THE RELATIONSHIP BETWEEN REJECTION SENSITIVITY AND SOMATIZATION: THE MEDIATION ROLE OF INTERPERSONAL DIFFICULTIES

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ÖZET

Bu çalışma, bir grup üniversite öğrencisi üzerinde somatizasyonun yordayıcılarını incelemekte ve reddedilme duyarlılığı ile somatizasyon arasındaki ilişkide kişilerarası problemlerin rolünü araştırmaktadır. 18 yaş üstü katılımcılar (298) çalışmaya dahil edilmiştir. Katılımcılar, Sosyal Demografik Form, Reddedilme Duyarlılığı Anketi, Kişilerarası Sorunlar Envanteri- Circumplex ve Bradford Somatik Envanteri'ni doldurmuştur. Sonuçlar, kişilerarası problemlerin reddedilme duyarlılığı ve somatizasyon ile pozitif ilişkili olduğunu göstermiştir. Ayrıca, reddedilme duyarlılığı ile somatizasyon arasındaki ilişkide kişilerarası problemlerin aracı rolü olduğu bulunmuştur. Mevcut çalışmanın bulguları önceki literatüre göre tartışılmıştır. Mevcut çalışmanın sınırlılıkları ve bulguların klinik çıkarımları ve gelecekteki çalışmalar için yönergeler belirtilmiştir.

Anahtar kelimeler: Reddedilme duyarlılığı, somatizasyon, kişilerarası problemler

ABSTRACT

The aim of the current study was to examine the predictive role of somatization and investigate the role of interpersonal difficulties in the relationship between rejection sensitivity and somatization on a group of university students. Participants (298) over the age of 18 were included in the study. Participants completed instruments including Social Demographic form, Rejection Sensitivity Questionnaire, Interpersonal Problems Inventory- Circumplex, Bradford Somatic Inventory (BSI). Results indicated that interpersonal difficulties were positively correlated with rejection sensitivity and somatization. Moreover, interpersonal difficulties had a mediating role in the relationship between rejection sensitivity and somatization. The findings of the current study were discussed according to previous literature. Limitations of the present study and clinical implications of the findings and directions for future studies were stated.

Key words: rejection sensitivity, somatization, interpersonal difficulties

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1. INTRODUCTION

The desire to be accepted and to avoid from rejection is recognized as a central human drive (Baumeister & Leary, 1995; Homey, 1937). People intrinsically tend to establish and sustain relationships (Mitchell & Black, 2016). Acceptance by others brings gains in the struggle for survival (Baumeister & Leary, 1995). People belonging to groups have a better chance of surviving and producing than people not belonging to groups (Leary, 2001). Being part of a community will make it more possible to share food, care for a child, and be mindful of enemies (Baumeister & Leary, 1995). While acceptance is evolutionarily protective of the person psychologically and physiologically; exclusion and rejection by the society lead to negative consequences on the person (Jaremka et al., 2013; Tang & Richardson, 2013). Erözkan (2007) stated that the experience of rejection creates problems in intimate relationships, causes depression and leads to challenging situations like rejection sensitivity. According to Creasey and Mclnnis (2001), Individuals who are rejected by significant others may feel worthless. Although some individuals can cope with it more optimistically when they experience negativities in relationships, in some individuals a small insensitive behavior by others can lead to rejection perception. (Creasey & Mclnnis, 2001). This difference among individuals may be due to rejection sensitivity.

1.1.Rejection sensitivity

Downey et al., (1994, p.497) defined rejection sensitivity as “the disposition to anxiously expect, readily perceive, and overreact to rejection in a wide variety of situations.” According to Downey and Feldman (1996), people who are highly sensitive to rejection think of others rejecting them, and they perceive small ambiguous cues as the sings of rejection. These individuals overreact to an absolute or imaginary rejection. The expectations of individuals with high rejection sensitivity are easily triggered by small impressions and lead them to perceive other people's behaviors as rejection easily. According to Downey and Feldman (1996)'s model, individuals who have anxious feelings of rejection tend to complete the following steps in their relationships:

a. Considering partner’s ambiguous behavior as intended rejection

b. Being desperate and insecure in their relationship

c. Reacting to the partner's rejection behavior via hostility, jealousy, and controlling behavior

Rejection sensitivity has been modeled as arising from early parental rejection and alternatively disrupting relations with significant others later (Downey, Lebolt et al., 1998). Rejection sensitivity Model is basically stemmed from cognitive-affective information-processing models of personality (CAPS) (Mischel & Shoda, 1995) and attachment theory (Bowlby, 1969). In attachment theory, Bowlby (1973) stated that the cognitive schemas of securely attached children are based on trust in others. He stated that when caregivers in early childhood meet the needs of children regularly and warmly, these children develop a secure attachment model and their expectations from others in their interpersonal relationships include a positive approach that they will receive acceptance and support. According to Bowlby (1973), rejection in early childhood can make a person susceptible to rejection in adulthood. At the point where children need assistance by significant others, they create a perception that they may be rejected and do their best to not experience rejection. This lead to form a feeling of anxiety the moment that they need other people (Özdemir, 2017). Being alert to rejection cues makes it easier to perceive as rejection (Levy et al., 2001)**.**

Cognitive-affective information-processing models of personality, on the other hand, examines the instantaneous cognitive and emotional effects of early rejection experiences (Downey & Feldman, 1996). According to Mischel and Shoda (1995), five cognitive-affective components related to processing of information are encoding (storing and using information), expectations (inference of other people's behaviors), values (repulsive conclusions and rewards of behavior), emotion (affects of individuals), self-regulation (capability of self-control). Cognitive-affective information-processing models of personality focus on explaining how certain person-situation conditions affect personality processes. The model basically highlights those early experiences of rejection or approval lead to form specific cognitive-emotional frameworks. In the adulthood, when any clues of rejection or acceptance behavior are experienced, this model is activated. Thus, when people encounter situations that they feel accepted or rejected, they show certain behaviors to avoid from being rejected or being accepted quickly (Özen & Güneri, 2018).

The defensive motivational system is another system that can also explain rejection sensitivity (Downey et al., 2004; Romero-Canyas et al., 2010). Sensitivity to rejection is a defensive reaction consisting of past experiences, which has the aim of protecting oneself against future rejection experiences (Romero-Canyas et al., 2010). When one experiences rejection as a threat, the rejection sensitivity system is activated.

Then, the person becomes ready to perceive this threat signal and takes immediate action to prevent danger and defend himself/herself by the activation of the rejection sensitivity system (Downey et al., 2004). In such a situation, fight/flight behaviors and avoidance result from the defensive motivational system (Gray, 1987).

The foremost component of the model is the anxious expectation of rejection. Expectation of rejection and experiencing high anxiety due to rejection indicate high rejection sensitivity (Downey & Feldman, 1996). One of the reasons of occurrence of anxious rejection expectancy is parental rejection. Emotional and physical abuse, raising with authoritarian parents and not getting unconditional love from parents are risk factors for anxious rejection expectancy (Feldman & Downey 1994). Thus, the rejection signal from parents is conveyed to the child through attitudes and behaviors. After anxious expectation of rejection is formed, the behaviors of other people are perceived as rejection with the occurrence of any triggering situation (Downey & Feldman, 1996). Later, intense negative reactions arise with perceived rejection and those hostile and aggressive negative reactions cause a real rejection (Ayduk et al., 2008). Feldman and Downey (1994) conducted a study examining the effects of childhood domestic violence exposure on attachment styles and rejection sensitivity. They suggest that rejection sensitivity in adulthood is associated with avoidant and ambivalent attachment behaviors experienced in childhood, and exposure to violence by parents in childhood creates problems in social relations in adulthood. Similarly, it has been found that interpersonal rejection sensitivity is rooted in experiences in childhood (Butler et al., 2007).

One of the psychoanalytic theorists is Horney (1937) who states that rejection sensitivity is a neurotic tendency that emerged unconsciously to cope with anxiety. Horney (1937) stated that individuals who have high levels of rejection sensitivity are extremely vulnerable to all rejection behaviors such as being unwanted and disruptions in fulfilling their wants such as sometimes a delay in meeting time or any response from significant other. Because rejection includes contempt, it leads the individual to feel anger, or instead of anger, it leads him/her to have an aloof manner. If rejection sensitivity develops too much, the person may try to avoid from almost any situation in which there is a possibility of rejection (Horney, 1937).

1.1.1. Rejection sensitivity and Its Characteristics

Children experiencing rejection have some common characteristics. In their researches, Sobol and Earn (1992) found that rejected children were different from

other children in perceiving some social situations (motives, personalities, relationships, efforts of others), and they showed less emphasis on person-situation interaction. It has been observed that children suffering from loneliness attribute social failure to their own personality traits, avoid from social situations, and especially lonely girls have high social anxiety levels. In addition, it has been found that such children are reluctant, introverted, passive, insensitive, superficial and coward in terms of social behavior, and they perceive themselves as negative, shy, depressive, suspicious, lacking emotional depth and assertiveness (Sobol & Earn, 1992). Other studies conducted on rejected students showed that self-esteem, positive social skills and academic skills of the students who were accepted by their peers were higher than the rejected students (Downey et al., 1998; Sad, 2007). It was determined that the students who were rejected by their peers had higher negative social skills, behavioral disorders, anxiety, introversion, attention problems and aggression levels than the accepted students (Sad, 2007). In short, previous experiences of rejection leave a psychological legacy that tends to be susceptible to rejection by significant others. This concept further reveals the potential meaning of rejection sensitivity for close relationships in adolescence/adulthood (Creasey & McLnnis, 2001).

According to Creasey and Mclnnis (2001), rejection-sensitive adults are insecure in their relationships and fail to communicate due to fear of rejection. They avoid from conflicts and close contact in their daily relationships because of anxious expectations of rejection (Creasey & Mclnnis, 2001). Erözkan is one of the pioneers of research on rejection sensitivity in Turkey. According to Erözkan (2004), being accepted in interpersonal relations causes the individual to establish healthy relationships with others, to approach other people, to share his thoughts and feelings while being rejected creates a negativity regarding the individual's feelings of self-worth and self-efficacy beliefs. It is seen that individuals who are accepted can establish healthy and close relationships and get closer to other people. These people may oppose other people to get their ideas accepted. As a result of opposition, these individuals can become self-sufficient when they get away from other people and are alone with themselves. They also know that they can always count on other people's support because they are accepted by others. Rejected individuals, on the other hand, regulate their behaviors according to the need to provide security and are in a constant effort to protect themselves from rejection because they are overwhelmed by feelings of inadequacy. As they take action not to provide satisfaction but to be protected, they

cannot trust themselves and others at first, and they may feel more and more alone and helpless. In this context, rejection in interpersonal relations has a feature that reduces well-being and impairs interpersonal functionality. Rejection is a factor that can reduce a person's productivity and harm emotional relationships by reducing the enjoyment of life (Erözkan, 2004). It was found that higher rejection sensitivity was associated with more aggressive behavior (Gao et al., 2019). In the same study, Gao et al. (2019) found that the person with anxious rejection expectation and the person with angry rejection expectation were associated with different behavior patterns. While anxiously rejection sensitive people experience more social anxiety and avoidance; people with an expectation of angry rejection experience more aggression. Similarly, Watson and Nesdale (2012) found that people show withdrawal or avoidance behavior as a way of coping with rejection sensitivity and rejection sensitivity to be a strong predictor of loneliness.

