53	15.4
	No	250	72.7
Medication Use	Yes	39	11.3
	No	264	76.7
Psychotherapy Experience	Yes	72	20.9
	No	231	67.2
Dermatological Complaints	Yes	147	42.7
	No	156	45.3
Amount of Dermatological Complaints	None	148	43
	One	98	28.5
	Two	42	12.2
	Three	12	3.5
	Four	3	0.9

2.2. Instruments

In the beginning of the study, Informed Consent Form (Appendix B) was given to participants. Also, a Sociodemographic Information Form (Appendix C) was developed by the researcher to gain information about participants of the study. To measure somatization, Somatization Subscale of Minnesota Multiphasic Personality Inventory (Appendix D) was used. Young Parenting Inventory (Appendix E) was used to measure perceived parenting attitudes. To measure emotion expression, The Emotional Expression Questionnaire (Appendix F) was conducted. Lastly, Self-Compassion Scale (Appendix G) was used to measure self-compassion. The tools used in the study for data collection will be discussed in detailed in the following sections.

2.2.1. Sociodemographic Form

Demographic information form was developed to gather sociodemographic data from the participants. Form included questions about participant's gender, age, education and income level, marital status, psychiatric/chronic health issue, medication usage and psychotherapy support.

2.2.2. Somatization Scale of Minnesota Multiphasic Personality Inventory

The somatic symptom scale used in the current study was taken from Minnesota Multiphasic Personality Inventory (MMPI) and was developed by Hathaway and Mckinley (1943). The scale aims to provide psychiatric information about patients with detection, characterization and measurement of psychoneurotic trends and it is considered as personality inventory (Hathaway, Mckinley, 1943).

The whole scale includes 566 items, 3 validity subscales and 10 personality subscales. Validity subscales are Lie (L), Frequency/Infrequency (F) and Defensiveness (K). The lie scale aims to detect those who are consciously attempting to avoid answering the items truthfully and frankly. The frequency/infrequency scale designed to identify unusual methods of responding to the test items, such as responding randomly. The correction scale is designed to identify signs of psychopathology in individuals whose characteristics would typically be considered

within the normal range. It evaluates aspects such as self-control, as well as familial and interpersonal interactions. Personality subscales are hypochondriasis, depression, hysteria, psychopathic deviate, masculinity-femininity, paranoia, psychasthenia, schizophrenia, hypomania, social introversion. It is answered based on three categories “True”, “False” and “Can not say”.

For the present study, only the somatization (Hypochondriasis) subscale was used, including 33 items. The questions aim examine somatic symptoms such as dizziness, gastrointestinal symptoms, numbness and chronic pain (e.g. “I feel tired most of the time.”; “Most of the time my head hurts all over.”). Each item has true or false options. Total score varies between 0-33. For scoring “True” calculated as 1 and “False” calculated as 0. Some items require reverse coding (2., 3., 8., 9., 13., 14., 15., 16., 17., 18., 24., 25., 28., 29., 30., 31.) Scores close to 33 can be considered as somatization disorder. The subscale has cut-off scores; participants who scored 7 and below 7 regarded as low group and participants who scored 17 and upper 17 regarded as upper group. Besides the raw scores, there is also the term “T” scores which is standardization way of the scores. The raw scores transformed to linear “T” scores based on mean and standard deviation of corresponding norm groups. For hypochondriasis subscale (Mean= 50, SD= 10), T scores higher than 80 means excessive somatic complaints and T scores between 21-49 means lower somatic complaints. A study done by Hunsley, Hanson and Parker (1988) found moderate reliability and stability scores for all scales; reliability values ranged from .71 to .84 and stability values ranged from .63 to .86.

The first Turkish adaptation studies done by Savaşır (1981) then done by Dülgerler (2000). In study done by Dülgerler (2000), internal consistency was found to be α = .83, test-retest reliability was found .996 and validity of the scale is found as .80. Split half correlation is found to be .63. In the present study, the alpha internal consistency reliability coefficient was found to be .86

2.2.3 Young Parenting Inventory

Young Parenting Inventory (YPI) is a self-report measure developed by Young (1994). The YPI aimed to measure perceived parenting attitudes since it is considered as a representation of the negative core beliefs.

In the original form, there are 72 items and 17 sub-dimension which are: Emotional

Deprivation (e.g. “Loved me, treated me as someone special.”), Mistrust/Abuse (e.g “Treated me as if I was stupid or untalented.”), Abandonment (e.g. “Made me feel unloved or rejected.”), Vulnerability to Harm (e.g. “Worried excessively that I would get hurt.”), Defectiveness/Shame (e.g. “Treated me as if there was something wrong with me.”), Subjugation (e.g. “Made me feel I couldn’t rely on my decisions or judgment.”), Self-Sacrifice (e.g. “Did too many things for me instead of letting me do things on my own.”), Failure to Achieve (e.g. "Expected me to be a failure in life.”), Dependence/Incompetence (e.g. “Treated me as if I were younger than I really was.”), Unrelenting Standards (e.g. “Had very high expectations for him/herself.”), Entitlement (e.g. “Was concerned with social status and appearance.), Insufficient Self Control/Self-Discipline (e.g. “Controlled my life so that I had little freedom of choice.”) , Enmeshment (e.g. “I felt that I didn’t have enough individuality or sense of self separate from him/her.”), Negativity/Pessimism (e.g. “Had a pessimistic outlook; often expected the worst outcome.”), Emotional Inhibition (e.g. “Was uncomfortable expressing affection or vulnerability.”), Punitiveness (e.g. “Would punish me when I did something wrong.”), and Approval-Seeking (e.g. “Treated me as if my opinions or desires didn’t count.”).

In the instruction, participants are asked to rate according to descriptive behaviors of their parents in a likert –scale from 1 (completely untrue) to 6 (describes him/her perfectly). First 5 items and 36., 45., 52., and 63. Items are reversed coded. Higher scores indicate negative parenting and perception that the parents behaved in ways that generate related core belief (Soygüt, Çakır ve Karaosmanğlu, 2008; Sheffield et al., 2006). Factors were included in each factor analysis if their eigenvalue was more than 1.00, and items were included if their loading was 0.40 or higher (Comrey and Lee, 1992). With eigenvalues ranging from 1.04 to 19.43 and percentages of variance explained between 1.77 and 26.98, there were 11 maternal factors. With eigenvalues ranging from 1.16 to 19.35 and percentages of variance explained between 1.54 and 26.87, there were 14 paternal factors. A scale was created utilizing only the items and factors that were shared by both parents because there was a significant overlap between the two factor structures. Consequently, the Young Parenting Inventory (YPI) consisted of nine factors that were shared by both mothers and fathers: emotionally depriving parenting, overprotective/anxious parenting, belittling/criticizing parenting, conditional/narcissistic parenting, pessimistic/worried parenting, controlling parenting, restricted/emotionally inhibited parenting, punitive

parenting, and perfectionist parenting. These factors were found to have good internal consistency. Original form's psychometric properties are found to be reliable and valid. The scale has strong test–retest reliability for both parents, ranging between 0.53 – 0.85, Cronbach's alpha of the all items were greater than 0.65, ranging between .67 - .92 (Sheffield et al., 2006).

Turkish adaptation studies done by Soygüt et al., (2008), for mother and father forms, common structure with 10 factors was reached since only 10 factor's eigenvalues were more than 1.00. In the Turkish adaptation study, according to factor analysis results, over-permissive/boundless parenting and exploitative/abusive parenting were added, perfectionist parenting was excluded and narcissistic parenting turned into achievement focused parenting; controlling parenting turned into normative parenting. Reliability for mother form is .38 - .83, for father form is .56 - .85. Validity for mother form is α = .53 - .86, for father form is α = .61 - .88. Factor analysis for both maternal and paternal forms showed ten common factors and results overlap between the Turkish adaptation study and Sheffield et al.,'s (2005) study. In the present study, the internal consistency reliability coefficient was found to be .96 for the whole scale, .94 for the mother form and .93 for the father form.

2.2.4. The Emotional Expression Questionnaire

The Emotional Expression Questionnaire is a self-report assessment created by King and Emmons (1990) to acquire information about emotion expression by both verbal and nonverbal ways.

Questionnaire includes 16 items (e.g., "When I am angry people around me usually know") aims to evaluate three dimensions which are "positive" "negative" and "closeness". The positive dimension pertains to the display of positive emotions such as laughter, liking, and affection. The closeness dimension involves expressions of liking, love, gratitude, and apologizing. Lastly, the negative dimension involves the expression of negative emotions such as anger and disappointment.

Scale is likert type from 1 (completely disagree) to 7 (completely agree). Positive emotions sub-scale has seven items (3., 4., 9., 11., 13. and 15.), closeness sub-scale has five items (1., 6., 7., 8. and 12.) and negative sub-scale has 4 items (2., 5., 10. and 14.). 6. and 14. items are negative items which requires reverse scoring. Scoring is done by adding all items together, high scores mean higher emotional expression.

Original study revealed that alpha reliability was .89, test-retest correlation was found to be .78.

Turkish adaptation studies done by Kuzucu (2011). In the Turkish version, scale has 15 items since one item was excluded due to high load on three factors. Results showed that the scale is reliable α =.85 and valid .78. "Positive emotion expression" factor has .74 internal consistency, "negative emotion expression" factor has .67 internal consistency and lastly, "closeness expression" factor has .63 internal consistency. All factors showed positive correlation with each other. In the present study, the internal consistency reliability coefficient was found to be .76 for the whole scale, .75 for the positive emotion expression, .41 for the negative emotion expression and .45 for the closeness expression.

2.2.5. Self-Compassion Scale

The Self-Compassion Scale is a self-report measure developed by Neff (2003) aimed to measure level of compassionate attitude of people to themselves.

Scale has 26 items with 5-point likert type (1=never, 5=always) and 6 sub-dimensions which are: Self-kindness (Questions; 2,6,13,17,21 e.g. "I'm kind to myself when I'm experiencing suffering."), self-judgement (Questions; 4,7,15,20,26, e.g. "When times are really difficult, I tend to be tough on myself."), common humanity (Questions; 1,8,12,22, e.g. "I try to see my failings as a part of the human condition."), isolation (Questions; 5,11,19,25, e.g. "When I'm feeling down I tend to feel like most other people are probably happier than I am."), mindfulness (Questions; 9,14,18,23, e.g. "When something painful happens I try to take a balanced view of the situation.") and over-identification (Questions; 3,10,16,24, e.g. "When something painful happens, I tend to blow the incidence out of proportion."). High scores obtained from each subscale means that the characteristic of that sub-scale is observable. Negative sub-scales such as self-judgement, isolation and over-identification can be reverse coded. The overall mean-score ranges from 1 to 5. Closer scores to the 5 means high self-compassion. In the original study, coefficients of internal consistency were .78, .77, .80, .79, .75 and .81 for self-kindness, self-judgement, common humanity, isolation, mindfulness, over-identification respectively. For the scale as a whole, the coefficient of internal consistency was .92.

Turkish adaptation study done by Akın, Akın and Abacı (2007). Results yield that

internal consistency of the scale varied between .72-.80 and test-retest reliability coefficients varied between .56-.69. These results are found to be consistent with the original study. Cronbach alpha results for the present study of self-compassion was found to be .95 for the whole scale and .87, .88, .84, .80, .81 and .82 for self-kindness, self-judgement, common humanity, isolation, mindfulness, over-identification respectively.

2.3. Procedure

First of all, an ethical approval was obtained from the Ethic Committee of IEU (REF number, and appendix). The data collection process was online since the Earthquake hit Türkiye (March 2023) and universities became online. All data collection process conducted online via Google Forms. It was aimed to reach participants with convenience sampling from Turkey population. Participants were reached through social media (e.g. Instagram, Twitter, WhatsApp) and were requested to complete the survey via online link. The process was voluntary. Participants with age over eighteen took part in the study. In the beginning, an informed consent was given to the participants which included the information about the study. The participants were informed about the voluntary nature of their participation and were given the freedom to withdraw from the study at any time they desired. After participants signed the informed consent, they filled out the questionnaires in the following order: Sociodemographic Information Form, Somatization Subscale of the Multiphasic Personality Inventory, Young Parenting Inventory, The Emotion Expression Questionnaire and Self-Compassion Scale. It took approximately 15 minutes to completion of scales.

2.4. Statistical Analysis

To analyze data, Statistical Package for Social Sciences (SPSS) version 20 and PROCESS v4.2 (Hayes, 2013) were used. The data was screened to control if there is any missing data. Preliminary analysis was conducted before the main analysis. Preliminary analysis included checking descriptive statistics and normality analyses for continuous variables and internal reliability analyses for the scales.

For the analysis of descriptive statistics, mean, standard deviation, percentage, and

frequency scores were calculated for continuous variables. Also, normality values were checked through the skewness and kurtosis values according to the range between +1.5, -1.5 (Tabachnick and Fidell, 2007). The Cronbach alpha values were checked with the original studies for all scales. It was found that all scales whole reliability scores were similar accordingly original studies.

To investigate the relationships among variables (ie. somatization, perceived parenting attitudes, emotion expression, self-compassion, psychodermatology) Pearson Correlation analysis were performed. For group differences, independent sample t-test analysis was conducted. Lastly, mediation analyses were operated to examine the mediating roles of emotion expression and self-compassion. The mediation model used in the study is displayed in Figure 5.

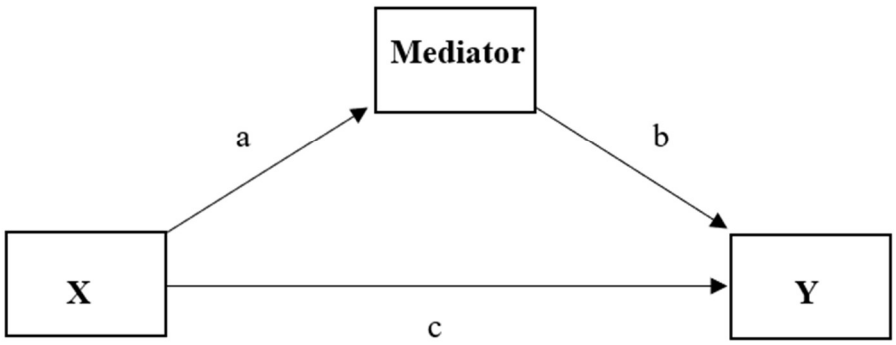


Figure 3. The mediation model used in the study.

CHAPTER 3: RESULTS

In this chapter, preliminary analyses and main analyses, will be presented respectively. Preliminary analysis consists of reliability tests, normality checks, and descriptive statistics. Main analysis consists of group differences of study variables, relationship among study variables, and simple mediation analyses.

3.1. Preliminary Analyses

3.1.1. Reliability Tests

Cronbach's Alpha values were calculated for each scale used in the study to measure their reliability. The Cronbach Alpha values of the scales were adequate, indicating that the items of scales had good internal consistency (Table 5.).

Table 5. Cronbach Alpha Values of The Scales.

Scales	*a*
Somatization Scales	.86
Young Parenting Inventory	.96
Mother Form	.94
Father Form	.93
Emotional Expression	.76
Positive Emotion	.75
Negative Emotion	.41
Closeness	.45
Self-Compassion	.95
Self-Kindness	.87
Self-Judgement	.88
Common Humanity	.84
Isolation	.80
Mindfulness	.81
Over-Identification	.82

3.1.2. Normality

To check the normality of the study variables, skewness and kurtosis variables were analyzed (Table 6.). All variables had skewness and kurtosis values fell between (-1.50) and (+1.50) which defined as critical values for normality (Tabachnick and Fidell, 2007).

Table 6. Skewness and Kurtosis Values of the Study Variables.

Variables	*Skewness*	*Kurtosis*
Somatization	0.144	-0.795
Young Parenting	0.255	-0.346
Emotional Expression	-0.519	0.450
Self-Compassion	0.130	-0.492
Psychodermatology	1.142	0.909

3.1.3. Descriptive Statistics

The study variables were analyzed to determine their descriptive statistics of the study which are the mean (M), standard deviation (SD), maximum (Max), and minimum (Min) scores (Table 7.).

Table 7. Descriptive Statistics of the Study Variables.

Scales	*M*	*SD*	*Max*	*Min*
Somatization	13.17	6.38	33	0
Young Parenting Inventory	354.92	116.65	864	0
Emotional Expression	71.68	12.10	112	16
Positive Emotional Expression	4.72	1.15	7	1
Negative Emotional Expression	4.73	1.02	7	1
Closeness Expression	4.89	0.99	7	1

Table 7. Descriptive Statistics of the Study Variables (Continued)

Self-Compassion	74.43	21.13	125	26
Self-Kindness	2.88	0.94	5	1
Self-Judgement	2.70	1.03	5	1
Common Humanity	3.04	0.97	5	1
Isolation	2.73	0.10	5	1
Mindfulness	3.21	0.87	5	1
Over-Identification	2.66	0.99	5	1

3.2. Main Analyses

3.2.1. Between-Group Differences

Gender

Independent samples t-tests were conducted to explore the disparities between female and male participants in terms of their scores on somatization, psychodermatology, perceived negative parenting, perceived mothering and perceived fathering, emotional expression and self-compassion (Table 8). Results revealed that there was significant difference between female and male participants according to somatization, t (300) = 3.695, $p < .05$. Results yielded that, female participants (M = 14.04, SE = .399) had reported more somatization compared to male participants (M = 9.13, SE = .716). According to results, female participants (M = .83, SE = .059) reported more dermatological complaints compare to male participants (M = .37, SE = .081), t (300) = 3.510, $p < .05$. Also, it was observed that female participants (M = 2.77, SE = .044) experienced more perceived negative parenting male participants (M = 2.46, SE =.084), t (300) = 2.256, $p <.05$. Similarly, female participants (M = 2.83, SE =.050) experienced more negative perceived mothering, (t (300) = 4.911, $p <.05$) compared to male participants (M = 2.44, SE =.0849). However, results revealed that there was no gender difference for perceived fathering, t (300) = 3.452, $p >.05$. In the same way, it was not observed gender difference for emotional expression, t (300) =0.050, $p > .05$. Contrarily, it was found significant gender difference between female and male participants according to self-

compassion, t (300) =2.877, $p < .05$. Results showed that male participants (M = 3.14, SE = .105), reported more self-compassion compared to female participants (M = 2.80, SE = .052) (Table 8)

Table 8. T-Test Values for the Gender According to Scales

	Gender	***N***	***M***	***SD***	***T***	***df***	***p***	***Effect Size***
Somatization	Female	248	14.04	6.27	3.695	300	.000*	0.9
	Male	54	9.13	5.26				
Psychodermatology	Female	248	.83	.93	3.510	300	.000*	0.6
	Male	54	.37	.59				
Perceived Negative Parenting	Female	248	2.77	.70	2.256	300	.003*	0.5
	Male	54	2.46	.61				
Perceived Negative Mothering	Female	248	2.83	.79	4.911	300	.000*	0.5
	Male	54	2.44	.66				
Perceived Negative Fathering	Female	248	2.71	.83	3.452	300	.057	0.3
	Male	54	2.48	.69				
Emotional Expression	Female	248	4.78	.89	0.050	300	.960	0.0
	Male	54	4.77	.81				
Self-Compassion	Female	248	2.80	.83	2.877	300	.005*	0.4
	Male	54	3.14	.70				

*p <.05

3.2.2. Correlation Analyses

Pearson product-moment correlation coefficients were computed to evaluate the associations between somatization, psychodermatology, perceived negative parenting attitudes, emotional expression, and self-compassion (Table 9). There was a weak positive correlation between somatization and perceived negative parenting $r = .34$, $p < .05$; a weak negative correlation between somatization and emotional expression $r = .21$, $p < .05$; and a moderate negative correlation between somatization and self-compassion $r = .50$, $p < .05$. Higher somatization was associated with increased negative parenting, whereas decreased somatization was related to increased

emotional expression and self-compassion. There was no correlation between psychodermatology and perceived parenting, $r = .10$, $p > .05$; perceived fatherhood $r = .03$, $p > .05$; emotional expression, $r = .06$, $p > .05$ and self-compassion, $r = -.05$, $p > .05$. However, there were weak positive correlations between somatization, $r = .13$, $p < .05$ and perceived mothering $r = .14$, $p < .05$. As somatization and negative mothering increased, psychodermatology also increased. There was no correlation between perceived parenting and emotional expression $r = -.04$, $p > .05$. On the other hand, there was a weak negative correlation between perceived negative parenting and self-compassion $r = -.32$, $p < .05$. As perceived negative parenting increased, self-compassion decreased. There was a weak positive correlation between emotional expression and self-compassion $r = .31$, $p < .05$. When emotional expression increased, self- compassion also increased.

Table 9. Pearson's Correlation Analysis Results for Somatization, Psychodermatology, Perceived Parenting, Perceived Mothering, Perceived Fathering, Emotional Expression, Sub-dimensions of Emotional Expression, Self-Compassion and Sub-dimensions of Self-Compassion

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Somatization	1															
2. Psychodermatology	.13*	1														
3. Perceived Parenting	.34**	.10	1													
4. Perceived Mothering	.36**	.14*	.87**	1												
5. Perceived Fathering	.24**	.03	.88**	.53**	1											
6. Emotional Expression	-.21**	.06	-.04	-.02	-.05	1										
7. Positive Emotional Expression	-.22**	.07	-.08	-.05	-.08	.91**	1									
8. Negative Emotional Expression	.06	.10	.14*	.18**	.08	.65**	.43**	1								
9. Closeness Expression	-.31**	-.01	-.12*	-.12*	-.09	.82**	.65**	.30**	1							
10. Self-Compassion	-.50**	-.05	-.32*	-.29**	-.28**	.31**	.65**	.01	.33**	1						
11. Self-Kindness	-.43**	-.04	-.27**	-.24**	-.23**	.37**	.37**	.06	.41**	.88**	1					
12. Self-Judgement	-.42**	-.09	-.29**	-.27**	-.24**	.21**	.19**	-.03	.31**	.87**	.69**	1				
13. Common Humanity	-.32**	.02	-.21**	-.18**	-.19**	.33**	.34**	.09	.32**	.77**	.75**	.75**	1			
14. Isolation	-.48**	-.03	-.32**	-.30**	-.26**	.21**	.18**	-.03	.32**	.83**	.59**	.76**	.48**	1		
15. Mindfulness	-.37**	-.07	-.19**	-.18**	-.15**	.29**	.29**	.02	.34**	.82**	.78**	.57**	.70**	.54**	1	
16. Over-Identification	-.47**	-.02	-.29**	-.29**	-.23**	.17**	.16**	-.04	.25**	.84**	.59**	.76**	.49**	.78**	.59**	1

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

Somatization was not found to be correlated only with over-permissive/boundless parenting, $r = .03$, $p > .05$. All other perceived negative parenting styles, emotionally depriving ($r = .28$, $p < .05$), overprotective/anxious ($r = .15$, $p < .05$), belittling/criticizing ($r = .35$, $p < .05$), conditional/ achievement focused ($r = .16$, $p < .05$), pessimistic/worried ($r = .33$, $p < .05$), punitive ($r = .29$, $p < .05$), restricted/emotionally inhibited ($r = .28$, $p < .05$), normative ($r = .34$, $p < .05$), and exploitative/abusive ($r = .27$, $p < .05$), were found to be positively correlated with somatization. Belittling/criticizing, pessimistic/worried and normative parenting was found to be moderate correlated with somatization. As emotionally depriving, overprotective/anxious, belittling/criticizing, conditional/achievement focused, pessimistic/worried, punitive, restricted/emotionally inhibited, normative and exploitative/abusive parenting increased, somatization also increased.

Psychodermatology was only found to be correlated with normative parenting ($r = .19$, $p < .05$), belittling/criticizing parenting ($r = .17$, $p < .05$), conditional/achievement focused parenting ($r = .15$, $p < .05$) punitive parenting ($r = .12$, $p < .05$). The correlations were weak and positive. Higher levels of normative, belittling/criticizing, conditional/achievement focused and punitive parenting associated with higher levels of psychodermatology.

There was a weak positive correlation between emotional expression and conditional motherhood ($r = .16$, $p < .05$) and fatherhood ($r = .12$, $p < .05$). As conditional motherhood and fatherhood increased, emotional expression also increased. Additionally, there was weak negative correlation between emotional expression and exploitive motherhood ($r = -.14$, $p < .05$) and fatherhood ($r = -.13$, $p < .05$). respectively. As exploitive motherhood and fatherhood increased, emotional expression decreased. Similarly, there was weak negative correlation between emotional expression and emotionally inhibited motherhood ($r = -.21$, $p < .05$) and fatherhood, ($r = -.22$, $p < .05$). Higher levels of emotionally inhibited motherhood and fatherhood were associated with lower levels of emotional expression.

It is founded that there was weak negative correlation between positive emotional expression and somatization, $r = .22$, $p < .05$. When somatization increased, positive emotional expression decreased. Contrarily, there was moderate positive correlation between positive emotional expression and self-compassion, $r = .31$, $p < .05$. As self-compassion increased, positive emotional expression also increased. Also, there was weak positive relation between positive emotional expression and conditional

motherhood, $r = .13$, $p < .05$. As conditional motherhood increased, positive emotional expression also increased. Contrarily, there were weak negative correlations between positive emotional expression and exploitive motherhood ($r = -.14$, $p < .05$) and emotionally inhibited motherhood ($r = -.25$, $p < .05$) and fatherhood ($r = -.25$, $p < .05$). Higher levels of exploitive motherhood and emotionally inhibited parenting associated with lower levels of emotional expression.

The study founded a weak positive correlation between negative emotional expression and perceived mothering, $r = .18$, $p < .05$. As negative perceived mothering increased, negative emotional expression also increased. Negative emotional expression was not found to be correlated with perceived fathering ($r = .08$, $p > .05$), somatization ($r = .06$, $p > .05$), and self-compassion ($r = .01$, $p > .05$). Moreover, there were weak positive correlations between negative emotional expression and conditional ($r = .22$, $p < .05$), pessimistic ($r = .22$, $p < .05$) and punitive ($r = .21$, $p < .05$) parenting. When conditional, pessimistic and punitive parenting increased, negative emotional expression also increased. Lastly, the weak positive relationship was found between controlling ($r = .14$, $p < .05$) and belittling motherhood ($r = .15$, $p < .05$). As controlling and belittling motherhood increased, negative emotional expression also increased.

There was moderate negative correlation with closeness expression and somatization, $r = -.31$, $p < .05$. With the increased of somatization, closeness expression decreased. Similarly, there was weak negative correlation between closeness expression and perceived mothering, $r = -.12$, $p < .05$. As negative mothering increased, closeness expression decreased. Also, there was moderate positive relationship between closeness expression and self-compassion, $r = .39$, $p < .05$. Higher levels of self-compassion associated with higher levels of closeness expression. However, there was no correlation between closeness expression and perceived fathering, $r = -.10$, $p > .05$. There were weak negative correlations between closeness expression and emotionally depriving parenting ($r = -.22$, $p < .05$), exploitive parenting ($r = -.17$, $p < .05$), pessimistic ($r = -.16$, $p < .05$) and emotionally inhibited motherhood ($r = -.12$, $p < .05$). As emotionally depriving parenting, exploitive parenting, pessimistic and emotionally inhibited motherhood increase, closeness expression decreases.