Gender was also associated with rejection sensitivity (Eralp, 2021). While some studies find no difference in terms of gender in rejection sensitvity (e.g., Downey & Feldman, 1996; Harper et al., 2006), some studies show that men have higher rejection sensitivity scores than women (Hafen et al., 2014), and some other studies show that women have greater rejection sensitivity levels than men (Erozkan, 2009). Mellin (2008), in his study concluded that female university students' rejection sensitivity scores were higher than male students**.** Similarly, Benazzi (2000) concluded that interpersonal rejection sensitivity is more common among women than men.

1.1.2. Rejection sensitivity and relationship variables

According to Downey and Feldman (1996), rejection sensitivity disrupts romantic relationships. It causes people to be insecure and dissatisfied with the relationship. In addition, the partners of individuals with rejection sensitivity find their relationships less satisfying. Sensitivity to rejection affects men and women differently in their relationships (Erözkan, 2004). They observed that whereas men with rejection sensitivity are more jealous in the relationship, try to control their partner's behavior and overestimate their partners' relationship displeasure, women with rejection sensitivity accuse their partners unfairly, show hostile attitudes and act in a way that discourages them (Downey & Feldman, 1996).

Downey et al. (2000) found that abusive men think that by controlling or minimizing their partners' relationships with people they mistakenly assume as rivals, they will prevent their partners from separating from them. At this point, it is stated that

rejection sensitivity in men may be a risk factor for physical abuse. Ayduk et al. (1999) stated that men sensitive to rejection and women sensitive to rejection have different reactions towards their rejecting partners, and that rejection causes hostile feelings in women who are sensitive to rejection. In particular, jealousy-related behaviors of male partners cause them to adopt a restrictive attitude towards the female partner and limit the behaviors of the female partner. Although such restrictive behaviors cause withdrawal in female partners and the inability to reveal their potential, they lead to feelings of anger and hostility towards individuals who reject them in a short time. The occurrence of such a situation in women who are sensitive to rejection automatically manifests itself against perceived rejection and triggers the negativity of the female partner in the process. Negative behavior patterns cause the real rejection. These situations also clearly show the difference between men and women in terms of reactions to rejection (Erözkan, 2004).

Although rejection-sensitive people's need for acceptance helps them maintain their faith in their relationships, sensitivity to rejection causes these people to act in a manner that eliminates the chance of having a fulfilling and supporting relationship. Thus, anxious rejection expectancy can be maintained with behaviors. In the light of this explanation, it is possible to see that rejection sensitivity has a self-sustaining aspect. Rejection expectations facilitate subjective rejection perceptions and vice versa (Downey et al., 2000). According to Downey et al. (1998), conflicts that arise naturally in the relationship reveal women's expectations of being rejected, and these expectations result in real rejection reaction, displeasure with the relationship, and think of leaving of their partners. Rejection anxiety predicts the end of the relationship for both genders (Downey et al., 1998). In the same study, a number of other findings emerged for women. While there was no significant difference in pre-conflict anger between the partners of highly rejection sensitive woman and lowly rejection sensitive woman; partners of women with high rejection sensitivity feel more anger towards the relationship after conflict than partners of low rejective women. It was also seen that highly rejection sensitive woman displayed more negative behavior than men when arguing with their partners (Downey et al., 1998).

Also, another study showed that college boys who have high rejection sensitivity and those who are highly invested in their romantic relationships tend to be more violent in the relationship than girls. Again, it was found that men with high rejection sensitivity and less romantic investment in the relationship had less serious

romantic relationships, had fewer close friends, and experienced more social avoidance and stress in social contexts than women (Downey et al., 2000). They interpret these results as a strategy used in coping with rejection that men with rejection sensitivity will invest more in the relationship to avoid rejection, so that they will think "if she loves me, she won't hurt me." When high investment in the relationship and high rejection anxiety are combined, they make the person more vulnerable to rejection. They argue that a man with high rejection anxiety who seeks closeness may react with physical violence to perceived rejection in extreme situations (Downey et al., 2000).

Many researches review that high rejection sensitive people tend to show psychopathology such as borderline personality disorder, depression, (Downey & Feldman, 1996; Feinstein et al., 2012; Rosenbach & Renneberg, 2014), anxiety, loneliness and body dysmorphic disorder (Gao, 2017). Also, rejection sensitivity is a higher risk for sexual victimization (Young & Furman, 2008), emotion regulation problems (Silvers et al., 2012), hostility and aggression (Ayduk et al., 2008). Additionally, some studies show that sensitivity to rejection is related to many personality dispositions like social anxiety, low self-esteem, neuroticism and attachment insecurity (Berenson et al., 2009).

According to Gao et al. (2017), the cognitive-affective processing system could be effective in explaining the relationship between rejection sensitivity and psychopathology. This theory clarifies that how and why people's behavior changes in different situations and how personality is constructed in certain person-situation interactions (Romero-Canyas et al., 2010). Gao et al. (2017) also suggest that another system is the defensive motivational system, which can explain the connection between rejection sensitivity and mental health problems. This system directs the person to avoidant behavior and/or fight-or-flight response, and these behavior responses may lead to emerging of the person's symptoms and or disorders.

1.2. Somatization

One of the most common mental illnesses is somatoform disorders (Henker et al., 2019). The category of somatic disorders was included in the DSM-III (Diagnostic and Statistical Manual of Mental Disorders – 3) published in 1980 for the first time. In the DSM-3, somatoform disorders contain somatization disorder, hypochondriasis, pain disorder, undifferentiated somatoform disorder, and conversion disorder. All these disorders are physical symptoms in the body, and these symptoms are not clarified with

the organic cause (Stuart & Noyes, 1999). In DSM-IV, somatization disorder is included in somatoform disorders. In DSM-IV, it is stated that for the diagnosis of somatization disorder, it must start before the age of 30, the person has many physical complaints, the symptoms cannot be explained medically, or the physical complaints are more than expected even if it is a medical condition. However, this approach has been criticized due to insufficient discriminating diagnostic criteria. Afterwards, the category of Somatic symptoms and related disorders was created in DSM-V (American Psychiatric Association, 2013). Below are the diagnostic criteria of somatization according to DSM-V (American Psychiatric Association, 2013).

To receive the diagnosis of somatic symptom disorder, a person must have the following symptoms.

A. Having one or more somatic symptoms that are bothering or that significantly interrupt daily life.

B. Enormous notions, emotions, or acts associated with somatic symptoms or accompanying health anxiety, as included by at least one of the following conditions:

1. Permanent thoughts that are disproportionate to the severity of the person's symptoms.

2. A permanently severe anxiety associated with health or symptoms.

3. Excessive time and inner effort is wasted on these symptoms or health concerns.

C. Even if no physical symptoms are constantly existing, the situation of being symptomatic is continuous (for longer than 6 months) (American Psychiatric Association, 2013, p.163)

Many authors in the literature have disagreement on the definition of somatization (Kellner, 1990). Somatization was thought to be associated with conversion diseases in earlier times so internal conflicts are expressed physically (Marin & Carron, 2002). According to this definition, there is a causality between having psychological problems and experiencing somatic symptoms (Craig et al., 1993). In another definition, somatization is explained as experiencing and expressing psychological stress through the body in the absence of the affective experience (Lipowski, 1988) and Lipowski (1988) states that somatization should not be viewed as a disease or disorder. From this point of view, expressing the wishes and conflicts of individuals through the use of the body is a form of nonverbal communication used from the first years of life (for example, a baby's crying when it is hungry) (Ünal, 2002).

According to Rodin (1991), many mental illnesses involve somatic symptoms and these somatic symptoms should not always be viewed as pathological. According to studies, it has been observed that the physical health of most individuals who experience psychological stress is also negatively affected (Smith et al., 2009).

When the symptoms of somatization first appear in the individual, it is seen as a physical disorder. However, over time, it has been seen that the underlying causes of the problems are related to social or psychological problems. The individual needs to seek help for these problems one has experienced, and somatization occurs as a result of the reflection of this need on the body (Ünal, 2002). However, individuals experiencing somatization are often unaware that it is caused by psychological problems. They do not accept that the physical symptoms that occur in them are a reaction that occurs in their bodies as a result of the psychological distress they have experienced. For this reason, they believe that the symptoms occur as a result of a physical illness and seek a serious treatment (Babacan, 2003).

Symptoms are mostly seen as pain in different parts of the body (back, waist, head, chest, etc.), disorders in the functioning of organs (gastrointestinal, palpilation, diarrhoea, etc.), fatigue and exhaustion. Individuals generally experience more than one physical symptom, as well as psychosocial disorders (Henningsen, 2007). According to Patel and Sumathipala (2006), common symptoms are; fatigue and exhaustion, aches and pains, particularly headache and general body aches, and abdominal pain.

Somatization is a very common phenomenon in daily life. 80% of healthy individuals experience one or more somatic symptoms, called non-continuous somatic sensations or complaints, within a week (Özer, 2010). Jacobi et al. (2004) stated that the lifetime prevalence of somatoform disorder in the general adult population in Germany was 16.2% in 4,181 individuals. There are limited studies on the prevalence of somatization disorder in our country (Inci, 2020). Atmaca (2012) stated that somatization disorder is 0.2-2% in women and below 0.2% in men, and it can start in adolescence. In a study conducted with 804 university students in Turkey, 7.7% of the students were found to have somatization disorder (Özenli et al., 2009). The prevalence of somatization in the general population varies between 5% and 7% (Kurlansik & Maffesi, 2016). However, according to Lipowsky (1988), the presence of functional complaints in the individual is not clinically accepted as somatization unless help-seeking behavior or medical treatment is applied (as cited in Özer, 2010). Although the symptoms begin before puberty, the search for treatment occurs before the age of 25

due to the deterioration of organ systems (Kirpinar et al., 2013). According to the studies, being a woman (Keskin et al., 2013; Özenli et al., 2009), a history of chronic illness (Mai, 2004; Özenli et al., 2009), living in rural areas (Mai, 2004) contribute to having somatization.