3.2.3. Mediation Analyses

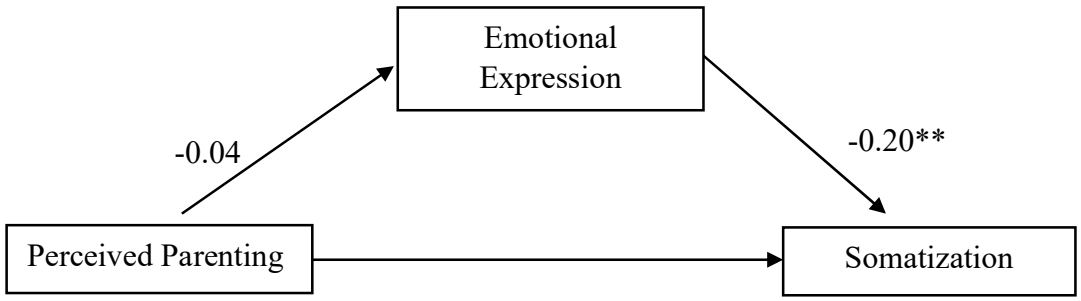
Mediation analysis was performed to examine the mediating role of emotional expression and self-compassion on the relationship between perceived negative parenting attitudes and somatization. The analysis followed the Simple Mediator Analysis procedure outlined by Hayes (2013) using the PROCESS Model 4. In this particular analysis, the predictor variable was perceived parenting attitudes, the outcome variable was somatization, and the mediators were emotional expression and self-compassion. To determine the significance of the mediating variables, a bootstrap sampling technique was employed with 5000 resamples with the 95% confidence interval.

3.2.3.1. The Mediating Role of Emotional Expression in the Relation Between Perceived Parenting Attitudes and Somatization

The initial simple mediation analyses aimed to examine the mediating role of emotional expression on the relationship between perceived parenting attitude and somatization. The mediation model was given in Figure 6.

Results showed that perceived parenting did not show direct effect on emotional expression, b = -0.04, t = -.71, p > .05. However, perceived negative parenting had a significant direct effect on somatization with the presence of emotional expression in the model, b = 3.06, t = 6.27, p < .05. There was a positive direct effect where perceived negative parenting increased, somatization also increased. Also, emotional expression had significant direct effect on somatization, b = -0.20, t = -3.76, p < .05. The effect was negative, as somatization increased, emotional expression decreased. This model explains 16% of the variance in somatization. As perceived negative parenting and emotional expression increased, somatization decreased. When emotional expression was not in the model, perceived negative parenting had significant direct effect on somatization b = 3.06, t = 6.29, p < .05, explaining 12% of the variance in somatization. The variance explained by the model when the mediator was involved was more than the model in which the predictor existed only. There was not a significant indirect effect of perceived parenting attitudes on somatization through emotional expression, b = 0.07, 95% BCa CI [-.161, .325]. For the standardized indirect effect, b = 0.01, 95% Bca CI [-.018, .035]. Bootstrapped

confidence intervals included zero. For this reason, emotional expression did not play a mediator role in the relation between perceived negative parenting attitudes and somatization.



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

Direct effect, b = 3.06, p <.05

Indirect effect, b = 0.07, 95% BCa CI [-.161, .325].

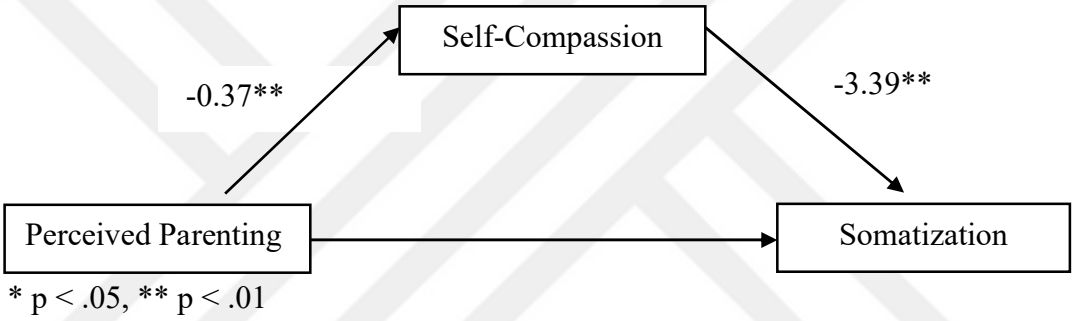
Figure 4. The mediation pathway for the relationship among perceived parenting and social somatization, mediated by emotional expression.

3.2.3.2. The Mediating Role of Self-Compassion in the Relation Between Perceived Parenting Attitudes and Somatization

The second simple mediation analysis was performed to analyze the mediating role of self-compassion on the relationship between perceived negative parenting attitude and somatization. The mediation model was given in Figure 7.

Results indicated that perceived negative parenting had significant direct effect on self-compassion, b = -0.37, t = -5.75, p < .05. The relationship between them was negative. Perceived negative parenting explained 10% of the variance in self-compassion, the negative b value indicates a negative relationship. As perceived negative parenting increased, self-compassion decreased. Also, perceived negative parenting showed significant direct effect on somatization with the presence of self-compassion, b = 1.88, t = 3.98, p < .05. There was found to be positive direct effect. High levels of perceived negative parenting linked with high levels of somatization. Similarly, self-compassion had significant direct effect on somatization b = -3.39, t = -8.41, p < .05. There was negative effect. As self-compassion increased, somatization decreased. The model explained 28% of the variance in somatization. Lastly,

perceived negative parenting did show significant direct effect on somatization, b = 3.13, t = 6.23, p < .05. The positive b value indicated a positive effect. Perceived parenting explained 12% of the variance in somatization. The variance explained by the model when the mediator was involved was more than the model where the predictor existed only. There was a significant indirect effect of perceived parenting on somatization through self-compassion b = 1.25, 95% BCa CI [.794, 1.760]. For the standardized indirect effect, b = 0.14, 95% BCa CI [.085, .189]. Bootstrapped confidence intervals do not include zero. Therefore, self-compassion played a mediator role in the relation between perceived parenting attitudes and somatization. As a conclusion, perceived parenting attitudes predicted high levels of somatization when mediated by self-compassion.



Direct effect, b = 1.88, p < .05

Indirect effect, b = 1.25, 95% BCa CI [.794, 1.760].

Figure 5. The mediation pathway for the relationship among perceived parenting and social somatization, mediated by self-compassion.

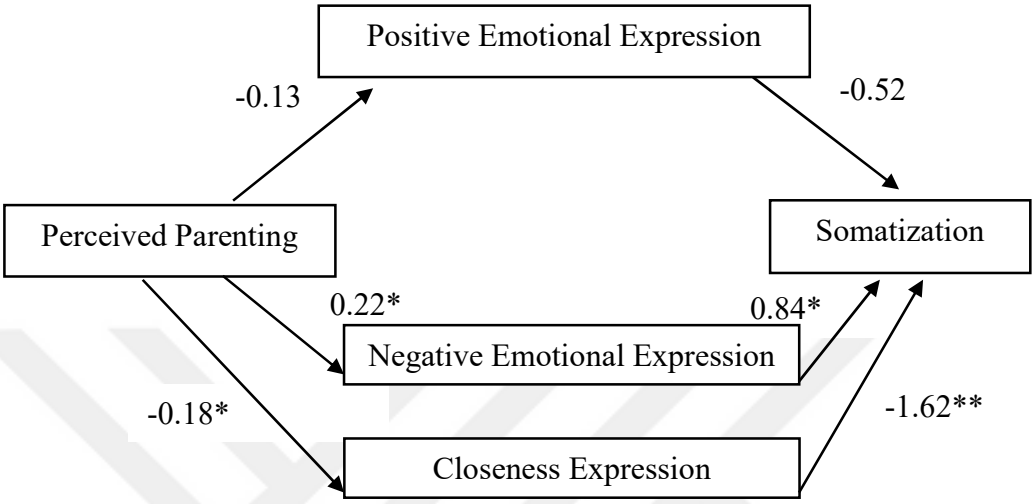
3.2.3.3. The Mediating Role of Positive, Negative Emotion and Closeness Expression in Relation Between Perceived Parenting Attitudes and Somatization

The third mediation analysis was multiple mediation analysis aimed to investigate the mediating role of positive, negative emotion and closeness expression on the relationship between perceived parenting attitude and somatization. The mediation model was given in Figure 8.

The results of mediation analysis revealed that perceived negative parenting attitude did not show direct effect on positive emotional expression, b = -0.13, t = -1.32, p > .05. However, perceived negative parenting attitudes had significant direct effect on negative emotion expression, b = 0.22, t = 2.59, p < .05. There was a positive direct

effect. Perceived negative parenting attitudes explained 2% of variance in negative emotion expression. Increased of negative parenting associated with increased of negative emotional expression. Also, perceived negative parenting attitudes show significant direct effect on closeness expression, b= -0.18, t = -2.16, p < .05. The effect was found to be negative. Perceived negative parenting attitudes explained 2% of variance in closeness expression. High level of perceived negative parenting related with low level of closeness expression. Similarly, perceived negative parenting had significant direct effect on somatization with the presence of positive, negative emotion and closeness expression, b = 2.60, t = 5.31, p < .05. The effect was positive. As perceived negative parenting increased, somatization also increased. However, positive emotion expression did not significantly predicted somatization, b = -0.52, t = -1.29, p > .05. On the other hand, negative emotion expression did show direct effect on somatization, b = 0.84, t = 2.30, p < .05. The b value indicated a positive effect. As negative emotion expression increased, somatization also increased. Also, closeness expression had significant direct effect on somatization, b = -1.62, t = -3.64, p < .05. The effect was negative. As closeness expression increased, somatization decreased. This model explained 20% of variance in somatization. Lastly, perceived negative parenting did significant direct effect on somatization, b =3.13, t = 6.29, p < .05. Perceived negative parenting attitudes explained 12% of variance in somatization. There was a positive effect. Increased of perceived negative parenting associated with increased somatization. The variance explained by the model when the mediators involved was more than the model where the predictor existed only. There was not significant indirect effect of perceived negative parenting on somatization through positive emotion expression b = 0.07, 95% BCa CI [-.052, .273]. For the standardized indirect effect, b = 0.01, 95% BCa CI [-.006, .031]. However, there was significant indirect effect of perceived negative parenting on somatization through negative emotional expression b = 0.18, 95% BCa CI [.005, .437]. For the standardized indirect effect, b = 0.02, 95% BCa CI [.001, .148]. Also, there was significant indirect effect of perceived negative parenting on somatization through closeness expression b = 0.28, 95% BCa CI [.011, .648]. For the standardized indirect effect, b = 0.28, 95% BCa CI [.011, .648]. Bootstrapped confidence intervals include zero for positive emotional expression but do not include zero for the negative emotional expression and closeness expression. Therefore, negative emotional expression and closeness expression both played a

mediator role in relation between perceived negative parenting attitudes and somatization. As a conclusion, perceived negative parenting attitudes predicted high levels of somatization when mediated by negative emotional expression and closeness expression.



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

Direct effect, $b = 2.60$, $p < .05$

Indirect effect positive emotional expression, $b = 0.07$, 95% BCa CI [-.052, .273].

Indirect effect negative emotional expression, $b = 0.18$, 95% BCa CI [.005, .437].

Indirect effect closeness expression, $b = 0.28$, 95% BCa CI [.011, .648].

Figure 6. Multiple Mediation Analysis Model for Emotional Expression with 3 Sub-Dimensions

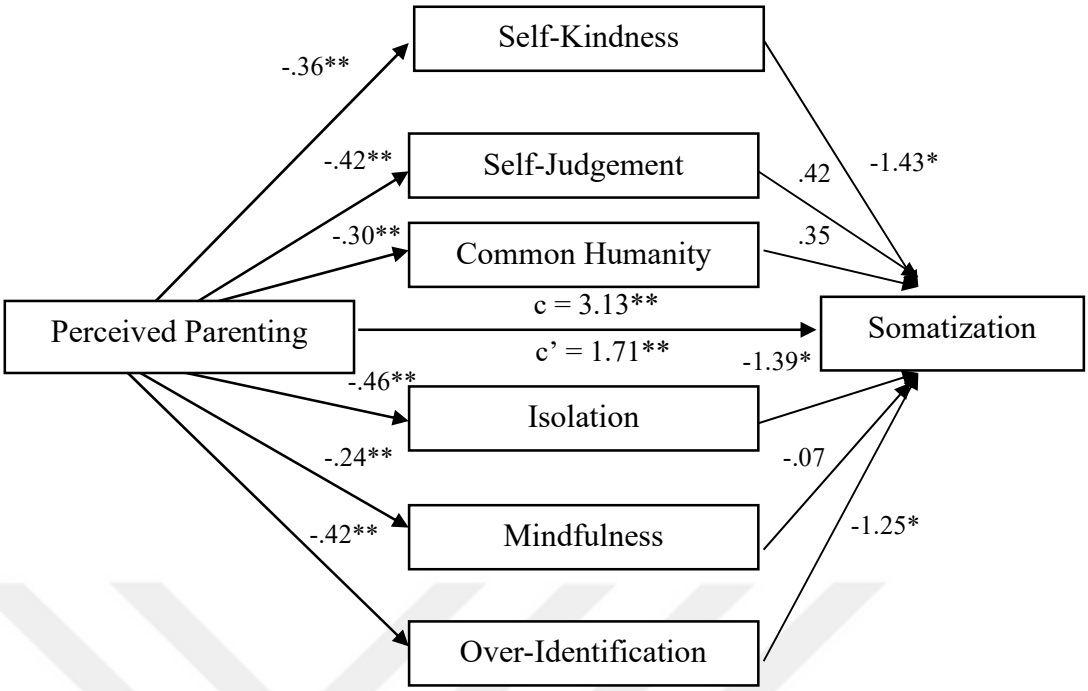
3.2.3.4. The Mediating Role of Self-Kindness, Self-Judgement, Common Humanity, Isolation, Mindfulness and Over-Identification in Relation Between Perceived Parenting Attitudes and Somatization

The last mediation analysis was also multiple mediation analyses conducted to investigate the mediating role of self-kindness, self-judgement, common humanity, isolation, mindfulness and over-identification in relation between perceived parenting attitudes and somatization. The mediation model was given in Figure 9.