Over the years, many researchers have proposed distinct theories to clarify somatization (Kellner, 1990). According to Stuart and Noyes (1999), two models come to the fore when explaining somatization. First, they stated that occuring of somatization is affected by negative childhood experiences. According to studies, the more negative the parenting that the child experience, the more likely they are to have the somatoform disorder (Lackner et al., 2004; Stuart & Noyes, 1999; Waldinger et al., 2006). Those adverse childhood factors are neglect (Tariq & Kauasr, 2015), sexual and physical abuse (Moeller & Bachman, 1993; Stuart & Noyes, 1999; Tariq & Kauasr, 2015), inadequate care (Tariq & Kauasr, 2015), parental criticism (Claar, Simons et al., 2008), disrupted attachment patterns (Tariq & Kauasr, 2015), conflict with the family (Leary, 2003), exposure to trauma (Stuart & Noyes, 1999), exposure to models of illness behaviour (Mai, 2004; Stuart & Noyes, 1999), rejection by parents and grief (Leary, 2003).

According to another model for the genesis of somatization is proposed by Stuart and Noyes (1999), somatization is a maladaptive learned response when dealing with stress. While illness behavior provides care from other people, it distracts the person's attention from the main issue. The interpersonal context of the individual with somatization includes his family and health workers. and physical symptoms can be an apparent symptom of both family conflicts and doctors' negative attitudes towards somatizing behavior (Stuart & Noyes, 1999). Childhood illness is an important factor for somatization (Stuart & Noyes, 1999). When the child experiences illness, the parents' reactions to them may also facilitate the somatization behavior. When a child falls and injures himself, if the care and attention is not given until the child hurts himself, this reaction will contribute to the somatization behavior (Stuart & Noyes, 1999). According to Bass and Murphy (1995), more than half of patients with somatization disease reported that one or both of their parents had a physical disability. Similarly, Craig et al. (1993) stated that the parents of people with somatization often experience the disease. All these findings show that how the parent copes with the illness, become a model for how the child copes with the illness, and this contributes to somatization.

According to Craig et al. (1993), somatization is best understood when combined with poor childhood care and illness experienced in childhood. Illness experienced in childhood can be a way of avoiding neglect, abuse, or care from parents who do not have the capacity to provide adequate care. Therefore, this illness experienced in childhood will reveal the caregiver behavior and will continue into adulthood. Moreover, not receiving care in early childhood makes the person vulnerable to psychopathology in stressful situations, while having or witnessing a childhood illness will cause stress to be expressed with somatization. (Craig et al., 1993), therefore, according to Stuart and Noyes (1999), childhood illness or physical abuse will affect the person's illness behavior and reveal maladaptive personality traits.

Stuart and Noyes (1999) propose that somatization behavior can be explained through attachment and interpersonal theory. Attachment is a pattern of behavior focused on seeking care and receiving comfort and reassuring responses from others. If this care-seeking behavior manifests itself as illness behavior, the person will tend to continue it into adulthood. The person will learn maladaptive methods to meet their attachment needs. Anxiety and insecure attachment lead the person to look for more care-seeking behavior. The interpersonal reactions of the person to the illness behavior led the person to the care-seeking behavior even more. Simply paying attention to the child's illness and ignoring other attachment needs can create a working model of significant others in which the child believes that care comes only when he or she is physically suffering. A child exposed to such an environment can learn to express emotional stress through physical pain. In adulthood, such a learning style disrupts interpersonal communication, causing them to be less tolerant of stress (Stuart & Noyes, 1999). Several studies have found that somatization is associated with insecure attachment (Ciechanowski et al., 2002; Taylor et al., 2000; Waldinger et al., 2006) and strongest association with fearful attachment style (Ciechanowski et al., 2002; Noyes et al., 2003). Waldinger et al. (2006) found that for women but not men, there is mediating effect of the insecure attachment, especially the fearful attachment, on the relationship between childhood experiences and somatization. According to Stuart and Noyes (1999), although insecure attachment and maladaptive behaviors of individuals with somatization initially reveal a caring behavior, they continue to display persistent care-seeking behavior. As a result, caregivers move away from these people. This interpersonal cycle ultimately results in these people not being able to find the care they seek.

1.3. Interpersonal Difficulties

In a study with college students in Turkey, it was found that 27% of college students suffer from the middle and high degree of experiencing depression; 41% had moderate to high anxiety; 27% of them also experienced stress (Bayram & Bilgel, 2008). According to Saleem and Mahmood (2013), many college students are prone to mental health problems with negative consequences. And these years are important for students in terms of setting social relationships and develop the ability to social interactions (Yeun & Woo, 2018). Having problems with social relationships and not being able to develop skills can lead to interpersonal difficulties (Lange & Couch, 2011). Problems that arise in a person's communication with the other person can be called interpersonal difficulties (Horowitz et al., 1993).

Sullivan (1938) argues that individuals inevitably maintain to interact with each other. Accordingly, the human mind and behaviors exist through interactions between individuals. The concept called "personality", on the other hand, is shaped within the framework of repetitive interpersonal behaviors in social life, and the individual cannot be understood unless this complex interactive process is taken into account (Sullivan, 1938). According to Sullivan, the basic motivation in interpersonal interaction, in which people affect each other's behavior, arises from the need for security and self-esteem (Akyunus & Gençöz, 2016).

Leary (1957) suggested the concept of "affiliation" instead of the concept of "security", one of the main motivations that shape Sullivan's (1953) interpersonal behaviors, and the concepts of "dominance " instead of the concept of "self-esteem". He also created a circular space consisting of the dimensions of these concepts as interpersonal behavior motivations. In the framework of this model, while the vertical axis represents dominant dimension; horizontal axis represents affiliation in the circumplex (Leary, 1957). The combination of these coordinates is used when describing interpersonal behaviors. (Akyunus & Gençöz, 2016; Alden et al., 1990; Horowitz et al., 2003). Alden et al. (1990) divided the interpersonal circular plane into 8 octants, which are formed from the combination of these two basic axes and define 8 distinct interpersonal problem fields. These octants formed the subscales of the Interpersonal Problems Inventory and those are domineering/controlling, intrusive-needy, self-sacrificing, overly accommodating, nonassertive, socially avoidant, cold-distant and vindictive/self-centered.

People with dominating behaviors are more controlling, manipulative in relationships and try to change others. Vindictive/self-centered people reports problems with distrust and suspicion of others, and problems with ignoring the needs and pleasure of others. Cold/distant people, on the other hand, have difficulty expressing their feelings and loving others. They have difficulty in long-term commitment. It's hard to forgive and get on with others for them. Socially avoidant people feel high anxiety and embarrassment when they are with others. It is problematic for them to commence social interactions, disclose emotions, and socialize with others. Nonassertive people have low self-confidence. They avoid being the center of attention and socially challenging situations. They avoid expressing their wishes for fear of disapproval and negative evaluation. people with overly accommodating problems have difficulty saying no, feeling and showing anger. They are easily persuaded. Self-sacrifice people try to please others, they are overly generous. They give trust and care. They care more about the needs of others than their own. People with intrusive needy behavior are those who need to relate to others, have trouble spending time alone, inappropriately open themselves to others, and have difficulty setting boundaries with others (Alden et al., 1990; Özer, 2017).

Many studies found that interpersonal problems are related to mental health problems. According to Davila and Beck (2002), isolation has been observed in people who fail in interpersonal relationships. Besides, decreased self-esteem and depression are related to poor interpersonal relationships (Huprich et al., 2016; Katz et al., 2011).

1.4. The Current Study

The current study aims to examine the mediating effect of interpersonal difficulties in the relationship between rejection sensitivity and somatization. When the literature is examined, there are some studies examining the relationship between rejection sensitivity and somatization. Nacak et al., (2021) found that individuals with somatoform disorder have a higher sensitivity to rejection than healthy individuals. In addition, another study found the moderation effect of rejection sensitivity between daily stress factors and somatization. In other words, it has been observed that somatization increases as the daily stressors such as conflicts and tension and the sensitivity to rejection increase (Yang, 2023). In the study of Naz and Kausar (2012) with adolescents with somatization, these individuals perceived their parents as rejecting, negligent and aggressive more than the control group. In addition, they

indicated that parental rejection and somatization disorder is related. They found that adolescents with somatoform disorders reported their parents as being more rejected. Tarıq and Kausar (2015) also found that conversion disorder is related to interpersonal problems. Especially, patients with conversion disorder reported cold/distant and over-accommodating behaviors.

According to De Panfilis et al. (2013), the relationship between high rejection sensitivity and psychopathology result from impairment of interpersonal relationships and this disruption may result in mental health problems. People with somatoform disorders have reported that they experience stress in interpersonal relationships, and they express this stress with somatic symptoms (Segrin, 2001, as cited in Tariq & Kausar, 2015). Waller and Scheidt (2006) suggest that somatoform diseases continue to exist with interpersonal difficulties. These problems experienced in interpersonal relationships arise from the first attachment relationships (Tariq and Kausar, 2015).

Many researchers have implied that rejection sensitivity creates problems in interpersonal relationships. Sensitivity to rejection is a process that includes anxious expectations of rejection and damage interpersonal relations by revealing difficulties in relationships during adolescence and adulthood (Downey & Feldman, 1996). Persons who sensitive to rejection may respond to the behavior which they perceive as rejection with a defensive action. Defensive action leads to ending the relationship or leads to behaviors that prevent the partner from ending the relationship (Fraley & Shaver, 2000). According to Cain et al. (2017), interpersonal problems differ according to the person's sensitivity to rejection. Results indicated that individuals who have a high anxious expectation of rejection sensitivity reported more socially avoidant interpersonal problems. On the other hand, individuals who have low anxious rejection sensitivity reported more vindictive interpersonal problems. Individuals who have high angry rejection sensitivity reported vindictive interpersonal problems whereas individuals who have low angry rejection sensitivity reported submissive interpersonal problems. In a study by Brookings et al. (2003), it was explored that highly rejection sensitive college students were unassured-submissive and aloof-introverted in relationships. This means that Individuals with high rejection sensitivity withdraw people instead of intimacy to avoid rejection (Cain et al., 2017).

Saleem et al. (2019) conduct a study that aims to examine the role of interpersonal difficulties in the relationship between parental rejection and mental health problems in Pakistani culture. Results pointed out that maternal rejection is one

of the significant vulnerability factors for interpersonal problems and mental health problems. In addition, another study proposes to explore the relationship between interpersonal difficulties and parental rejection in patients with conversion disorder showed that patients have conversion disorder have more non-assertive, vindictive/self-centered, cold/distant, and overly-accommodating behaviors than other patients (Tarıq & Kausar, 2015). Also, Tarıq and Kausar (2015) indicated that negligence from parents and undifferentiated rejection are associated with dominating and self-sacrificing behavior. To explain, individuals who perceive their parents as neglectful and rejecting can sometimes behave controlling and dominant, while sometimes they can behave in a self-sacrificial way.