Results revealed that perceived parenting attitudes show significant direct effect on self-kindness, $b = -0.36$, $t = -4.84$, $p < .05$. The effect was negative. Perceived parenting attitudes explained 7% of variance in self-kindness. As negative parenting increased, self-kindness decreased. Also, perceived parenting attitudes had

significant direct effect on self-judgement, b = -0.42, t = -5.19, p < .05. The effect was negative. Perceived negative parenting attitudes explained 8% of variance in self-judgement. Increased of negative parenting associated with decreased self-judgement. Similarly, perceived negative parenting attitudes show significant direct effect on common humanity, b = -0.29, t = -3.74, p < .05. b value indicated a negative direct effect. Perceived negative parenting attitudes explained 5% of variance in common humanity. As negative perceived negative parenting increase, common humanity decrease. Likewise, perceived negative parenting attitudes yielded significant direct effect on isolation, b = -0.46, t = -5.87, p < .05. There was a negative direct effect. Perceived negative parenting attitudes explained 10% of variance in isolation. Higher levels of negative perceived negative parenting associated with lower levels of isolation. Moreover, perceived negative parenting attitudes had significant direct effect on mindfulness, b = -0.24, t = -3.30, p < .05. The effect was negative. Perceived negative parenting attitudes explained 4% of variance in mindfulness. As negative perceived negative parenting increased, mindfulness decreased. Lastly, perceived negative parenting attitudes had significant direct effect over-identification, b = -0.42, t = -5.33, p < .05. There was a negative direct effect. Perceived negative parenting attitudes explained 9% of variance in over-identification. As negative perceived negative parenting increased, over-identification decreased. Perceived negative parenting show significant direct effect on somatization with the presence of self-kindness self-judgement, common humanity, isolation, mindfulness and over-identification, b = 1.71, t = 3.60, p < .05. The effect was positive. Higher levels of negative perceived negative parenting associated with higher levels of somatization. Similarly, self-kindness had significant direct effect on somatization, b = -1.43, t = -2.14, p < .05. The effect was negative. As individuals' self-kindness increased, somatization decreased. However, self-judgement did not show significant direct effect on somatization, b = 0.42, t = 0.75, p > .05. Likewise, common humanity did not show significant direct effect on somatization, b = 0.35, t = 0.69, p > .05. Contrarily, isolation had significant direct effect on somatization b = -1.39, t = -2.53, p < .05. The effect was found to be negative. As isolation increased, somatization decreased. Differently, mindfulness did not show significant direct effect on somatization, b = -0.07, t = -0.12, p > .05. Lastly, over-identification had significant direct effect on somatization, b = -1.25, t = -2.21, p < .05. Negative effect was found between them. Higher levels of over-

identification linked with lower levels of somatization. The model explains 31% of variance in somatization. Lastly, perceived negative parenting had significant direct effect on somatization, b =3.13, t = 6.29, p < .05. Perceived negative parenting attitudes explained 12% of variance in somatization. The variance explained by the model when mediators involved was more than the model where the predictor existed only. There was significant indirect effect of perceived negative parenting on somatization through self-kindness, b = 0.52, 95% BCa CI [0.045, 1.090]. For the standardized indirect effect, b = 0.06, 95% BCa CI [-.005, .118]. However, there was not a significant indirect effect of perceived negative parenting on somatization through self-judgement, b = -0.18, 95% BCa CI [-0.661, 0.259]. For the standardized indirect effect, b = -0.02, 95% BCa CI [-.071, .028]. Similarly, there was not a significant indirect effect of perceived negative parenting on somatization through common humanity, b = -0.10, 95% BCa CI [-0.449, 0.208]. For the standardized indirect effect, b = -0.01, 95% BCa CI [-.049, 022]. Contrarily, there was significant indirect effect of perceived negative parenting on somatization through isolation, b = 0.64, 95% BCa CI [0.223, 1.174]. For the standardized indirect effect, b = 0.07, 95% BCa CI [-.024, .128]. Unlikely, there was not a significant indirect effect of perceived negative parenting on somatization through mindfulness, b = 0.17, 95% BCa CI [-0.304, 0.340]. For the standardized indirect effect, b = 0.00, 95% BCa CI [-.007, .115]. Lastly, there was significant indirect effect of perceived negative parenting on somatization through over-identification, b = 0.53, 95% BCa CI [0.062, 1.062]. For the standardized indirect effect, b = 0.06, 95% BCa CI [.007, .115]. Bootstrapped confidence intervals include zero for self-judgement, common humanity and mindfulness but do not include zero for the self-kindness, isolation and over-identification. Therefore, self-kindness, isolation and over-identification played a mediator role in relation between perceived negative parenting attitudes and somatization. As a conclusion, perceived negative parenting attitudes predicted high levels of somatization when mediated by self-kindness, isolation and over-identification.



* p < .05, ** p < .01, c'= direct effect, c = total effect

Figure 7. Multiple Mediator Analysis Model for Self-Compassion with 6 sub-dimensions

CHAPTER 4: DISCUSSION

4.1. Discussion of the Results

The purpose of the present study was to investigate the mediating roles of emotional expression and self-compassion in the relationship between parenting attitudes and somatization in male and female participants. First of all, a gender difference was not found for emotional expression. However, gender difference was found for somatization, psychodermatology, perceived negative parenting (mothering and fathering) and self-compassion. Secondly, a correlation was found between somatization and all the study variables, perceived parenting, emotional expression, and self-compassion, respectively. As negative perceived parenting increased, somatization also increased, and contrarily, as emotional expression and self-compassion decreased, somatization increased. Regarding the main analysis, self-compassion was found as a significant mediator in the relationship between perceived parenting and somatization, especially the subscales self-kindness, isolation, and over-identification. Additionally, emotional expression played a significant mediator role in the same relationship, particularly closeness expression. The findings acquired from the analyzes will be discussed in the light of the literature. Findings linked to research questions, limitations, and recommendations for future research are discussed in the next section.

4.1.1. Gender Differences for Somatization, Psychodermatology, Perceived Parenting, Emotional Expression, Self-Compassion Scales

The present study found gender differences in somatic complaints. It was found that female participants reported more somatic complaints compared to male participants. Regarding the literature, it has been found that somatization disorder is observed 5 to 20 times more frequently in women compared to men (Işık et al., 2008). Literature demonstrated that somatic complaints may be more common among females because they may perceive such complaints as a socially acceptable means of expressing their anxiety and distress, compared to more overt ways of communication (Ladwig et al., 2001). Women tend to be more sensitive to bodily sensations and seek medical help more frequently. Culturally, women also experience less pressure than men to accept

illness and the sick role. In many cultures, male illness is seen as weakness (Wool and Barsky, 1994). Therefore, men often disregard their physical symptoms and avoid seeking medical help. As a result, when considering medical consultations, the proportion of women is higher (Wool and Barsky, 1994). Also, children may prone to take same-sex parent as a role model, as they have a tendency to mirror their parents (van de Putte et al., 2006). Being female was associated with higher levels of somatization for adolescents in the US (Link Egger, Costello, Erkanli and Angold, 1999), in Pakistan (Rehna et al., 2016), in various ethnic groups in Israel (Genizi, Srugo and Kerem, 2013), and Germany (Barkmann et al., 2011). Females overall reported higher somatization compared to males in studies from diverse cultural backgrounds (Alricsson et al., 2006; Barkmann et al., 2011; Link et al., 1999; Rehna et al., 2016). Thus, the results of the present study regarding gender differences are consistent with the literature. It is understandable that somatization tends to be higher among women due to same-sex identification between child and parent. Additionally, considering the cultural differences in the responses that women and men are exposed to, it appears more acceptable for women to report higher levels of somatization symptoms compared to men.

Female participants reported more dermatological complaints compared to male participants in the present study. Similarly, in the field of dermatology, it has been observed that women generally have a higher prevalence of psychiatric comorbidity (Jafferany, 2007). Female dermatology patients often experience issues related to body image, increased levels of anxiety, depression, and obsessive-compulsive behavior, which are associated with various dermatological conditions (Koblenzer, 1997). According to Koblenzer (1997), the prevalence of dermatological conditions such as dermatitis, acne, chronic urticaria, pruritus, psoriasis, and trichotillomania are higher among women compared to men. Koblenzer (1997) suggests that these gender differences may stem from family dynamics and gender-related socialization. Girls are often perceived as more fragile and susceptible, and societal expectations place emphasis on them being compliant and agreeable to receive parental affection and fulfill the role of "daddy's little girl." Also, the literature revealed a relationship between maternal disturbances that individuals perceived and dermatological symptoms. From this result, it can be concluded that females perceive more maternal disturbances compared to males.

In line with the previous result, female participants perceived their parents and

specifically mothers more negatively compared to male participants. The literature indicated that females were more prone to anticipate disapproval from their fathers compared to males (Hampton et al., 2005). Endendjik, Groeneveld, Bakermans-Kranenburg, and Mesman (2016) conducted a meta-analysis study examining the relationship between gender and parental attitudes. The results revealed that parents tend to exhibit more controlling attitudes towards boys compared to girls and employ stricter physical disciplinary methods with boys. The same study also suggested that families adhering to traditional gender roles may display more gender-biased parenting. Similarly, Çeçen (2008) found differences in parental attitudes experienced by women and men in a study conducted with university students in Turkey. Cankardaş (2016) found out that that parental attitudes experienced by women and men differ as expected. When examining the perceived parental attitudes based on participants' gender, it was found that men experienced higher levels of perceived rejection from their parents, while their levels of emotional warmth were lower. Similarly, in a study conducted by Akgül and Dirik (2018) with adolescents, it was found that women perceived higher levels of emotional warmth from their parents compared to men. The same study also observed that women experienced higher levels of overprotectiveness compared to men. The different perceptions of parental attitudes between women and men can be explained within the context of gender roles. Considering gender roles, it is known that parents exhibit different approaches toward their children based on their biological gender (Brody, 1999). Brody (2000) stated that this difference is particularly observed in the expression of emotions, where it is more acceptable for men to express anger and aggression while expressions of sadness, shame, depression, and fear are not as accepted. On the other hand, parents may believe that boys do not require as much emotional warmth as girls do, leading them to be colder and more distant towards their sons. This may contribute to men perceiving higher levels of rejection from both their mothers and fathers. Additionally, the greater acceptance of women's emotions by their parents may increase the level of perceived emotional warmth from them. The present study had a contrary result compared to the literature regarding the more negative perception of parenting among women. This finding is consistent with the higher prevalence of somatization and skin disorders observed among women, which are also associated with perceived parenting. The more negative perception of parenting among women contributes to their increased vulnerability to somatization and skin

disorders. Also, negatively perceived mothering by female participants could be investigated in detailed. This result indicates that in the Turkish population, children perceive their mothers more negatively in mother-daughter relationships. This may be due to fathers being colder and more distant compared to mothers, leading to mothers having a closer relationship with their children. In this close relationship, the perceived positive or negative emotions may have increased even more.

In the present study, gender differences according to emotional expression was not found. However, numerous research studies and meta-analyses have revealed gender differences in emotional expression in adulthood in the United States and certain Western European countries. Women generally exhibit greater overall emotional expression, particularly when it comes to positive emotions and internalizing negative emotions such as sadness and anxiety. On the other hand, men tend to display higher levels of aggression and anger in certain contexts (Brody and Hall, 1993; Kring and Gordon, 1998; LaFrance, Hecht, and Levy Paluck, 2003). Men are more likely to experience anger and more comfortable about expression of anger compared to women (Liu et al., 2011). The reason for the lack of significant findings regarding gender differences in emotional expression in this study may be that although men and women express different emotions (typically anger in men and sadness/positive emotions in women), ultimately both genders express their emotions.

Lastly, in the present study, when we look at the gender differences in self-compassion, results revealed gender differences according to self-compassion. It was found that male participants reported more self-compassion than female participants. In the literature, it was found that women are often socialized to prioritize the needs of others over their own, which can potentially hinder their ability to show self-compassion (Baker-Miller, 1986; Raffaelli and Ontai, 2004; Ruble and Martin, 1998). Moreover, research has shown that women tend to be more self-critical and engage in more negative self-talk compared to men (DeVore, 2013; Leadbeater et al., 1999). On the other hand, there are also indications that the opposite may be true. Self-compassion entails actively providing oneself with soothing and comfort in times of suffering (Neff, 2009), which are qualities traditionally associated with femininity (Baker-Miller, 1986; Raffaelli and Ontai, 2004; Ruble and Martin, 1998). As mentioned above, literature on gender differences in self-compassion has yielded inconsistent results. Some studies have reported lower levels of self-compassion

among females compared to males (Neff, 2003a; Neff, Hseih, Dejitthirat, 2005; Neff and McGehee, 2010; Raes, 2010; Yarnell and Neff, 2012), while others have found no significant differences between the sexes (Iskender, 2009; Neff, Pisitsungkagarn, and Hseih, 2008; Neff, Kirkpatrick, et al., 2007; Neff and Pommier, 2013; Raque-Bogdan et al., 2011). However, it is important to note that systematic examinations of potential gender differences in self-compassion are lacking, making it difficult to make generalized statements about which gender exhibits higher levels of self-compassion. In the present study, the higher self-compassion reported among men may be attributed to women engaging in more self-criticism, experiencing more inward negative emotions, and engaging in more rumination compared to men (Nolen-Hoeksema, Larson, and Grayson, 1999). On the other hand, men may experience criticisms and negative expressions more outwardly compared to women, which could have prompted them to be more self-compassionate towards themselves. Gender differences were hypothesized in somatization, dermatological disorders, perceived parenting attitudes, emotional expression, and self-compassion. When examining the results, this hypothesis was confirmed for all concepts except emotional expression.