Bowlby's attachment theory is an important model explain relationships between early rejection and adulthood relationships (Bowlby, 1969). The most basic need of human beings is to be accepted. According to Bowlby (1969), when this need is not met in childhood, sensitivity to the experience of rejection develops. In this period, when individuals perceive rejection from their parents, they can develop an expectation that they will be rejected over time. With this expectation, they begin to make an effort not to be rejected, and they tend to unconsciously sense the rejection clues. This situation will cause the individual to perceive the situations he encounters negatively, which will further disrupt the social relations of the individual. Ciechanowski and colleagues (2002) suggest that the attachment model should be considered when examining the relationship between how we perceive symptoms and health-seeking behavior. Securely attached people can seek support when they experience stress (Waller et al., 2004). However, people with insecure attachment assume that their needs will not be met and do not expect much from their care-seeking behavior (Ciechanowski et al., 2002). Many studies have found that preoccupied and fearful attachment are associated with more somatization behavior (Ciechanowski et al., 2002; Richardson, 2015). Also, many studies showed that rejection sensitivity is significantly related fearful and preoccupied attachment styles (Ciechanowski et al., 2002; Erözkan, 2009; Khoshkam et al., 2012). While preoccupied people perceive themselves as unworthy or unloved, they have a positive perception of others. They seek love and approval from others. They fear abandonment and have a sticky relationship. Fearfully attached people perceive both themselves and others negatively. They experience themselves as worthless while they experience others as rejecting and untrustworthy. Although these people want to establish close relationships, they are

afraid of being abandoned. They are socially avoidant (Bartholomew & Horowitz, 1991). They have problems in establishing and maintaining relationships, which makes them susceptible to rejection (Erozkan, 2009). Therefore, these people experience more insecure and inconsistent relationships in interpersonal relationships (Khoshkam et al., 2012). At the same time, people with high-anxious rejection sensitivity were found to display avoidant behavior in their interpersonal relationships (Cain et al., 2017).

According to Yang (2023), people with high rejection sensitivity may show more social withdrawal or revenge behavior to reduce the negative feelings they experience in negative social relationships. And this behavior may have contributed to somatization behaviors by causing more internal conflicts to arise. Interpersonal theory states that insecure attachment manifests itself as maladaptive behaviors in interpersonal relationships. These behaviors result in interpersonal problems. These problems cause the person to show more care-seeking behavior (Noyes et al., 2003).

This study is based on attachment model and Interpersonal theory. Considering the previous studies and their results, in the current study, it is assumed that people with rejection sensitivity will experience certain interpersonal problems arising from their insecure attachment, and they will express the stress they experience in these interpersonal problems with somatization behavior. That is, individuals with rejection sensitivity experience more interpersonal problems and the stress they experience in these interpersonal relationships leads to more somatic symptoms. When the literature is examined, there is no study investigating the mediating role of interpersonal difficulties between rejection sensitivity and somatization. This study intends to complete this gap in the literature and the current study is the first study in which three variables will be examined together. This study is expected to be useful in understanding the link between rejection sensitivity and somatization.

1.5. Hypotheses of the study

This study mainly purposes to explore the mediating role of interpersonal difficulties in the relationship between rejection sensitivity and somatization. In the study, rejection sensitivity was defined as the independent variable, interpersonal difficulties as the mediator variable and somatization as the dependent variable. Based on the main aim three hypotheses question are examined in the study.

1. Is there a significant relationship between the variables of the study?

2. Do interpersonal difficulties have a mediator role in the relationship between rejection sensitivity and somatization?

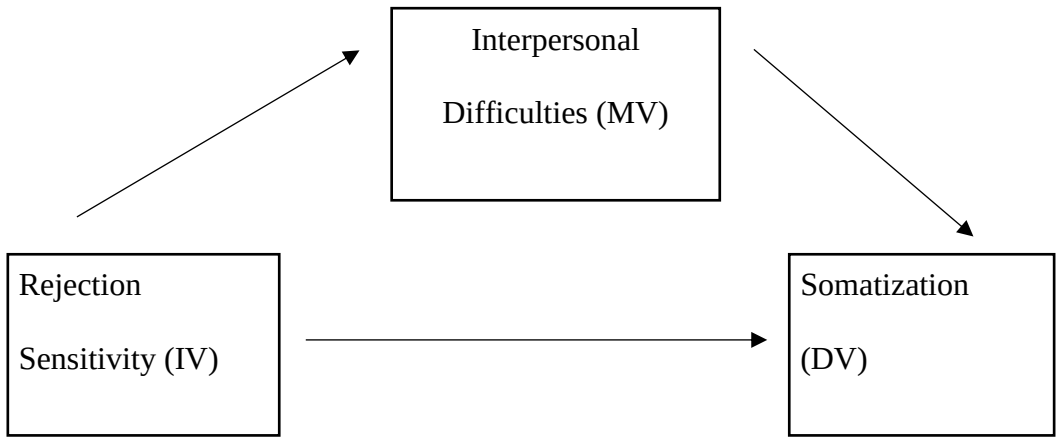

Figure 1 The Proposed Model of the Study (Model 4)

2. METHOD

2.1. Participants

In this study, convenience and criterion sampling was used in order to acquire a research sample. Participants were invited to the research via different social media platforms and data collection was carried out via Google Forms. Participants were required to be at least 18 years old and university students to participate in the study. A total of 300 individuals completed the study. Two people were excluded from the data because they were under the age of 18. Since the somatization values were positively skewed in the study, the Durbin-Watson value deteriorated when the outliers were removed. For this reason, somatization values were transformed to the Square Root Analysis. After the data screening procedure, data from 298 college students (207 females, 90 males, 1 others) is found suitable for the analysis. Participants between the ages of 18 and 53 participated in the study. Detailed demographic information was presented in table 1.

Table 1

Demographic Characteristics of the Sample

Variables		*N*	*%*	*M*	*SD*	*Range*
Age		298		24,32	4,74	18-53
Gender						
	Female	207	70,4			
	Male	90	29,2			
	Diğer	1	0,3			
Marital Status						
	no relationship at all	23	7,7			
	single	136	45,6			
	intimate	139	46,6			
Residence Status						
	village	29	9,7			
	town	9	3			
	district	55	18,8			

	state	95	31,9
	metropolis	107	35,9
	abroad	3	1
Raising Family Status			
	nuclear family	268	89,9
	extended family	26	8,7
	alone	3	1
	others	1	0,3
Psychopathological Diagnosis	Yes	41	13,8
	No	257	86,6
Chronic İllness	Yes	40	13,4
	No	258	86,6

Note. N = 298.

2.2. Instruments

In the current study, the participants were given informed consent form, Social Demographic Form, Rejection Sensitivity Questionnaire, Interpersonal Problems Inventory- Circumplex, Bradford Somatic Inventory (BSI) and Debriefing Form.

2.2.1. Social Demographic Form

In the form, the participants were asked about their age, gender, romantic relationship status, residence status, by whom they were raised until the age of 5, psychopathological diagnoses of participants and whether they had a chronic illness.

2.2.2 Rejection Sensitivity Scale (RSS)

In the study, the Rejection Sensitivity Scale (RSS) was used to measure the rejection sensitivity levels of the participants. RSS has 18-item scale developed to determine the rejection sensitivity levels of young adults (Downey & Feldman, 1996). These 18 hypothetical items examine thoughts of young adults about possible rejection situations. The situations in these items represent the interpersonal relationships of young people and are related to their possible rejection. The hypothetical situations in the rejection sensitivity scale are examined in two sub-dimensions for each item. In the first dimension, the extent of the participant's anxiety and worry about the result of given situation, and in the second dimension, the participant is asked to guess about the

feelings and thoughts of the other party (expectations of acceptance or rejection) (You ask someone in the class if you can borrow their notes- 1st dimension: whether the person would like to give their grades or not). How much would you worry or worry about this person? - 2nd dimension: I would expect this person to willingly give me their grades.). In the first dimension, a Likert-type scale was used to indicate the degree of anxiety of individuals regarding the outcome of each situation (1=I don't worry at all; 6=I worry a lot). In the second dimension, a Likert type scale was used to make predictions about the feelings and thoughts of the other party (1 = very unlikely; 6 = very likely). Internal reliability was found as .83 and test-retest reliability was found as .83 ($p < .001$) (Downey & Feldman, 1996).

Rejection Sensitivity Scale was adapted into Turkish in 2010 and the number of questions was increased to 26 by adding 8 new questions that fit the Turkish culture, taking into account cultural differences (Özen et al., 2010). Cronbach's Alpha coefficient for peer relationship was found .85 and for parents was found .73. In the current study, Cronbach's Alpha coefficient was found to be .92.

2.2.3 Interpersonal Problems Inventory- Circumplex (IIP-C)

It was originally developed as a scale consisting of 127 items to determine the difficulties experienced in interpersonal relationships (Horowitz et al., 1988). Alden et al. (1990) reduced the scale to 64 items, then Horowitz et al. (2003) developed a 32-item form of the scale while maintaining the same factor structure (as cited in Akyunus & Gençöz, 2016). The scale consists of 8 sub-dimensions: Domineering/Controlling subscale, Vindictive/Self-centered subscale, Cold-Distant subscale, Socially inhibited subscale, Nonassertive subscale, Overly Accommodating subscale, Self-sacrificing subscale, and Intrusive/Needy subscale. As scores of the scale and the subscale increase, distress experienced by the person in interpersonal relationships and specific interpersonal problems increase. The short form of the scale was adapted into Turkish by Akyunus and Gençöz (2016). The internal consistency of the whole scale was 0.86 and the internal consistency of the subscales was found 0.66-0.86 ranges, and test-retest reliability was found as 0.78. In the current study, Cronbach's Alpha value was found to be .87.

2.2.4 Bradford Somatic Inventory (BSI)

Bradford Somatic Inventory (BSI) was originally developed by Mumford et al. (2000) that determine somatic symptoms experienced in depression and anxiety. The

Cronbach's alpha coefficient of the BSI was 0.86 and were found good test–retest reliability. Turkish version of the scale was adopted by Kose et al. (2017). The study was completed at the Marmara University School of Medicine with a total of 201 healthy students. The Cronbach's alpha coefficient was 0.90 and the test–retest correlation coefficient was 0.75. In the current study, Cronbach's Alpha value was found to be .95.

2.3 Procedure

Before the data collection process start, all of the questionnaires, processes in data collection, and method used in this study were approved and permitted by Yeditepe University Human and Social Research Ethics Committee. The data was collected from participants aged 18 and over the age of 18 via convenience and criterion sampling method. All individuals participate voluntarily through online platforms. Before data collection, informed consent was provided to participants and debriefing form at the end of the study. All scales were filled out in the following order: Social Demographic Form, Rejection Sensitivity Questionnaire, Interpersonal Problems Inventory-Circumplex and, Bradford Somatic Inventory (BSI). It took approximately 20- 25 minutes to fill all scales.