4.1.2. Discussion of Relationships Between, Somatization, Psychodermatology Perceived Parenting, Emotional Expression, Self-Compassion Scales

Present study revealed that perceived parenting attitudes positively associated with somatization, showing that higher negative perceived parenting attitudes was linked to higher somatization in individuals. Similarly, literature suggested that the nature of the parent-child relationship may play a role in influencing the development and manifestation of somatization (Scharf, Mayseless and Rousseau, 2016). It is stated that individuals with somatization disorder often grew up in unhealthy family environments during their childhood and having various traumatic experiences (Kinzl et al., 1995; Kırpınar, 2014; Kesebir, 2004; Katon et al., 2001; Imbierowicz and Egle, 2003; Spitzer et al., 2008).

When looking at perceived parenting attitudes, the results of the study showed that normative, emotionally depriving, exploitative/abusive, belittling/criticizing, pessimistic/worried, restricted/emotionally inhibited and punitive parenting had demonstrated strong positive associations with somatization. However,

overprotective/anxious and conditional/achievement focused parenting did not show as strong correlation with somatization compared to other parenting styles. Lastly, the present study similarly found no significant correlation between over-permissive/boundless parenting with somatization disorder.

Studies showed that higher parental over-protection, psychological control, neglect and abuse is significantly associated with somatization (Fisher and Chalder, 2003; Janssens, Oldehinkel and Rosmalen, 2009; Janssens et al., 2009; Rousseau et al., 2013). Another study highlighted that adolescents reported more somatization if their parents are characterized with lack of emotional support, high levels of intrusiveness and irritability (Eray, Vural and Çetinkaya, 2015). Except overprotective parenting, all parenting attitudes were found to be parallel to the literature. Contrary to the literature, in this study, overprotective parenting was not found to be strongly correlated with somatization compared to other parenting attitudes. One possible reason for this is that due to the excessive attention given by overprotective parents, the child may not feel the need to seek attention through somatization.

The 'psychosomatogenic family model described by Minuchin and his colleagues (1975) presented four interaction patterns of family which leads to somatization: enmeshment, over-protectiveness, rigidity, and lack of conflict resolution (Minuchin et al., 1975). It was found that children express their concerns and stress through somatization rather than verbalization if parenting is insensitive to the children's needs such as security, closeness, competence, and autonomy (e.g., intrusive parenting) with the inadequate ways of emotion regulation (e.g., distant, cold and punitive parenting) (Kring and Sloan, 2010; Segerstrom and Miller, 2004). Studies have showed that higher levels of punishment and lower levels of warmth were also associated with somatization (Cicchetti and Toth, 1995; Van Der Bruggen et al., 2008). In line with the literature, in the present study, enmeshment parenting could be observed in the worried parenting which was one of the strongest correlations among parenting styles with somatization. Similarly, rigidity of family could be observed in the normative parenting style which was also one of the strongest correlations among parenting styles with somatization.

In a similar way, one study investigated the early maladaptive schemas of somatoform patients and it was found that somatoform patients had higher scores in the schemas "emotional deprivation," "abandonment/instability," and "mistrust/abuse" compared to healthy controls (Henker et al., 2018). Based on

Young's theory, these cognitive schemas are linked to experiences of significant maltreatment during childhood (Young et al., 2003). Early experiences with a detached, abusive, or unpredictable family environment appear to have a significant impact on individuals with somatoform disorders. Furthermore, somatoform patients tend to exhibit higher levels of both the "negativity/pessimism" and "insufficient self-control" schemas (Henker et al., 2018). It can be concluded that belittling parenting can result in the development of insufficient self-control schema; pessimistic parenting can result in the development of pessimism schema; emotionally inhibited parenting can result in the development of emotional deprivation schema and lastly punitive parenting can result in the development of abandonment, mistrust schemas of children. Similarly, it was revealed that children who have been raised in emotionally cold, unsupportive, neglectful and abusive family environments in higher risk to have somatization disorder (Brown et al., 2005; Feldman et al., 2010; Rhee et al., 2005; Güleç et al., 2013).

On the other hand, higher warmth in parenting behavior was connected to lower amounts of somatization (Feldman et al., 2010; Rhee et al., 2005). Baumrind's model revealed that permissive/indulgent parenting style characterized with high in warmth and low in control dimensions (Baumrind, 1966; 1978). Permissive parents characterized with tolerant and accepting attitude. They do not exert control over their children, contrarily, they liberate their children as much as possible (Baumrind, 1966; 1978). Since permissive parenting presented as opposite of over-protective parenting, the result of the no significant correlation between over-permissive/boundless parenting with somatization can be explained by the fact that over-protective parenting is highly associated with somatization.

In line with the literature, the present study found that perceived mothering was more strongly associated with somatization compared to perceived fathering. As negative perceived mothering increased, somatization also increased. Insufficient or disrupted mother-child relationships were found to independently predict somatization (Luminet, 1994). It is claimed that psychosomatic patients often report having mothers who are either excessively possessive and overwhelming or mothers who are unresponsive to the child's needs (Gubb, 2013).

Also, not only somatization but also dermatological complaints were found to be positively correlated with perceived mothering but not with perceived fathering. It is believed that factors are also have significant involvement disturbances to the skin

although this concept is mostly underestimated (Gupta and Gupta, 1996; Jafferany, 2006). According to the literature, skin is recognized as the body's largest and earliest organ to develop during embryonic development (Koblenzer, 1997; Anzieu, 1989). Both the skin and the central nervous system have their origins in the embryonic ectoderm (Anzieu, 1989; Koblenzer, 1997; Osman et al., 2011). The common embryonic origin of the skin and central nervous system can be metaphorically interpreted to prompt reflection on the interconnectedness between the physical and psychological aspects of an individual (Osman et al., 2014). It is believed that skin-to-skin contact is important for regulating the physiological functions of newborn infants and placing the infant on the mother's body has a calming effect on the nervous system and eventually, the skin becomes a channel for preverbal communication between the mother and child (Koblenzer, 1997; Levine and Stanton, 1984). As a result of this contact, the mother can convey various emotions ranged from love to range through the skin (Koblenzer, 1997). It is claimed that this kind of care contributes to the infant's susceptibility to skin disorders (Hofer, 1987). Conor (20014) stated that the skin has the ability to express emotions, inner states, and distress that individuals have limited control over. Considering the significant relationship observed in the literature between skin conditions and mothering, it is understandable that the increase in perceived negative motherhood in this study is associated with an increase in skin disorders.

Emotional expression was found to be negatively correlated with somatization means higher emotional expression associated with lower somatization. Additionally, positive emotional expression and closeness expression was linked with reduced somatization. On the other hand, the correlation was not found between negative emotional expression and somatization. Positive emotional expression means expression of positive emotions such as laughter, liking and affection. Closeness expression means expression of liking, love, gratitude, and apologizing and lastly, negative emotional expression refers the expression of negative emotions such as anger and disappointment (Kuzucu, 2011). Emotional expression became an important construct for development of somatization because according to literature, it is considered as one of the primary causes of somatization (Koh, 2013; Dattore, Shortz, and Coyne, 1980). Somatization explained as expression of distress, interpersonal problems and inner emotional conflicts as physical symptoms. Individuals who display somatic symptoms commonly referred to as emotional "non-

expressiveness" and it is founded that they are at risk to develop somatization (Uğur, 2015; Akyıldız, 2011; Bozo, Yılmaz and Tathan, 2012; Riggio and Riggio, 2002; Alexander, 1950). Breuer and Freud hypothesized that conversion arose because of the suppressed affect at the time of trauma and the symptoms became result of the failure to express. Somatic symptoms symbolically represented the repressed material (Breuer and Freud, 1895). Grinker and Spiegel (1945) observed in World War II veterans and realized psychosomatic conditions and explained the symptoms with the absence of the conscious experience of emotional distress. The results of the study are parallel to the literature except the negative emotional expression. Since how negative emotions are expressed can be crucial, the lack of a significant association between this concept and somatization can be interpreted. Uncontrolled expression of negative emotions can have a destructive effect and can damage social relationships. Given the correlation between perceived parenting and the significant relationship with somatization, it is believed that the manner in which negative emotions are expressed could be a meaningful factor. The lack of a significant relationship in this study may be due to the fact that this concept was not thoroughly examined.

Regarding the results of self-compassion, the present study found that self-compassion and six sub-types of self-compassion was negatively associated with somatization. As self-compassion level of individuals gets higher, somatization level of individuals gets lower, which is in line with the literature. In a study about self-compassion and somatization, it was found that people with somatization had lower levels of self-compassion compared to general population. Furthermore, lower self-compassion was linked with more physical symptoms, higher dysfunctional level of health status and lower quality of life (Dewsaran-van der Ven et al., 2017). Literature showed that self-compassion has an effect on individuals' coping mechanisms for pain and physical symptoms. Self-compassion is linked to reduced levels of negative emotions, avoidance behaviors, catastrophizing, stress, and rumination (Costa and Pinto-Gouveia, 2011, 2013; Wren et al., 2012; Hayter and Dorstyn, 2014; Pinto-Gouveia et al., 2014; Purdie and Morley, 2015). Furthermore, self-compassion is considered as a general resilience factor and it acts as a buffer against distress (Neff et al, 2007a, 2007b; Neff and McGehee, 2010; Terry and Leary, 2011; Costa and Pinto-Gouveia, 2011, 2013; Hall et al., 2013; Pinto-Gouveia et al., 2014).

Also, because self-compassion and emotional expression are highly associated with

somatization and serve as a buffer effect for it, they are found to be positively correlated with each other. As self-compassion increased, emotional expression also increased or vice versa.

Furthermore, results of the study found significant negative correlation between perceived parenting and self-compassion. As negative perceived parenting increased, self-compassion of individuals decreased. This finding is very congruent with the literature. Based on the literature, individuals who are raised in safe, secure, and supportive environments tend to develop the capacity to respond to themselves with compassion. Conversely, individuals who grow up in insecure, stressful, or threatening environments tend to be more self-critical (Gilbert and Proctor, 2006). In short, it is seemed that how individuals treat and respond themselves could be modeled in the family.

Lastly, in the present study, it was revealed that emotional expression had no relationship with perceived parenting. However, positive emotional expression was found to be positively correlated with conditional mothering and negatively correlated with exploitive and emotionally inhibited mothering. Similarly, negative emotional expression was positively, closeness expression was negatively correlated with perceived mothering. As negative perceived mothering increased, negative emotional expression was also increased but closeness expression decreased. Literature showed that emotional expression of parents plays a crucial role as the primary context within the family, where children initially learn about the rules governing emotional displays and develop an understanding of how others express their emotions (Halberstadt et al., 1995). Also, parent's emotional expression is an important factor to shape children's beliefs about what to expect in close relationships regarding emotional expression (Denham, 1998; Dunsmore and Halberstadt, 1997). With emotional displays, mothers communicate emotionally with their children (Hu et al., 2017). In the same way, Sineiro and Paz Míguez (2007) found out that children whose mothers experience higher levels of anxiety were more at risk to exhibit higher levels of negative emotions (Sineiro and Paz Míguez, 2007). When examining the positive emotional expression that is positively correlated with conditional motherhood, we can consider positive emotional expression as a "condition" which is demanded. It can be hypothesized that when positive emotional expression increases, conditional parents may display a more positive attitude towards their children. On the other hand, the decrease in positive emotional

expression in exploitative and emotionally inhibited mothering is also understandable. While exploitative mothering may restrict positive emotional expression, emotionally suppressive mothering may lead the child to mimic the parent's behavior as they may view the parent as a role model. Similarly, from the role model perspective it was demonstrated that the way mothers manage and express their emotions provide children with chances to observe, mimic, and acquire skills in emotional display. It can be understood that negative perceived mothering was positively correlated with negative emotional expression. Lastly, since closeness expression involves liking, love, gratitude and apologizing, it can be concluded that these constructs would decrease in negative motherhood and it is not surprising that the decreased in closeness expression with the increased in perceived negative motherhood.

4.1.3. Discussion of Mediating Role of Emotional Expression in the Relationship Between Perceived Parenting and Somatization

Regarding the mediating role of emotional expression, results yielded that while emotional expression as a whole did not act as a mediator, negative emotional expression and closeness expression emerged as significant mediators in the relationship between perceived parenting attitudes and somatization.

Present study revealed that perceived parenting attitudes did not predict the emotional expression. However, the literature has contrary results. It is founded that various parental processes, such as modeling, have an impact on the emotional expressiveness of children, leading to similarities between parents and their children (Strayer and Roberts, 2004). The emotional expression of parents significantly contributes to the social development of children by assisting them in understanding their own emotions as well as the emotions of others (Eisenberg et al., 1998). It has been observed that that the warmth exhibited by parents, particularly their attentiveness to children's emotional experiences is internalized by children. This internalization then contributes to children's empathic responses and appropriate expression of emotions (Dix, 1991; Dunn and Brown, 1994; Zahn-Waxler, 1991). When considering that perceived parenting attitudes did not predict emotional expression in the current study, it becomes important to explore whether emotional expression is predicted by other factors. A crucial question arises as to whether

emotional expression is influenced by factors beyond parental attitudes, such as the child's social environment, peers, school interactions, television, books, digital media etc.

Although the perceived parenting did not predict emotional expression, it positively predicted negative emotional expression and negatively predicted closeness expression. Contrarily, perceived parenting attitudes did not predict positive emotional expression. Research studies focusing on families characterized by harsh discipline and parental rejection have also provided corroborating evidence in support of this notion. For instance, toddlers and preschoolers who have experienced physical abuse tend to respond to others' distress by displaying threatening or aggressive behavior towards them (Main and George, 1985). Similarly, it was revealed that children's anger was associated with parenting. Children who are angry had less empathic and less warm parents. They had more authoritarian fathers and anxious mothers (Strayer and Roberts, 2004).