2.4 Data Analysis

The object of the current study was to examine the mediating role of interpersonal difficulties in the relationship between rejection sensitivity and somatization. The Statistical Package of Social Sciences (SPSS), version 27 for Windows was used for data analyses. Firstly, data screening, testing the assumptions of the model (normality, assumption checks, data screening, outlier analysis, normality tests, linearity, homoscedasticity, multicollinearity), and descriptive statistics were conducted. Then, independent samples t-test was conducted to check whether there was a difference in the total scores of the scale according to the gender and the correlational analysis conducted to evaluate relationships between variables. In the final stage, a simple mediation analysis was performed to investigate the direct and indirect impacts of interpersonal difficulties on relationship between rejection sensitivity and somatization. In order to conduct the mediation analysis (rejection sensitivity as a predictor, interpersonal difficulties as a mediator, and somatization as an outcome variable), version 27 of SPSS (IBM Corp., 2019) and the PROCESS macro for SPSS (Hayes, 2022) model 4, which uses a regression-based approach to mediation, were used.

3. RESULTS

The study mainly purposes to investigate mediator role of interpersonal difficulties on the relationship between rejection sensitivity and somatization. Before simple mediation analysis, assumption checks, data screening, outlier analysis, normality tests, linearity, homoscedasticity, multicollinearity, descriptive statistics of study variables and bivariate correlations were conducted.

3.1. Descriptive Analyses

The descriptive statistics (sample size, minimum-maximum scores, mean, standard deviation, and skewness and kurtosis values) of the Rejection Sensitivity Questionnaire (RSS), Interpersonal Problems Inventory- Circumplex (IPI-C), Bradford Somatic Inventory (BSI) were summarized in the Table 2. Skewness and kurtosis assessed to check normality assumption. According to George and Mallery (2010), if the skewness and kurtosis values are found to be between -2 and +2, the distribution can be considered normal. In this study, the assumption of normality is not violated (see table 2).

Table 2

Descriptive, Skewness and Kurtosis Statistics of Measures

Measures	N	Min	Max	M	SD	Skewness	Kurtosis
IPI-C	298	42,00	134,00	73,91	16,54	0,64	0,75
BSI	298	0,00	9.11	4,24	2,054	-0,19	-0,30
RSS	298	1,65	23,15	8,83	3,37	0,84	1,69

Note. N = 298. IPI-C Interpersonal Problems Inventory- Circumplex, BSI Bradford Somatic Inventory, RSS Rejection Sensitivity Scale

3.2. Bivariate Correlations among Variables of the Study

To investigate associations among rejection sensitivity, interpersonal difficulties and somatization Pearson's bivariate correlation analyses were conducted. According to the results, the mediator variable of the study, interpersonal difficulties, was positively and significantly correlated with rejection sensitivity ($r = .22$, $p < .001$) and was positively and significantly correlated with somatization ($r = .27$, $p < .001$).

Finally, it was found that there was no significant correlation between rejection sensitivity and somatization (r = .02, p = .72) (see Table 3).

Table 3

Pearson's Correlation Coefficients of the Study Variable

	1	2	3
1.Rejection Sensitivity	1	.228*	.021
2.Interpersonal Difficulties	.228*	1	.275*
3.Somatization	.021	.275*	1

*p<0.01

3.3. Gender Differences

Independent sample t-test was conducted to determine differences between gender in terms of variables of the study. According to results, there was no statistically significant difference between woman's somatization scores and man's somatization scores $t(295) = 1.87$, $p = .06$. Also, no statistically significant gender difference was found for rejection sensitivity scores, $t(295) = -.23$, $p = .82$ and interpersonal difficulties scores, $t(295) = -1.15$, $p = .25$.

3.4. Mediation Analyses

The bootstrapping method was used to examine the mediating role of interpersonal problems. This method reduces the risk of type 1 error and provides an effective statistical power (Hayes, 2018). Certain assumptions must be met to use this method. It was found that the linearity assumption was met in the analysis. When the homoscedasticity assumption was tested, it was revealed that the variance of the residuals is constant (Std. Residual Min = -2.43, Std. Residual Max = 2.59). When the multicollinearity assumption tested, it was seen that there is no multicollinearity in data of the study (Interpersonal Difficulties, Tolerance = .94, VIF = 1.05; Rejection Sensitivity, Tolerance = .94, VIF = 1.05). The data met the assumption that residuals are independent (Durbin-Watson value = 1,97). And finally, there were no influential cases biasing the model since all Cook's Distance values were all under 1.

According to the model in which the mediation analysis first emerged, there must be a significant relationship between the predictor and the outcome variables in order to carry out this analysis (Baron & Kenny, 1986). However, Hayes says that even

if there is no such relationship, mediator variable analysis can be done. According to Hayes (2018), since the total effect between the variables expresses all of the direct and indirect effects, indirect effects can be significant even though the total effect is not significant. Therefore, although the relationship between the predictor and the outcome variable is not significant, mediator analysis can be conducted (Hayes, 2018).

The outcome variable of the study was somatization, the predictor variable was rejection sensitivity, and the mediator variable was interpersonal difficulties. According to results, rejection sensitivity scores were significantly associated with interpersonal difficulties sores (β= 1.11, *SE* = .027, *p* <.001). It means that individuals who have rejection sensitivity were more likely to experience interpersonal difficulties. Also, interpersonal difficulties scores were significantly associated with somatization scores (β= .03, *SE* = .007, *p* <.001). That is, the more individuals have interpersonal difficulties they more likely to experience somatization. When the total effect was examined, it was found that there was no significant relationship rejection sensitivity and somatization (β = .01, *SE* = .03, *p* = .72). Similarly, direct effect was not significant when interpersonal difficulties variable was included to the analysis (β = -.02, *SE*=.03, *p* = .43). However, there is a significant indirect relationship between rejection sensitivity and somatization via interpersonal difficulties (β = .04, *SE*= .012, %95CI [.0184, .0655]) (see Figure 1). According to results, there is a full mediator effect of interpersonal difficulties between rejection sensitivity and somatization. In these regression analyses, 5000 resamples were used in to identify full indirect effects of interpersonal difficulties on the relationship between rejection sensitivity and somatization with a 95% confidence interval.

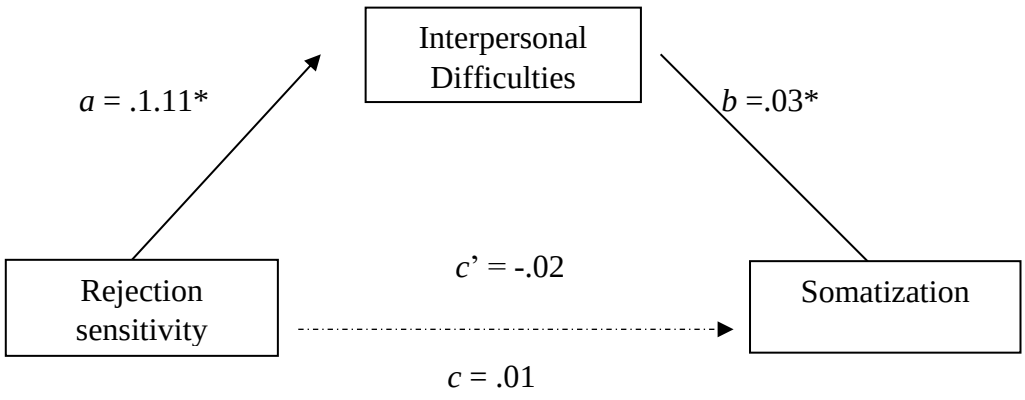

Figure 2 Mediation model of rejection sensitivity, interpersonal difficulties, and somatization (Model 4, Hayes, 2018)

Note. $*p < .001$; a is effect of rejection sensitivity on interpersonal difficulties; b is effect of interpersonal difficulties on somatization; c is total effect of rejection sensitivity on somatization; c' is direct effect of rejection sensitivity on somatization.

4. DISCUSSION

The main aim of the current study is to examine whether interpersonal problems play a mediating role between rejection sensitivity and somatization in participants over the age of 18. In this part of the study, the findings obtained from the statistical analyzes in order to answer the research questions of the study were evaluated in the light of the literature. First, the findings on the relationships between rejection sensitivity, interpersonal problems and somatization variables are discussed. Then, the role of interpersonal problems in the relationship between rejection sensitivity and somatization was examined. Afterward, the limitations of the study and clinical implications will be suggested.

4.1. Gender Differences

According to the results of the current study, there is no significant difference between man and woman on the variables of the study. Some previous studies showed that no significant relationship between rejection sensitivity and gender, while some studies revealed that women had more rejection sensitivity, and some studies revealed that men had more rejection sensitivity. Therefore, a consensus about gender differences on rejection sensitivity could not be reached in the literature. It was determined that the scores obtained from the somatization scale did not show a statistically significant difference according to gender. This result is consistent with some previous researches (Barlas et al., 2010). Although there is no significant difference between men and women in the current study, it is seen that women have higher somatization scores than men (Yatar, 2020). The reason why there is no significant difference can be explained by the fact that the participants have the same education level.

4.2. Interpretation of correlational analyses

The first hypothesis was that whether there is a relationship between the variables. The findings revealed that sensitivity to rejection is positively and significantly related with interpersonal difficulties. That is, individuals who have experience rejection sensitivity, tend to struggle with interpersonal difficulties. People with a high sensitivity to rejection give maladaptive reactions when faced with behavior that includes any hint of rejection. These maladaptive responses can lead to negative results in the relationships of individuals with other people (Romero-Canyas et al., 2010). This conclusion is similar to the results in the study by Brookings et al. (2003)

who have founded that students with high rejection sensitivity also showed unassured-submissive and aloof-introverted traits in interpersonal relationships. That is, people with high rejection sensitivity avoid rejection by distancing themselves from other people in the relationship (Cain et al., 2017). Similarly, Cain et al. (2017) examined interpersonal problems separately and their relations with RS, explore that highly anxious rejection sensitive individuals show avoidant behavior in their interpersonal relationships and struggle with severe interpersonal distress. Meeting someone, socializing and getting close are challenging experiences for them. In contrast, people with low anxious rejection sensitivity reported more self-confidence in social interaction and less interpersonal distress.