Present study founded that emotional expression negatively predicted somatization; similarly, closeness expression negatively predicted somatization however negative emotional expression positively predicted somatization. Positive emotional expression did not predict somatization. Results showed that somatization gets higher when closeness expression gets lower and negative emotional expression gets higher.

Increasing evidence suggests that advantageous physical and psychological health outcomes are linked to positive emotions (Tugade, Fredrickson and Barrett 2004). Research has indicated that individuals who possess a dispositional optimism tend to experience fewer health issues and have better recovery rates, potentially attributed to the chronic positive emotional states they often exhibit. Positive emotions, particularly hope, may play a distinct role in contributing to the health benefits observed in individuals with dispositional optimism (Aspinwall and Leaf, 2002). In a study conducted by Pennebaker and Francis (1996), it was found that individuals who used a greater number of positive emotion words when writing about a mild stressor, had fewer visits to physicians for illness-related reasons over the subsequent two months, in comparison to participants in the control group.

> *"Cheerfulness is the best promoter of health, and is as friendly to the mind as to the body."* –Joseph Addison

Closeness is defined as “incorporating another person's assets, viewpoints, and individual identities into one's own self.” (Mashek and Aron, 2004). According to literature, within close relationships, individuals engage in the sharing of their deepest emotions, expressing their needs and desires, demonstrating affection, and cultivating emotional bond (Parmley, 2015). As closeness in the relationships increases, the intensity of emotional expressions between those individuals also increases (Aune et al., 1994; Fischer and Evers, 2011). Attachment Approach claimed that the quality of attachment between caregiver and infant plays an important role in the brain development and it enables to regulate child’s experiences, emotional states and own arousals (Gubb, 2013). Also, closeness was associated with empathic concern especially toward person in pain (Grynberg and Konrath, 2020).

In literature, there are different statements about expression of negative emotions. From one perspective, literature suggest that the act of suppressing emotions is to be particularly significant in the development and worsening of psychosomatic illnesses (Dattore, Shortz, and Coyne, 1980). Repression of particularly negative emotions, such as anger is believed to facilitates the onset of cancer (Temoshok, 1987). In a study conducted by Koh et al., (2005), 47 patients with somatoform disorders were surveyed, revealing that the act of suppressing anger was identified as a predictor of somatic symptoms. Denollet, Sys, and Brutsaert (1995) conducted a study involving 105 myocardial infarction survivors, which demonstrated a positive correlation between somatization and distressed personality. Distressed personality was defined as having a disposition towards experiencing anger and other negative emotions, as well as inhibiting the expression of distress (Denollet et al., 2010; Perbandt et al., 2006). The expression of negative emotions has long been recognized as an important factor for psychosocial wellbeing (Lieberman and Goldstein, 2006). Also, it is stated that interference of experience and express of negative emotion is damaging for health (Levenson, 1994).

On the other hand, Murray (1985) and Tavris (1984) have highlighted that negative emotions like aggression, anger, and hostility pose particular challenges for individuals due to the potential social consequences associated with expressing these emotions. Additionally, research has indicated that individuals who tend to repress their emotions report fewer health issues compared to those who are more expressive (Bell and Byrne, 1978). Pennebaker (1985) proposed that the absence of emotional

expression itself may not be the cause of pathology, but rather the combination of the inability to express emotions with a strong desire or need to do so could contribute to the development of pathology. It was found that expression and inhibition of anxiety and anger have been associated with raised blood pressure and hypertension (Hayward, 1995; Sommers-Flanagan and Greenberg, 1989). Spielberger et al., (1985) described two dimensions of anger expression: anger-in and anger-out. Anger-in corresponds to rumination and suppression of angry feelings rather than expressing them overtly. Contrarily, anger-our means an expression of anger toward other people or to the environment (Spielberger et al., 1985). Difficulties in managing anger (such as a tendency towards anger or suppressing anger) were found to be associated with somatization (Liu et al., 2011). Also, proneness to experience anger is empirically associated with somatization (Compare, Manzoni, and Molinari, 2006). Friedman and Booth-Kewley (1987) conducted a study with Type A personality which is characterized by aggression and emotional expression. It was found that Type A personality was associated with coronary heart disease.

Contrary to hypothesis, emotional expression did not mediate the relationship between perceived parenting and somatization. This suggests that overall emotional expression may not be the driving force in explaining the influence of perceived parenting on somatization outcomes. However, a closer examination of the specific dimensions of emotional expression shed light on the underlying mechanisms.

Negative emotional expression emerged as a significant mediator in the relationship between perceived parenting and somatization. The findings indicated that higher levels of perceived negative parenting attitudes were associated with increased levels of negative emotional expression. In turn, individuals who exhibited greater negative emotional expression were more likely to experience higher levels of somatization. This suggests that negative emotional expression plays a crucial role in translating the influence of perceived parenting into somatization outcomes. Although the literature suggest that expression of emotions is associated with lower levels of somatization, this result provide another perspective to the literature saying that negative emotional expression could have detrimental consequences such as developing somatization. As implied by these results, it is believed that not only the act of expressing emotions but also the motivation behind expression, how they are expressed, and the effects they generate after expression can be significant.

Additionally, closeness expression was found to mediate the relationship between

perceived parenting and somatization. Higher levels of negative perceived parenting were associated with decreased levels of closeness expression. Furthermore, individuals who experienced higher closeness expression were more likely to exhibit lower levels of somatization. These findings suggest that the ability to express emotional closeness acts as a protective factor against somatization, and perceived parenting attitudes play a significant role in shaping this aspect of emotional expression.

Overall, the results highlight the importance of considering the specific dimensions of emotional expression when examining the link between perceived parenting and somatization. While emotional expression as a whole did not account for the mediating effect, the subscales of negative emotional expression and closeness expression played significant mediating roles. This underscores the complexity of the relationship between perceived parenting, emotional expression, and somatization, and the need to examine the specific components of emotional expression in understanding psychological well-being.

4.1.4. Discussion of Mediating Role of Self-Compassion in the Relationship Between Perceived Parenting and Somatization

As hypothesized, the results suggested mediation role of self-compassion in the relationship between perceived parenting and somatization. Also, not only self-compassion but subscales of self-compassion, self-kindness, isolation, and over-identification were found to be mediators in the relationship between perceived parenting attitudes and somatization. As far as known from the literature, self-compassion is both related with parenting and somatization.

To begin with, self-compassion was negatively predicted by perceived parenting means as negative perceived parenting increased, self-compassion of individuals decreased. Researchers have demonstrated that parenting styles have an important impact on the functioning of child (Ahmed and Bhutto, 2016). The way individuals handle challenging situations or setbacks can be influenced by their family experiences. Children who grow up with parents who exhibit anger, coldness, or criticism may internalize these behaviors and be more inclined to be harsh and critical toward themselves. Conversely, children who have warm, caring, and supportive parents may reflect these positive qualities in their internal dialogue

(Gilbert and Proctor, 2006). Hall (2015) found out that individuals who received maternal support, experienced more harmonious family functioning, and developed secure attachments during childhood tended to have higher levels of self-compassion in adulthood (Hall, 2015). According to Gilbert and Irons (2005), when a baby receives nurturing and affection from their primary caregiver, they form a relationship with themselves that is influenced by their internalization of relationships with others, particularly within their family (Ahmed and Bhutto, 2016). Contrarily, paternal coldness was related to self-criticism (Thompson and Zuroff, 1999). Also, a correlation was found between "poor parenting" characterized by low parental warmth, overprotection, and high parental rejection, and lower levels of self-compassion in adults (Pepping et al., 2015) The study suggested that high levels of parental sensitivity could be associated with high parental warmth, while low levels of parental sensitivity could be associated with high parental rejection. The findings indicated that low parental sensitivity was linked to lower levels of self-compassion, whereas high parental sensitivity was associated with higher levels of self-compassion (Pepping et al., 2015). The result of the study is in line with the literature saying negative perceived parenting is an effective function to holding self-compassionate attitude toward oneself. Individuals who perceived their parents negatively had lower self-compassion.

The findings revealed a negative association between self-compassion and somatization, indicating that individuals with higher levels of self-compassion reported lower levels of somatization. The literature suggests that self-compassion may act as a protective factor, potentially serving as a buffer against mental disorders such as somatization (MacBeth and Gumley, 2012; Muris and Petrocchi, 2017). It is revealed that individuals with somatization had reported lower levels of self-compassion (Dewsaran-van der Ven, 2018). Unless there is an improvement in symptoms, it is highly possible to misinterpret symptoms, as well as the tendency to ruminate in somatization (Brown, 2004). Also, studies founded that perfectionism is a risk factor for experiencing somatic symptoms (Flett et al., 2012; Sumi and Kanda, 2002). Sumi and Kanda (2002) demonstrated that when individuals were unable to meet their own high standards, it heightened the probability of experiencing psychosomatic symptoms. Individuals with somatization tend to focus on avoiding physical and emotional harm, instead of being mindful and taking accepting stance toward suffering (Lind et al., 2014; Huang et al., 2016). The mindfulness component

of self-compassion can be seen as the opposite of focusing on and misinterpreting symptoms and engaging in rumination which are concepts that related with somatization. Mindfulness can be explained as being consciously aware of one's present moment experience in a balanced and non-judgmental manner, and being receptive to one's suffering rather than avoiding or disconnecting from it. (Neff, 2003a). This state of awareness and openness may potentially contribute to enhancing emotional awareness, which has been found to be diminished in somatoform disorder (Subic-Wrana et al., 2010), as well as reducing rumination. Research has shown a negative correlation between scores on the Self-Compassion Scale (SCS) and rumination (Raes, 2010). Also, mindfulness component of self-compassion could be an antidote against the core features of somatization (Dewsaran-van der Ven et al., 2018). The present study proved the literature. Dewsaran-van der Ven et al., (2018) stated that in the face of medical conditions, the nurturing, caring and kind relationship with oneself might lead to better management of physical symptoms (Dewsaran-van der Ven et al., 2018). From literature and the present study result, it can be assumed that self-compassion could be a protective factor towards developing somatization.

In the present study, it was found that self-kindness, isolation and over-identification was negatively predicted by perceived parenting and negatively predicted somatization.

When we look at the literature, it can be seen that self-kindness and common humanity could serve as a factor that promote resilience (Dewsaran-van der Ven et al., 2018). Instead of adopting a critical or judgmental attitude towards oneself, self-kindness entails being gentle, understanding, and caring (Neff, 2009). Insecure attachment, which is characterized by fear of interpersonal relationships and mistrust of others, has also been identified as a factor in somatoform disorder (Koelen et al., 2015). The aspect of self-compassion referred to as common humanity addresses issues related to poor interpersonal relationships and mistrust by cultivating a sense of connection with others. It involves acknowledging that all individuals are flawed, encounter suffering and failure, and recognizing one's own limitations and challenges within the broader framework of the universal human experience (Neff, 2003a; Neff, 2009; Neff and Vonk, 2009). Also, it is the awareness of one’s emotions and the ability to face with painful thoughts and feelings rather than avoid and deny, without drama or self-pity (Neff, Kirkpatrick and Rude, 2007). Isolation component of self-

compassionate is the counterpart of sense of common humanity and over-identification is the counterpart of mindfulness (Muris, 2015). Also, over-identification paired with self-focused rumination (Lyubomirsky and Nolen-Hoeksema 1995). In the light of the literature and present findings, it can be concluded that rumination, being critical, and judgmental towards oneself and poor interpersonal relationships might be important for developing somatization and self-compassion act as a protective factor since it provides a perspective for all concepts mentioned.

Mediation analysis revealed that self-compassion significantly mediated the relationship between perceived parenting and somatization. These findings suggest that individuals who perceive more positive and nurturing parenting tend to develop higher levels of self-compassion, which in turn contributes to lower levels of somatization. These results highlight the importance of considering self-compassion as a potential mechanism through which parenting influences somatization outcomes. Also, results revealed that self-kindness, isolation, and over-identification acted as significant mediators, while the subscales of self-judgment, common humanity, and mindfulness did not mediate the relationship. Contrary to expectations, self-judgment, common humanity, and mindfulness were not found to mediate the relationship between perceived parenting and somatization. This suggests that these specific aspects of self-compassion may not play a significant role in explaining the influence of perceived parenting on somatization outcomes. However, a closer examination of the remaining subscales shed light on their mediating effects.

Self-kindness emerged as a significant mediator in the relationship between perceived parenting and somatization. The results indicated that lower levels of perceived parenting were associated with increased levels of self-kindness. In turn, individuals who displayed higher levels of self-kindness were less likely to experience somatization. This suggests that cultivating self-kindness may serve as a protective factor against somatization, and perceived parenting attitudes play a crucial role in shaping this dimension of self-compassion.

Isolation which is counterpart of common humanity component of self-compassion also played a mediating role in the relationship between perceived parenting and somatization. Lower levels of perceived parenting were associated with increased feelings of common humanity, which, in turn, predicted lower levels of somatization. This suggests that the sense of being a part of bigger thing then oneself acts as a

pathway through which perceived parenting influences somatization outcomes. It highlights the importance of social connectedness and the need for supportive relationships in buffering against somatization symptoms.

Furthermore, over-identification which is a counterpart of mindfulness emerged as a significant mediator. Lower perceived parenting predicted higher levels of mindfulness, and individuals who exhibited higher mindfulness were less likely to experience somatization. These findings suggest that the tendency to taking a mindful attitude toward negative experiences and emotions may serve as a protective factor against somatization, and perceived parenting attitudes contribute to shaping this aspect of self-compassion.