Another finding was that interpersonal difficulties was significantly and positively correlated with somatization. To explain, the more problems individuals have in their relationships, the more they tend to experience somatization. According to Noyes et al. (2001), interpersonal problems are basic problems for somatoform disorders. According to Waller et al. (2004), interpersonal problems associated with insecure attachment appear in individuals with somatoform disease. In another study, it was found that hypochondriasis is actually related to interpersonal problems. In the study, it was observed that people with Hypochondriasis tended to be introverted, emotionally distant, self-sacrificing, and needy (Noyes et al., 2003). According to Segrin (2001), people with somatoform diseases experience more stress in interpersonal relationships and express stress through somatic symptoms (as cited in Tariq & Kausar, 2015). Tariq and Kausar concluded in their study that interpersonal problems are associated with conversion disease (2015). In addition, another important finding in the same study is that participants who have conversion disease scored more cold/distant, nonassertive, and vindictive/self-centered, overly accommodating behaviors (Tariq & Kausar, 2015). As mentioned before, somatization is based on inadequate care in childhood and experiencing an illness. The child will continue the dysfunctional behaviors learned in childhood into adulthood. If the child give care with an illness, he/she will show the dysfunctional behavior that he/she learned in childhood to meet his/her attachment needs, that is, he/she will physically express the negative emotions and this will disrupt the person's interpersonal relationships (Stuart & Noyes, 1999).

When the relationship between sensitivity to rejection and somatization was examined, no direct significant relationship was found between these two variables. There is very little research in the literature examining the relationship between these

two variables (Yang, 2023). According to Yang (2023), people with rejection sensitivity tend to perceive rejection and are more open to biological responses caused by stress. Yang (2023) found that somatization and rejection sensitivity were related and that rejection sensitivity had a mediating role between daily stressors and somatization. According to Yang, when people with rejection sensitivity experience negativities in social interactions, they have more social withdrawal or feelings of revenge in order to cope with that emotion. In such a situation, these people internalize the conflicts more, which leads to more somatization. Another study found that people with somatoform disease experience more rejection sensitivity than healthy people (Nacak et al., 2021). As stated in the literature review, rejection sensitivity is a condition that disrupts interpersonal relationships. At this point, after these people develop sensitivity to rejection, they experience certain interpersonal problems in relationships, and the negative emotions and conflicts that these problems create in the person may lead to the emergence of somatization behavior. In the current study, it was found that the relationship between these two variables became significant through interpersonal problems.

4.3. Interpretation of Mediation Analysis

When the connection between sensitivity to rejection and somatization was examined, no direct significant relationship was found between these two variables. However, when the interpersonal problem was included in the relationship, it was found that the interpersonal problems had a full mediator effect between the two variables. In the model tested in the study, interpersonal problems were found to be mediator. In other words, it was found that rejection sensitivity was indirectly related to somatization through interpersonal problems. Therefore, individuals with high rejection sensitivity experience interpersonal difficulties in their relationships, this in turn lead these individuals to have more somatizing behavior.

When relevant literature was examined, no study was found examining the mediator role of interpersonal difficulties on the relationship between rejection sensitivity and somatization. However, there are study results that are similar to the current study findings. Many studies found that rejection sensitivity had mediating roles in the relationship between perceived rejection from parents and psychological symptoms (Abacı, 2018; İnce,2020; Saleem et al., 2019). Another study was conducted with conversion patients that try to explore the relationship between interpersonal problems and parental rejection/control in individuals with conversion disease. Results

of the study showed that perceived rejection from the mother was related to interpersonal problems. It was also found that individuals with conversion disease were significantly more vindictive/self-centered, non-assertive, overly accommodating and cold/distant (Tariq & Kausar, 2015).

In the light of all these studies, it is seen that individuals with rejection sensitivity behave distantly in their relations with other people in order to avoid rejection. At the same time, meeting new people and socializing are stressful situations for these people. (Cain et al., 2017). According to Cain et al., (2017), although these people are socially avoidant, they actually attach importance to bonding and intimacy with others. Again, in the light of studies, as mentioned in the introduction section, individuals with somatoform disease were found to be more introverted, emotionally distant, self-sacrificing, needy (Noyes et al., 2003), vindictive, nonassertive, overly accommodating, and cold distant. When we look at the results of the current study, it can be a stressful situation for people with rejection sensitivity to be distant in their relations with others because they actually need to establish relationships and bonds, but are afraid of rejection. As Segrin (2001) said, these people with high sensitivity to rejection may express the stress they experience in interpersonal relationships with somatic symptoms (as cited in Tariq & Kausar, 2015).

According to Stuart and Noyes, although anxious and dysfunctional attachment behaviors of people with somatization initially reveal caring behavior, people with an insecure attachment, especially a fearful attachment, will have problems in interpersonal relationships because these individuals continue to seek help persistently and unsatisfiedly. They propose that somatization behavior is best understood in interpersonal relationships that arise from the insecure attachment. Rejection, which is perceived and experienced by important people in one's life, encourages somatization behavior. This person tries to get attention and care through somatization behavior. However, this behavior cycle results in a real rejection and further increases the person's somatization behavior (Stuart & Noyes, 1999).

These people experience more interpersonal problems due to rejection sensitivity and therefore they develop somatization. According to the results of this research, people with high sensitivity to rejection experience somatization when they experience problems in interpersonal relationships. However, not every person with rejection sensitivity exhibits somatization behavior. Perhaps, people who have improved in interpersonal relationships and have more functional interpersonal

relationships may not have shown somatization behavior because they did not experience stress in interpersonal relationships.

4.4. Clinical Implications

In the present study, the relationship between sensitivity to rejection and somatization and the concept of rejection sensitivity, which is thought to be effective for this relationship, were studied. According to results of the study, it was found that when individuals with high rejection sensitivity experienced interpersonal problems they more tend to have somatization. For this reason, it is thought that it is important to consider the sensitivity of rejection and interpersonal problems when addressing the somatic symptoms of people who apply to psychotherapy. Considering that these variables may also be effective in the problems of people who apply to us in the clinical setting, it is necessary to plan and conduct the interviews and structure the necessary interventions by taking these variables into account. According to Stuart and Noyes (2006), interpersonal psychotherapy is one of the effective treatments for individuals with somatization behavior. This therapy method aims to relieve the person's immediate symptoms and increase their interpersonal functionality. It provides this by regulating an individual's interpersonal relationships and changing their perceptions of other people. This method teaches the person to receive the support they need from others in healthier ways by focusing on the patient's attachment relationships and improve the interpersonal relationships (Stuart & Noyes, 2006). To protect university students from various negative outcome of rejection sensitivity, early and timely intervention and awareness programs are needed. Examining whether individuals with rejection sensitivity experience interpersonal problems and, if they do, applying interventions to regulate these relationships will protect them against developing somatization.

The university period is the year when individuals have the most social interaction. In particular, this period will be one of the most suitable times to compensate for the negative experiences and insecure attachment behaviors of people in childhood. For this reason, recognizing the mechanisms that are effective in the formation and continuity of interpersonal problems in university students can support the creation of intervention plans to reduce or control problematic behaviors. Including practices regarding attachment styles and interpersonal emotion regulation strategies in clinical intervention programs may support the reduction of problematic behaviors in the social context.

4.5. Limitations and Future Directions

In the study, the variable of interpersonal problems, which may be important in the relationship between rejection sensitivity and somatization, was examined and a model was created. More comprehensive studies are needed to have more information about the development of somatization and the effect of rejection sensitivity on it and to plan more effective interventions. Current research variables have not been examined before in the literature. For this reason, it will be important to address the limitations of the study and future directions while discussing the findings. The first and most fundamental limitation of the study is that its generalizability is limited due to the sample group. Since the study was conducted with university students, it can be generalized to the education group that has the characteristics of this sample group. For future research on this subject, it may be recommended to work with different education groups or to conduct a longitudinal study. By examining the long-term interpersonal relationships of people with rejection sensitivity in childhood, it can be examined how they differ in terms of somatization in the different ages. Thus, by investigating the relationships between these variables in more depth, it would be understood whether they will differ developmentally.

Another suggestion that can be made at this point may be to work with a clinical sample. This will enable to reach more detailed findings about somatization. In the future, similar studies can be carried out in different countries and with different sample groups, so that a supracultural perspective can be approached and universally valid findings can be reached. Clinicians and researchers working in the field can evaluate these variables by looking beyond culture, language, and traditional features. This study includes measurements based on self-report. In future studies, various qualitative methods can be used to investigate these variables that may affect somatization in more detail. Thus, the disadvantages of the self-report approach will be avoided. These methods can also be important in revealing culture-specific features. Although the relationship between the expectations of rejection and possible negative consequences of people with rejection sensitivity is supported by studies, not everyone with rejection sensitivity experiences the same interpersonal problem and is not affected by this sensitivity to the same degree. Thus, while creating a treatment plan for individuals with high somatization and rejection sensitivity in the clinical setting, it will be beneficial for clinicians to include the sub-dimensions of interpersonal problems in the research and to obtain results for future studies.

Another limitation in this regard is the high number of scale items used. This situation causes unwillingness or inability to maintain their attention in the participants and increases data loss. No matter how eager they are to participate in the study, fatigue and boredom can be observed in the participants, and there is always the possibility that this will affect their answers to the questions and that they have marked them randomly. Paying attention to the number of questions in the research may be a recommendation for further research. Another methodological weakness of the study is that it is a relational and cross-sectional study. When evaluating the results of the study, the nature of the study should be considered and causal conclusions should not be drawn.

Also, it has been observed that individuals with anxious rejection expectation and angry rejection expectation have different behavioral samples (Gao et al., 2019). It would be important to examine how these different behavioral patterns affect interpersonal problems and somatization.

4.6. Conclusion

The current study purpose to investigate the mediating role of interpersonal difficulties between rejection sensitivity and somatization. According to results, interpersonal difficulties had full mediation effect in association between rejection sensitivity and somatization. To our knowledge, no research has been found in the literature examining the mediator role of interpersonal difficulties in the relationship between rejection sensitivity and somatization. For this reason, this research is a useful study in terms of closing this gap in the literature and clinical settings. The present study is considered to be unique in the literature, as it is the first study to examine the variables of rejection sensitivity, somatization, and interpersonal problems together. As a result of the analyses, it is thought that it will be important for other clinical psychology studies investigating similar concepts. It is thought that this study makes a contribution to the fields of psychopathology and clinical work by showing the importance of interpersonal relationships.

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Appendix A: Informed Consent Form

BİLGİLENDİRİLMİŞ ONAM FORMU

Bu araştırma Yeditepe Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Zühra Mercan tarafından Dr. Öğr. Üyesi Seray Akça danışmanlığında bitirme tezi projesi olarak yürütülmektedir. Bu form katılımcılara ilgili araştırma hakkında bilgi sağlamak amacıyla hazırlanmıştır. Bu araştırma kişilerarası ilişki deneyimleri ve bedensel deneyimleri arasındaki ilişkiyi anlamayı amaçlamaktadır. Bu araştırmaya katılabilmek için 18 yaş üzeri olmanız yeterlidir. Araştırmaya katılmayı kabul etmeniz durumunda sizden beklenen, size sunulmuş olan ölçeklerdeki soruları içtenlikle cevaplamanızdır. Tüm soruları cevaplamanın ortalama olarak 10-15 dakika süreceği tahmin edilmektedir.

Bu araştırmaya katılımınız tamamen gönüllülük esasına dayanmaktadır. Araştırmanın hiçbir aşamasında sizden kimlik belirleyici bilgiler istenmemektedir. Verdiğiniz cevaplar tamamıyla gizli tutulacak, yalnızca araştırmacı tarafından değerlendirilecektir. Katılımcılardan elde edilecek bilgiler bireysel olarak değil, toplu bir şekilde değerlendirilecek ve yalnızca bilimsel amaçlı kullanılacaktır. Araştırmaya katılmanın sizin için herhangi bir risk oluşturması beklenmemektedir. Ancak yine de sorulardan ya da herhangi bir sebepten dolayı kendinizi rahatsız hisseder ve devam etmek istemezseniz, cevaplamayı istediğiniz zaman bırakabilirsiniz.

Yukarıdaki bilgileri okudum ve bu çalışmaya tamamen gönüllü olarak katılıyorum. İstediğim zaman cevaplamayı bırakabileceğim konusunda bilgilendirildim. Sağladığım bilgilerin bilimsel amaçlarla kullanılmasına izin veriyorum.

İmza:

Appendix B: Demographic Information Form

Demografik Bilgi Formu

1. Cinsiyetiniz: ( ) Kadın ( ) Erkek ( ) Diğer

2. Yaş:

3. Medeni Durumunuz: ( ) ilişkim var ( ) ilişkim yok ( ) hiç ilişkim olmadı

4. Geldiğiniz/yetiştiğiniz aile türü: ( ) Çekirdek aile (anne, baba, kardeşler aynı evde) ( ) Geniş aile (bazı akrabalarla aynı evde) ( ) Yalnız ( ) Diğer:
…….

5. Büyüdüğünüz yerleşke türü: ( ) köy ( )kasaba ( )ilçe ( )il ( ) Metropol ( )yurtdışı

6. Şu anda herhangi bir psikolojik/psikiyatrik rahatsızlığınız var mı? ( ) Evet ( ) Hayır
Cevabınız EVET ise, tanısı nedir?: …….

Appendix C: Rejection Sensitivity Scale

Reddedilme Duyarlılığı Ölçeği (Rejection Sensitivity Questionaire; RSQ)

Aşağıdaki her bir madde genelde üniversite öğrencilerinin bazen diğer kişilerden talep ettiği şeyleri tanımlamaktadır. Lütfen, her bir durumda/koşulda bulunduğunuzu düşünün ve cevaplarınızı ona göre verin. Her bir soruda, sizin için uygun olan numarayı daire içine alarak işaretlemeleri yapınız.

- Maddeleri değerlendirirken, karşınızdaki kişinin (örneğin, bir hocanız veya bir arkadaşınızla ilgili olan maddelerde) lütfen belirli bir kişiyi değil, **ORTALAMA BİR KİŞİYİ DÜŞÜNEREK** yanıt veriniz.
- Araştırma, **özel kişilere karşı olan tutumlarınızı** değil, **GENEL TUTUMLARINIZI** incelemektedir.

Her bir maddenin ardından gelen şu soruları yanıtlamanız beklenmektedir:

1) Başkalarının size tepkisi konusunda ne kadar **endişe eder veya kaygı duyarsınız**?
2) İlgili durumda diğer kişilerin ne tür tepki verebileceğini düşünürsünüz?

1. Sınıftaki birine notlarını ödünç alıp alamayacağınızı soruyorsunuz.

a) Kişinin notlarını vermek isteyip istemeyebileceği ile ilgili olarak ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Bu kişinin notlarını bana isteyerek vermesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

2. Romantik partnerinizden sizinle aynı eve taşınmasını istiyorsunuz.

a) Romantik partnerinizin sizinle aynı eve taşınmayı isteyip istemeyeceği ile ilgili ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Romantik partnerimin benimle aynı eve taşınmayı istemesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

3. Yurtdışı gezisine gitmek için ebeveynlerinizden destek istiyorsunuz.

a) Ebeveynlerinizin size yardımcı olmayı isteyip istemeyebileceği ile ilgili ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Onların (Ebeveynlerimin) bana yardım etmek için istekli olmalarını beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

4. Yeni tanıştığınız birine çıkma teklif ediyorsunuz.

a) Kişinin sizinle çıkmak isteyip istemeyebileceği ile ilgili ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) O kişinin benimle çıkmayı istemesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

5. Romantik partneriniz bütün arkadaşlarla birlikte dışarı çıkmayı planlıyor, ancak siz geceyi sadece partnerinizle geçirmek istiyorsunuz, ve bunu ona söylediniz.

a) Romantik partnerinizin bu isteğinizi kabul edip etmeyebileceği ile ilgili ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Romantik partnerimin bu isteğimi kabul etmeye istekli olmasını beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

6. Günlük harcamalarınızı karşılamak için ebeveynlerinizden harçlığınızı arttırmalarını istiyorsunuz.

a) Ebeveynlerinizin bu isteğinizi kabul edip etmeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Ebeveynlerimin yardımcı olmaya istekli olmalarını beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

7. Derste yeni tanıştığınız birine birlikte kahve içmeyi teklif ediyorsunuz.

a) Kişinin sizinle gelmeyi isteyip istemeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Diğer kişinin benimle gelmeyi istemesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

8. Yakın bir arkadaşınıza onu ciddi şekilde üzecek bir şey söyledikten ya da yaptıktan sonra, yaklaşıyor ve konuşmak istiyorsunuz.

a) Arkadaşınızın bu durumda sizinle konuşmak isteyip istemeyeceği ile ilgili ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6

Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Hemen benimle konuşup sorunlarımızı çözmek istemesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

9. Dersten sonra hocanıza anlamadığınız bir konuda soru yöneltip size fazladan zaman ayırıp ayıramayacağını soruyorsunuz.

a) Hocanızın size yardım etmeyi isteyip istemeyeceği ile ilgili ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Hocamın bana yardımcı olmak için istekli olmasını beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

10. Okulunuzu bitirdikten sonraki yıllarda ailenizden para istiyorsunuz.

a) Ebeveynlerinizin size para vermeyi isteyip istemeyebilecekleri konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6

Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Ebeveynlerimin para talebimi kabul etmek konusunda istekli olmalarını beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

11. Okul tatilinde bir arkadaşınıza birlikte tatile gitmeyi teklif ediyorsunuz.

a) Arkadaşınızın sizinle tatile gelmeyi isteyip istemeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Teklifimin memnuniyetle kabul edilmesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

12. Çok kırıcı bir tartışmadan sonra romantik partnerinize telefon ediyor ve onu görmek istediğinizi söylüyorsunuz.

a) Romantik partnerinizin sizi görmeyi isteyip istemeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6

Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Romantik partnerimin de beni görmeye istekli olmasını beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

13. Arkadaşınıza ondan bir şeyini ödünç alıp alamayacağınızı soruyorsunuz.

a) Arkadaşınızın size istediğiniz şeyi verip vermeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Arkadaşımın istediğim şeyi ödünç vermeye istekli olmasını beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

14. Ebeveynlerinizden sizin için önemli ancak onlar için sıkıcı ve gelmesi zahmetli olabilecek bir etkinliğe sizinle beraber gelmelerini istiyorsunuz.

a) Ebeveynlerinizin sizinle gelmeyi isteyip istemeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6

Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Ebeveynlerimin benimle gelmeyi kabul etmelerini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

15. Bir arkadaşınızdan size ciddi bir yardımda bulunmasını istiyorsunuz.

a) Arkadaşınızın bu yardımı yapmak isteyip istemeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Arkadaşımın bu yardım isteğimi kabul etmesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

16. Romantik partnerinize sizi gerçekten sevip sevmediğini soruyorsunuz.

a) Romantik partnerinizin sizi gerçekten sevdiğini söyleyip söylemeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6

Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Romantik partnerimin beni gerçekten çok sevdiğini söylemeye istekli olmasını beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

17. Bir partiye gidiyorsunuz ve odanın diğer köşesinde birini fark ediyorsunuz, sonra ona beraber dans etmeyi teklif ediyorsunuz.

a) Dans etmeyi teklif ettiğiniz kişinin teklifinizi kabul edip etmeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Dans etmeyi teklif ettiğim kişinin bu teklifimi memnuniyetle kabul etmesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

18. Ailenizle tanıştırmak üzere romantik partnerinizden sizinle eve gelmesini istiyorsunuz.

a) Romantik partnerinizin ailenizle tanışmayı isteyip istemeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Romantik partnerimin ailemle buluşmayı memnuniyetle kabul etmesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

19. Başka bir şehirde yaşayan bir arkadaşınıza evinde 10 gün kalmak istediğinizi söylüyorsunuz.

a) Arkadaşınızın bu isteğinizi kabul edip etmeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Arkadaşımın evinde kalma isteğimi memnuniyetle kabul etmesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

20. Yeni tanıştığınız bir hemcinsinize birlikte bir şeyler yapmayı öneriyorsunuz.

a) Bu kişinin önerinizi kabul edip etmeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6

Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Arkadaşımın benimle dışarı çıkmayı memnuniyetle kabul etmesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

21. Romantik partnerinizden sizi ailesiyle tanıştırmasını istiyorsunuz.

a) Romantik partnerinizin sizi ailesiyle tanıştırmayı isteyip istemeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Romantik partnerimin bu isteğimi memnuniyetle kabul etmesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

22. Evde arkadaşlarınızla parti yapmak için anne ve babanızın akşam için başka bir yere gitmelerini istiyorsunuz.

a) Ebeveynlerinizin bu isteğinizi kabul edip etmeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6

Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Ebeveynlerimin bu isteğimi kabul etmelerini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

23. Ebeveynlerinize romantik partnerinizle tatile gitmek istediğinizi söylüyorsunuz.

a) Ebeveynlerinizin bu isteğinizi kabul edip etmeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Ebeveynlerimin romantik partnerimle tatile çıkmamı kabul etmelerini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

24. Ebeveynlerinize mezuniyetten sonra onlardan farklı bir şehirde yaşamak istediğinizi söylüyorsunuz.

a) Ebeveynlerinizin bu isteğinizi kabul edip etmeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Ebeveynlerimin kararımı kabul etmelerini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

25. Çok iyi yemek yapan bir akrabanızdan (hala, teyze, vb.) çok iyi yaptığı bir yemeği sizin için özel olarak yapmasını istiyorsunuz.

a) Akrabanızın sizin için özel olarak yemek yapmayı isteyip istemeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Akrabamın bu isteğimi memnuniyetle kabul etmesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

26. Sınavdan bir gün önce sizinle aynı sınava girecek olan bir arkadaşınızdan anlamadığınız konuları size anlatmasını istiyorsunuz.

a) Arkadaşınızın bu isteğinizi kabul edip etmeyebileceği konusunda ne kadar **endişe eder veya kaygı duyarsınız**?