Overall, the results highlight the differential mediating roles of self-compassion subscales in the relationship between perceived parenting and somatization. Self-kindness, isolation, and over-identification were identified as significant mediators, while self-judgment, common humanity, and mindfulness did not show mediating effects. The findings suggest that self-kindness, the sense of isolation, and over-identification are important dimensions of self-compassion that may be particularly relevant in understanding the influence of perceived parenting on somatization outcomes.

4.2. Limitations and Future Suggestions

Besides the valuable contributions of this study to the existing literature and clinical practice, it is crucial to acknowledge its limitations when interpreting the results.

A comprehensive study was undertaken to explore the mediating role of various variables in the association between perceived parenting attitudes and somatization. As a result, many participants provided feedback regarding the length of the scale and the excessive number of questions, expressing concerns about potential boredom or distraction. Additionally, the similarities of questions in self-compassion scale may have led participants to perceive redundancy or repetitiveness, further contributing to potential fatigue or disengagement.

The study's sample comprised 303 individuals who were selected through a simple random sampling method. However, there was an unequal distribution of gender within the sample, with a higher number of female participants compared to male participants. Conducting future studies with a simple random sampling method that

ensures a more balanced representation of genders would enhance the generalizability of the research findings. Therefore, it is important to note that the study's results may have limitations in terms of generalizability, specifically regarding gender.

Furthermore, since the scales used in the study were self-report measures, participants' level of self-awareness becomes an important factor. How individuals perceive themselves or how they choose to portray themselves can significantly influence responses in such measures.

Additionally, since the data collection process took place after the Kahramanmaraş earthquake on February 6th, it is possible that participants were affected by this earthquake, experiencing somatic complaints related to the earthquake, and may have responded differently in terms of emotional expression and self-compassion measures compared to their pre-earthquake state.

Also, the internal consistency variable of the subscales of emotional expression scale is below the average, the original scale has also yielded below average internal consistency variables so it can be thought to use different emotional expression scale which has high internal consistency variables for the further studies.

Lastly, this study focusing on the mediating role emotional expression and self-compassion with subscales of them in the relationship between perceived parenting and somatization has made significant contributions to the literature in various aspects. While the literature has extensively examined the expression of emotions, the specific subdimensions of positive, negative emotions and closeness expressions have received limited attention in the context of parenting and somatization. Similarly, due to the relatively recent emergence of the concept of self-compassion, there is a scarcity of studies examining its relationship with parenting and somatization. Conducting future studies that investigate the specific subdimensions of emotional expression and delve deeper into the complexities of self-compassion has the potential to offer valuable insights to the existing literature.

CHAPTER 5: CONCLUSION

Regarding the present study's findings, which aimed to investigate the role of emotional expression and self-compassion in the relationship between perceived parenting attitudes and somatization, all variables were found to related to somatization and most of them were found to related to perceived parenting attitudes. The findings of this study revealed that emotional expression did not serve as a mediator in the relationship between perceived parenting attitudes and somatization. However, the subscales of negative emotional expression and closeness expression demonstrated a mediating effect. Moreover, self-compassion emerged as a mediator in the relationship between perceived parenting attitudes and somatization. Also, from the components of self-compassion, self-kindness, isolation and over-identification were found as mediators in the relationship between perceived parenting attitudes and somatization.

The present study is the first one investigated the emotional expression and self-compassion in the relationship between perceived parenting and somatization. The findings of this study enhance our understanding of the mediating factors that influence the association between perceived parenting and somatization, thereby contributing valuable insights to the existing literature. Furthermore, it can be noted that this study is the first to examine not only emotional expression but also the subscales of positive emotional expression, negative emotional expression, and closeness expression, as well as the subcomponents of self-compassion as meditators in the relationship between perceived parenting and somatization. Also, the study is the first study focused the relationship of somatization, emotional expression and self-compassion with perceived parenting from schema perspective.

Additionally, this study holds significant clinical implications. Somatization, with its unexplained physical symptoms and negative consequences for individuals, may not respond to traditional physical treatments. In such cases, focusing on various factors such as family dynamics, emotional expression and self-compassion, as identified in this study, may provide greater insights and potentially make a more substantial contribution towards addressing somatization.

Hence, it is believed that psychodynamic therapy which is focused on the family dynamics and emotional expression; Shema Therapy which is focused on the unmet

needs in childhood from parents and other therapeutic approaches such as Mindfulness-Based Interventions (MBIs), Mindfulness-Based Cognitive Therapy (MBCT), or Acceptance and Commitment Therapy (ACT), which incorporate mindfulness, present moment awareness, acceptance, and the integration of mindfulness with cognitive techniques, can be effectively utilized in the treatment of somatization.

5.1. Implications

The study highlights the significance of thoroughly and comprehensively exploring these variables from various perspectives. It emphasizes the importance of considering these factors not only in academic research but also in clinical applications, such as therapy, as they can have a profound impact on individuals' mental health. The findings of this study hold considerable implications for both research and treatment settings.

Since it is revealed that somatization is predicted by perceived parenting attitudes from the schema perspective, it would be useful to use Schema Therapy to understand family dynamics, unmet needs and maladaptive core beliefs of individuals. Also, it has been demonstrated that emotional expression is important for somatization in any ways, for expressing emotions, therapies such as psychodynamic therapy or techniques such as expressive writing could be implied. The expressive writing (EW) paradigm, initially developed by Pennebaker and Beall (1986), involves participants writing freely and openly about a traumatic event or an emotionally charged topic. EW has demonstrated success across various domains, including enhancing emotional well-being, immune measures, academic performance, and reducing visits to healthcare centers (Pennebaker and Beall, 1986).

Lastly, self-compassion could have clinical relevance and may impact the outcome of therapy. It could serve as a therapeutic target for individuals with somatoform disorder who have low levels of self-compassion (Dewsaran-van der Ven et al., 2018).

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APPENDIX

Appendix A: Ethics Committee Approval

SAYI : B.30.2.İEÜ.0.05.05-**020**-*264* 28.02.2023

KONU : Etik Kurul Kararı hk.

Sayın Dr. Öğretim Üyesi Yasemin Meral Öğütçü ve Hilal Yorulmaz,

"Perceived Parenting Attitudes and Somatization: The Moderator Role of Emotion Expression and Selfcompassion" başlıklı projenizin etik uygunluğu konusundaki başvurunuz sonuçlanmıştır.

Etik Kurulumuz 28.02.2023 tarihinde sizin başvurunuzun da içinde bulunduğu bir gündemle toplanmış ve Etik Kurul üyeleri projeleri incelemiştir.

Sonuçta 28.02.2023 tarihinde **"Perceived Parenting Attitudes and Somatization: The Moderator Role of Emotion Expression and Selfcompassion"** konulu projenizin etik açıdan uygun olduğuna oy birliğiyle karar verilmiştir.

Gereği için bilgilerinize sunarım.

Saygılarımla,

Prof. Dr. Murat Bengisu
Etik Kurul Başkanı

Appendix B: Informed Consent Form

Sayın Katılımcı,

Bu çalışma, İzmir Ekonomi Üniversitesi Klinik Psikoloji Yüksek Lisans programı öğrencisi Hilal Yorulmaz tarafından yürütülen ve Dr. Öğretim Üyesi Yasemin Meral Öğütçü danışmanlığında sürdürülen bir tez çalışmasıdır.

Çalışma kapsamında algılanan ebeveyn tutumları ile somatizasyon arasındaki ilişkide duyguları ifade etme ve öz-şefkatin aracı rolüne ilişkin bilgi toplamak amaçlanmaktadır.

Bu çalışmada sizden, ekte sunulacak olan ölçekleri eksiksiz olarak doldurmanız beklenmektedir. Çalışma toplamda 4 bölümden oluşmakta ve yaklaşık olarak 30 dakika sürmektedir. Çalışmaya katılabilmeniz için 18 yaş ve üstü olmanız gerekmektedir.

Katılımınız araştırma hipotezinin test edilmesi ve yukarıda açıklanan amaçlar doğrultusunda literatüre sağlayacağı katkılar ve klinik uygulamalar bakımından oldukça önemlidir. Bu sebeple, soruların samimi bir şekilde ve eksiksiz doldurulması büyük önem arz etmektedir. Ölçekleri doldururken sizi tam olarak yansıtmadığını düşündüğünüz durumlarda size en yakın yanıtı işaretleyiniz.

Çalışma kapsamında katılımcılardan elde edilen veriler isim kullanılmaksızın analizlere dahil edilecektir; yani çalışma sürecinde size bir katılımcı numarası verilecek ve isminiz araştırma raporunda yer almayacaktır.

Çalışmaya katılmanız tamamen kendi isteğinize bağlıdır. Katılımı reddetme ya da çalışma sürecinde herhangi bir zaman diliminde devam etmeme hakkına sahipsiniz. Eğer görüşme esnasında katılımınıza ilişkin herhangi bir sorunuz olursa, araştırmacıyla e-posta adresi üzerinden iletişime geçebilirsiniz.

Bu çalışmaya tamamen gönüllü olarak katılmayı kabul ediyorum ve verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.

EVET ☐ HAYIR☐

Appendix C: Sociodemograpfic Form

Yaşınız :

Cinsiyetiniz : Kadın ☐ Erkek ☐ Diğer ☐

Eğitim seviyeniz : İlkokul ☐ Ortaokul ☐ Lise ☐ Üniversite ☐

Yüksek Lisans ☐ Doktora ☐

Kendinizi aşağıdaki gelir seviyelerinden hangisinde görüyorsunuz?: Alt ☐ Alt-Orta ☐ Orta ☐ Orta-Üst ☐ Üst ☐

Herhangi bir kronik rahatsızlığınız var mı?

Evet ☐ Belirtiniz: Hayır ☐

Herhangi bir psikiyatrik bir tanı aldınız mı?

Evet ☐ Belirtiniz: Hayır ☐

Son 3 ayda herhangi bir psikiyatrik ilaç kullandınız mı?

Evet ☐ Belirtiniz: Hayır ☐

Son 3 aydır psikoterapi aldınız mı?

Evet ☐ Belirtiniz: Hayır ☐

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

Evet ☐Hayır ☐

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

Sedef

Egzama

Gül hastalığı

Ürtiker (Kurdeşen)

Zona

Vitiligo

Liken

Saçkıran

Uçuk

Diğer _____

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

Yaralanma / yanık

Bakteri / Virüs / Enfeksiyon

Hormonal

Kalıtımsal

Psikolojik

Diğer _____

Appendix D: Somatization Scale

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

1.Çoğu zaman boğazım tıkanır gibi olur.

Doğru Yanlış

2.İştahım iyidir.

Doğru Yanlış

3. Başım pek az ağrır.

Doğru Yanlış

4. Ayda bir iki defa ishal olurum.

Doğru Yanlış

5. Midemden oldukça rahatsızım.

Doğru Yanlış

6. Çoğu kez midem ekşir.

Doğru Yanlış

7. Bazen utanınca çok terlerim.

Doğru Yanlış

8. Sağlığım beni pek kaygılandırmaz.

Doğru Yanlış

9. Hemen hemen hiçbir ağrım ve sızım yok.

Doğru Yanlış

10. Bazen başımda sızı hissederim.

Doğru Yanlış

11. Çoğu zaman başımın her tarafı ağrır.

Doğru Yanlış

12. Sağlığım birçok arkadaşımınki kadar iyidir.

Doğru Yanlış

13. Pek seyrek kabız olurum.

Doğru Yanlış

14. Ensemde nadiren ağrı hissederim.

Doğru Yanlış

15. Vücudumda pek az seğirme ve kasılma olur.

Doğru Yanlış

16. Çabucak yorulmam.

Doğru Yanlış

17. Pek az başım döner ya da hiç dönmez.

Doğru Yanlış

18. Yürürken dengemi hemen hemen hiç kaybetmem.

Doğru Yanlış

19. Soğuk günlerde bile kolayca terlerim.

Doğru Yanlış

20. Çoğu zaman yorgunluk hissederim.

Doğru Yanlış

21. Hemen her gün mide ağrılarından rahatsız olurum.

Doğru Yanlış

22. Tekrarlayan mide bulantısı ve kusmalar bana sıkıntı verir.

Doğru Yanlış

23. Çoğu zaman bütün vücudumda bir halsizlik duyarım.

Doğru Yanlış

24. Son birkaç yıl içerisinde sağlığım çoğu zaman iyiydi.

Doğru Yanlış

25. Çok defa sabahları dinç ve dinlenmiş olarak kalkarım.

Doğru Yanlış

26. Çoğu zaman bana kafam şişmiş ya da burnum tıkanmış gibi gelir.

Doğru Yanlış

27. Çoğu zaman başım sıkı bir çember içindeymiş gibi hissederim.

Doğru Yanlış

28. Kalp ve göğüs ağrılarından hemen hemen hiç şikayetim yokmuş gibi hissederim.

Doğru Yanlış

29. Hayatımda hiçbir zaman kendimi şimdiki kadar iyi hissetmedim.

Doğru Yanlış

30. Kalbimin hızlı çarptığını hemen hemen hiç hissetmem ve çok seyrek nefesim tıkanır.

Doğru Yanlış

31. Hiç felç geçirmedim ya da kaslarımda olağanüstü bir halsizlik duymadım.

Doğru Yanlış

32. Ortada hiçbir neden yokken haftada bir ya da daha sık birdenbire her yanımı ateş basar.

Doğru Yanlış

33. Vücudumun bazı yerlerinde çok defa yanma, gıdıklanma, karıncalanma ve uyuşukluk hissederim

Doğru Yanlış

Appendix E: Young Parenting Inventory

Aşağıda anne ve babanızı tarif etmekte kullanabileceğiniz tanımlamalar verilmiştir. Lütfen her tanımlamayı dikkatle okuyun ve ebeveynlerinize ne kadar uyduğuna karar verin. 1 ile 6 arasında, çocukluğunuz sırasında annenizi ve babanızı tanımlayan en yüksek dereceyi seçin. Eğer sizi anne veya babanız yerine başka insanlar büyüttü ise onları da aynı şekilde derecelendirin. Eğer anne veya babanızdan biri hiç olmadı ise o sütunu boş bırakın.