1	2	3	4	5	6
Hiç endişelenmem / Kaygı duymam					Çok endişelenirim / Kaygı duyarım

b) Arkadaşımın beni çalıştırmayı memnuniyetle kabul etmesini beklerdim.

1	2	3	4	5	6
Çok küçük ihtimalle					Çok büyük ihtimalle

Appendix D: Interpersonal Problems Inventory- Circumplex

Inventory of Interpersonal Problems (IIP-32) Turkish Form

İnsanlar başkalarıyla ilişkilerinde aşağıda belirtilen problemleri yaşadıklarını ifade etmektedirler. Lütfen aşağıdaki ifadeleri okuyun ve her maddeyi hayatınızdaki **HERHANGİ BİR ÖNEMLİ KİŞİ**YLE (aile bireyleri, dostlar, iş arkadaşları gibi) İLİŞKİNİZDE sizin için problem olup olmadığına göre değerlendirin. Problemin SİZİN İÇİN NE KADAR RAHATSIZ EDİCİ OLDUĞUNU numaralandırılmış daireleri yuvarlak içine alarak belirtiniz.

Aşağıdaki ifadeler başkalarıyla ilişkilerinizde yapmakta ZORLANDIĞINIZ şeylerdir. Benim için,	**Hiç değil**	**Biraz**	**Orta derecede**	**Oldukça**	**Fazlasıyla**
1. Başkalarına “hayır” demek zordur.	1	2	3	4	5
2. Gruplara katılmak zordur.	1	2	3	4	5
3. Birşeyleri kendime saklamak zordur.	1	2	3	4	5
4. Birine beni rahatsız etmemesini söylemek zordur.	1	2	3	4	5

5. Kendimi yeni insanlara tanıtmak zordur.	1	2	3	4	5
6. İnsanları ortaya çıkan problemlerle yüzleştirmek zordur.	1	2	3	4	5
7. Başkalarına kendimi rahatlıkla ifade etmek zordur.	1	2	3	4	5
8. Başkalarına kızgınlığımı belli etmek zordur.	1	2	3	4	5
9. Başkalarıyla sosyalleşmek zordur.	1	2	3	4	5
10. İnsanlara sıcaklık/ şevkat göstermek zordur.	1	2	3	4	5
11. İnsanlarla anlaşmak/ geçinmek zordur.	1	2	3	4	5
12. Başkalarıyla ilişkimde, gerektiğinde kararlı durabilmek zordur.	1	2	3	4	5
13. Başka birisi için sevgi/ aşk hissetmek zordur.	1	2	3	4	5
14. Başka birinin hayatındaki amaçları için destekleyici olmak zordur.	1	2	3	4	5
15. Başkalarına yakın hissetmek zordur.	1	2	3	4	5
16. Başkalarının problemlerini gerçekten umursamak zordur.	1	2	3	4	5
17. Başkalarının ihtiyaçlarını kendi ihtiyaçlarımdan öne koymak zordur.	1	2	3	4	5
18. Başka birinin mutluluğundan memnun olmak zordur.	1	2	3	4	5
19. Başkalarından benimle sosyal amaçla bir araya gelmesini istemek zordur.	1	2	3	4	5
20. Başkalarının duygularını incitmekten endişe etmeksizin kendimi rahatlıkla ifade etmek zordur.	1	2	3	4	5

Aşağıdaki ifadeler ÇOK FAZLA yaptığınız şeylerdir.	**Hiç değil**	**Biraz**	**Orta derecede**	**Oldukça**	**Fazlasıyla**
21. İnsanlara fazlasıyla açılırım/ içimi dökerim.	1	2	3	4	5
22. Başkalarına karşı fazlasıyla agresifim/ saldırganım.	1	2	3	4	5
23. Başkalarını memnun etmek için fazlasıyla uğraşırım.	1	2	3	4	5
24. Fark edilmeyi fazlasıyla isterim.	1	2	3	4	5
25. Başkalarını kontrol etmek için fazlasıyla uğraşırım.	1	2	3	4	5
26. Sıklıkla (fazlasıyla) başkalarının ihtiyaçlarını kendi ihtiyaçlarımın önüne koyarım.	1	2	3	4	5
27. Başkalarına karşı fazlasıyla çömertim	1	2	3	4	5
28. Kendi istediğimi elde edebilmek için başkalarını fazlasıyla yönlendiririm.	1	2	3	4	5
29. Başkalarına kişisel bilgilerimi fazla anlatırım.	1	2	3	4	5
30. Başkalarıyla fazlasıyla tartışırım.	1	2	3	4	5
31. Sıklıkla (fazlasıyla) başkalarının benden faydalanmasına izin veririm.	1	2	3	4	5
32. Başkalarının ızdırapından/ mağduriyetinden fazlasıyla etkilenirim.	1	2	3	4	5

Appendix E: Bradford Somatic Inventory

BSI-44

Bradford bedensel belirti envanteri

Anketi Nasıl Dolduracaksınız:

Son bir ay içinde herhangi bir bedensel belirtinizin olup olmadığını öğrenmek istiyoruz. Lütfen aşağıdaki tüm sorular için en uygun seçeneği işaretleyin. Burada yalnızca son bir aydaki belirtilerinizi öğrenmek istiyoruz, daha önce ya da geçmişte varolanları değil. Tüm soruları yanıtlamaya çalışmanız çok önemlidir. Yardımlarınız ve katkınız için içtenlikle teşekkür ederiz.

ÖLÇEĞİN GEÇERLİ OLABİLMESİ İÇİN TÜM MADDELERİN DOLDURULMASINA ÖZEN GÖSTERİNİZ

Son bir ay boyunca ...	Yok	Geçen ay15 Gündendaha AZ var	Geçen ay15 Gündendaha ÇOK var
1. Şiddetli baş ağrılarınız oldu mu?	☐	☐	☐
2. Midenizde çarpıntı ya da hareket eden bir şeyhissi oldu mu?	☐	☐	☐
3. Boynunuz ve omzunuzda ağrı veya gerginlik hissettiniz mi?	☐	☐	☐
4. Cildinizde yanma ya da kaşıntı hissi oldu mu?	☐	☐	☐
5. Kafanız, dışarıdan sımsıkı bir şekilde bastırılıyormuş gibi bir sıkışma hissi oldu mu?	☐	☐	☐
6. Göğsünüzde ya da kalbinizde sancı hissettiniz mi?	☐	☐	☐
7. Ağzınızda ya da boğazınızda kuruluk hissi oldu mu ?	☐	☐	☐
8. Gözlerinizin önünde kararma ya da sislenme oldu mu?	☐	☐	☐
9. Midenizde yanma hissettiniz mi?	☐	☐	☐
10. Çoğu zaman enerji eksikliği (zayıflık) hissettiğiniz oldu mu?	☐	☐	☐
11. Başınızda sıcaklık ya da yanma hissi oldu mu?	☐	☐	☐
12. Çoğu kez terlediğiniz oldu mu?	☐	☐	☐
13. Göğsünüzde ya da kalbinizde basınç ya da gerginlik hissettiniz mi?	☐	☐	☐
14. Karnınızda ağrı ya da rahatsızlıktan muzdarip olduruz mu?	☐	☐	☐
15. Boğazınızda boğulma hissi oldu mu?	☐	☐	☐
16. Ellerinizde ya da ayaklarınızda iğnelenme ya da uyuşma hissi oldu mu?	☐	☐	☐
17. Bedeninizin her yerinde ağrı hissettiniz mi?	☐	☐	☐
18. Bedeninizde sıcaklık hissettiğiniz oldu mu?	☐	☐	☐
19. Çarpıntılarınızın (kalp çarpıntısı) farkına vardınız mı?	☐	☐	☐
20. Gözlerinizde ağrı ya da yanma hissettiniz mi?	☐	☐	☐
21. Hazımsızlık yaşadınız mı?	☐	☐	☐
22. Titreme ve sarsıntı hissettiniz mi?	☐	☐	☐
23. Daha sık idrara çıktığınız oldu mu?	☐	☐	☐
24. Belinizden sorununuz oldu mu?	☐	☐	☐
25. Karnınızda şişkinlik ya da kabarma hissi oldu mu?	☐	☐	☐
26. Başınızda ağırlık hissi oldu mu?	☐	☐	☐
27. Çalışmadığınız zamanlarda bile yorgunluk hissettiniz mi?	☐	☐	☐
28. Bacaklarınızda ağrı hissettiğiniz oldu mu?	☐	☐	☐
29. Midenizde rahatsızlık (bulantı) hissettiniz mi?	☐	☐	☐
30. Kafanızın içinde sanki patlayacakmışçasına bir basınç hissine kapıldınız mı?	☐	☐	☐
31. Dinlenirken bile solurum güçlüğünüz oldu mu?	☐	☐	☐
32. Bedeninizin her yerinde karıncalanma (iğnelenme) hissettiniz mi?	☐	☐	☐
33. Kabızlıktan rahatsız olduruz mu?	☐	☐	☐
34. Her zamankinden daha sık barsaklarınızı boşaltmak (tuvalete gitmek) istediğiniz oldu mu?	☐	☐	☐
35. Avuçlarınızda çok terleme oldu mu?	☐	☐	☐
36. Boğazınızda sanki bir yumru varmış gibi yutma güçlüğü yaşadınız mı?	☐	☐	☐
37. Baş dönmesi ya da sersemleme hissi oldu mu?	☐	☐	☐
38. Ağzınızda acı bir tat hissi oldu mu?	☐	☐	☐
39. Tüm bedeninizde ağırlık hissi oldu mu?	☐	☐	☐
40. İdrar yaparken yanma hissi oldu mu?	☐	☐	☐
41. Kulaklarınızda ya da kafanızın içinde bir uğultu işittiniz mi?	☐	☐	☐
42. Kalbinizde zayıflık ya da batma hissi oldu mu?	☐	☐	☐
43. Aşırı gaz ya da geğirme hissi oldu mu?	☐	☐	☐
44. Ellerinizde ya da ayaklarınızda soğukluk hissettiniz mi?	☐	☐	☐

Appendix F: Debriefing Form

KATILIM SONRASI BİLGİ FORMU

Bu araştırma daha önce de belirtildiği gibi Yeditepe Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Zühra Mercan tarafından Dr. Öğr. Üyesi Seray Akça danışmanlığında bitirme tezi projesi olarak yürütülmektedir.

Bu araştırmanın amacı katılımcıların yakın ilişkilerdeki yaşadıkları problemleri ve reddedilme kaygılarının somatizasyonu ne ölçüde yordadığını incelemektir.

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