	Anne	Baba	
1.	____	____	Beni sevdi ve bana özel birisi gibi davrandı.
2.	____	____	Bana vaktini ayırdı ve özen gösterdi.
3.	____	____	Bana yol gösterdi ve olumlu yönlendirdi.
4.	____	____	Beni dinledi, anladı ve duygularımızı karşılıklı paylaştık.
5.	____	____	Bana karşı sıcaktı ve fiziksel olarak şefkatliydi.
6.	____	____	Ben çocukken öldü veya evi terk etti.
7.	____	____	Dengesizdi, ne yapacağı belli olmazdı veya alkolikti.
8.	____	____	Kardeş(ler)imi bana tercih etti.
9.	____	____	Uzun süreler boyunca beni terk etti veya yalnız bıraktı.
10.	____	____	Bana yalan söyledi, beni kandırdı veya bana ihanet etti.
11.	____	____	Beni dövdü, duygusal veya cinsel olarak taciz etti.
12.	____	____	Beni kendi amaçları için kullandı.
13.	____	____	İnsanların canını yakmaktan hoşlanırdı.
14.	____	____	Bir yerimi inciteceğim diye çok endişelenirdi.
15.	____	____	Hasta olacağım diye çok endişelenirdi.
16.	____	____	Evhamlı veya fobik/korkak bir insandı.
17.	____	____	Beni aşırı korurdu.
18.	____	____	Kendi kararlarıma veya yargılarıma güvenememe neden oldu
19.	____	____	İşleri kendi başıma yapmama fırsat vermeden çoğu işimi o yaptı.
20.	____	____	Bana hep daha çocukmuşum gibi davrandı.
21.	____	____	Beni çok eleştirirdi.
22.	____	____	Bana kendimi sevilmeye layık olmayan veya dışlanmış bir gibi hissettirdi.
23.	____	____	Bana hep bende yanlış bir şey varmış gibi davrandı.
24.	____	____	Önemli konularda kendimden utanmama neden oldu.

25. ____ ____ Okulda başarılı olmam için gereken disiplini bana kazandırmadı.

26. ____ ____ Bana salakmışım veya beceriksizmişim gibi davrandı.

27. ____ ____ Başarılı olmamı gerçekten istemedi.

28. ____ ____ Hayatta başarısız olacağıma inandı.

29. ____ ____ Benim fikrim veya isteklerim önemsizmiş gibi davrandı.

30. ____ ____ Benim ihtiyaçlarımı gözetmeden kendisi ne isterse onu yaptı.

31. ____ ____ Hayatımı o kadar çok kontrol altında tuttu ki çok az seçme özgürlüğüm oldu.

32. ____ ____ Her şey onun kurallarına uymalıydı.

33. ____ ____ Aile için kendi isteklerini feda etti.

34. ___ ____ Günlük sorumluluklarının pek çoğunu yerine getiremiyordu ve ben her zaman kendi payıma düşenden fazlasını yapmak zorunda kaldım.

35. ____ ____ Hep mutsuzdu ; destek ve anlayış için hep bana dayandı.

36. ____ ____ Bana güçlü olduğumu ve diğer insanlara yardım etmem gerektiğini hissettirdi.

Anne Baba

37. ____ ____ Kendisinden beklentisi hep çok yüksekti ve bunlar için kendini çok zorlardı.

38. ____ ____ Benden her zaman en iyisini yapmamı bekledi.

39. ____ ____ Pek çok alanda mükemmeliyetçiydi; ona göre her şey olması gerektiği gibi olmalıydı.

40. ____ ____ Yaptığım hiçbir şeyin yeterli olmadığını hissetmeme sebep oldu.

41. ____ ____ Neyin doğru neyin yanlış olduğu hakkında kesin ve katı kuralları vardı.

42. ____ ____ Eğer işler düzgün ve yeterince hızlı yapılmazsa sabırsızlanırdı.

43. ____ ____ İşlerin tam ve iyi olarak yapılmasına, eğlenme veya dinlenmekten daha fazla önem verdi.

44. ____ ____ Beni pek çok konuda şımarttı veya aşırı hoşgörülü davrandı.

45. ____ ____ Diğer insanlardan daha önemli ve daha iyi olduğumu hissettirdi.

46. ____ ____ Çok talepkardı; her şeyin onun istediği gibi olmasını isterdi.

47. ____ ____ Diğer insanlara karşı sorumluluklarımın olduğunu bana öğretmedi.

48. ____ ____ Bana çok az disiplin veya terbiye verdi.

49. _____ _____ Bana çok az kural koydu veya sorumluluk verdi.

50. _____ _____ Aşırı sinirlenmeme veya kontrolümü kaybetmeme izin verirdi.

51. _____ _____ Disiplinsiz bir insandı.

52. _____ _____ Birbirimizi çok iyi anlayacak kadar yakındık.

53. _____ _____ Ondan tam olarak ayrı bir birey olduğumu hissedemedim veya bireyselliğimi yeterince yaşayamadım.

54. _____ _____ Onun çok güçlü bir insan olmasından dolayı büyürken kendi yönümü belirleyemiyordum.

55. _____ _____ İçimizden birinin uzağa gitmesi durumunda, birbirimizi üzebileceğimizi hissederdim.

56. _____ _____ Ailemizin ekonomik sorunları ile ilgili çok endişeli idi.

57. _____ _____ Küçük bir hata bile yapsam kötü sonuçların ortaya çıkacağını hissettirirdi.

58. _____ _____ Kötümser bir bakışı açısı vardı, hep en kötüsünü beklerdi.

59. _____ _____ Hayatın kötü yanları veya kötü giden şeyler üzerine odaklanırdı.

60. _____ _____ Her şey onun kontrolü altında olmalıydı.

61. _____ _____ Duygularını ifade etmekten rahatsız olurdu.

62. _____ _____ Hep düzenli ve tertipliydi; değişiklik yerine bilineni tercih ederdi.

63. _____ _____ Kızgınlığını çok nadir belli ederdi.

64. _____ _____ Kapalı birisiydi; duygularını çok nadir açardı.

65. _____ _____ Yanlış bir şey yaptığımda kızardı veya sert bir şekilde eleştirdiği olurdu.

66. _____ _____ Yanlış bir şey yaptığımda beni cezalandırdığı olurdu.

67. _____ _____ Yanlış yaptığımda bana aptal veya salak gibi kelimelerle hitap ettiği olurdu.

68. _____ _____ İşler kötü gittiğinde başkalarını suçlardı.

69. _____ _____ Sosyal statü ve görünüme önem verirdi.

70. _____ _____ Başarı ve rekabete çok önem verirdi.

71. _____ _____ Başkalarının gözünde benim davranışlarımın onu ne duruma düşüreceği ile çok ilgiliydi.

72. _____ _____ Başarılı olduğum zaman beni daha çok sever veya bana daha çok özen gösterirdi.

Appendix F: Emotional Expression Scale

1- İnsanlara sık sık onları sevdiğimi söylerim.

(1) (2) (3) (4) (5) (6) (7)

2- Öfkeli olduğum zaman genellikle çevremdeki insanlar bunu anlar.

(1) (2) (3) (4) (5) (6) (7)

3- Sohbet esnasında genellikle arkadaşlarıma dokunurum

(1) (2) (3) (4) (5) (6) (7)

4- Çok gülerim.

(1) (2) (3) (4) (5) (6) (7)

5- İnsanlar yüz ifadelerime bakarak ne hissettiğimi söyleyebilirler.

(1) (2) (3) (4) (5) (6) (7)

6- İnsanlar ne zaman benim için güzel şeyler yapsa, utandığımı hissederim ve minnettarlığımı göstermekte zorlanırım.

(1) (2) (3) (4) (5) (6) (7)

7- Birilerinden gerçekten hoşlandığımda, bunu bilirler.

(1) (2) (3) (4) (5) (6) (7)

8- Yanlış bir şey yaptığımda özür dilerim.

(1) (2) (3) (4) (5) (6) (7)

9- Televizyon seyretmek veya kitap okumak beni güldürebilir.

(1) (2) (3) (4) (5) (6) (7)

10- Halka açık bir yerde birisine öfkelendiğimde, öfkelendiğimi diğerleri anlarlar.

(1) (2) (3) (4) (5) (6) (7)

11- Sık sık gözlerim yaşarıncaya ya da yanaklarım ağrıyıncaya kadar gülerim.

(1) (2) (3) (4) (5) (6) (7)

12- Yalnızken, geçmişten bir şeyler hatırlayarak kendi kendime gülebilirim.

(1) (2) (3) (4) (5) (6) (7)

13- İşler istediğim gibi gitmediğinde, memnuniyetsizliğimi her zaman ifade ederim.

(1) (2) (3) (4) (5) (6) (7)

14- Gülüşüm yumuşak ve kontrollüdür.

(1) (2) (3) (4) (5) (6) (7)

15- Birini sevdiğimi ona sarılarak veya dokunarak gösteririm

(1) (2) (3) (4) (5) (6) (7)

Appendix G: Self-Compassion Scale

Bu anketten elde edilen sonuçlar bilimsel bir çalışmada kullanılacaktır. Sizden istenilen bu ifadeleri okuduktan sonra kendinizi değerlendirmeniz ve sizin için en uygun seçeneğin karşısına çarpı (X) işareti koymanızdır. Her sorunun karşısında bulunan; (1) Hiçbir zaman (2) Nadiren (3) Sık sık (4) Genellikle ve (5) Her zaman anlamına gelmektedir. Lütfen her ifadeye mutlaka TEK yanıt veriniz ve kesinlikle BOŞ bırakmayınız. En uygun yanıtları vereceğinizi ümit eder katkılarınız için teşekkür ederim.

1. Bir yetersizlik hissettiğimde, kendime bu yetersizlik duygusunun insanların birçoğu tarafından paylaşıldığını hatırlatmaya çalışırım.

(1) (2) (3) (4) (5)

2. Kişiliğimin beğenmediğim yönlerine ilişkin anlayışlı ve sabırlı olmaya çalışırım.

(1) (2) (3) (4) (5)

3. Bir şey beni üzdüğünde, duygularıma kapılıp giderim.

(1) (2) (3) (4) (5)

4. Hoşlanmadığım yönlerimi fark ettiğimde kendimi suçlarım.

(1) (2) (3) (4) (5)

5. Benim için önemli olan bir şeyde başarısız olduğumda, kendimi bu başarısızlıkta yalnız hissederim.

(1) (2) (3) (4) (5)

6. Zor zamanlarımda ihtiyaç duyduğum özen ve şefkati kendime gösteririm.

(1) (2) (3) (4) (5)

7. Gerçekten güç durumlarla karşılaştığımda kendime kaba davranırım.

(1) (2) (3) (4) (5)

8. Başarısızlıklarımı insanlık halinin bir parçası olarak görmeye çalışırım.

(1) (2) (3) (4) (5)

9. Bir şey beni üzdüğünde duygularımı dengede tutmaya çalışırım.

(1) (2) (3) (4) (5)

10. Kendimi kötü hissettiğimde kötü olan her şeye kafamı takar ve onunla meşgul olurum.

(1) (2) (3) (4) (5)

11. Yetersizliklerim hakkında düşündüğümde, bu kendimi yalnız hissetmeme ve dünyayla bağlantımı koparmama neden olur.

(1) (2) (3) (4) (5)

12. Kendimi çok kötü hissettiğim durumlarda, dünyadaki birçok insanın benzer duygular yaşadığını hatırlamaya çalışırım.

(1) (2) (3) (4) (5)

13. Acı veren olaylar yaşadığımda kendime kibar davranırım.

(1) (2) (3) (4) (5)

14. Kendimi kötü hissettiğimde duygularıma ilgi ve açıklıkla yaklaşmaya çalışırım.

(1) (2) (3) (4) (5)

15. Sıkıntı çektiğim durumlarda kendime karşı biraz acımasız olabilirim.

(1) (2) (3) (4) (5)

16. Sıkıntı veren bir olay olduğunda olayı mantıksız biçimde abartırım.

(1) (2) (3) (4) (5)

17. Hata ve yetersizliklerimi anlayışla karşılarım.

(1) (2) (3) (4) (5)

18. Acı veren bir şeyler yaşadığımda bu duruma dengeli bir bakış açısıyla yaklaşmaya çalışırım.

(1) (2) (3) (4) (5)

19. Kendimi üzgün hissettiğimde, diğer insanların çoğunun belki de benden daha mutlu olduklarını düşünürüm.

(1) (2) (3) (4) (5)

20. Hata ve yetersizliklerime karşı kınayıcı ve yargılayıcı bir tavır takınırım.

(1) (2) (3) (4) (5)

21. Duygusal anlamda acı çektiğim durumlarda kendime sevgiyle yaklaşırım.

(1) (2) (3) (4) (5)

22. Benim için bir şeyler kötüye gittiğinde, bu durumun herkesin yaşayabileceğini ve yaşamın bir parçası olduğunu düşünürüm.

(1) (2) (3) (4) (5)

23. Bir şeyde başarısızlık yaşadığımda objektif bir bakış açısı takınmaya çalışırım. (1) (2) (3) (4) (5)

24. Benim için önemli olan bir şeyde başarısız olduğumda, yetersizlik duygularıyla kendimi harap ederim.

(1) (2) (3) (4) (5)

25. Zor durumlarla mücadele ettiğimde, diğer insanların daha rahat bir durumda

olduklarını düşünürüm.

(1) (2) (3) (4) (5)

26. Kişiliğimin beğenmediğim yönlerine karşı sabırlı ve hoşgörülü değilimdir.

(1) (2) (3) (4) (5)