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ASSOCIATION OF RELATIONSHIP OBSESSIVE-COMPULSIVE SYMPTOMS WITH DEPRESSION, ANXIETY AND STRESS: MARRIAGE AND CHILD RELATED FACTORS AS MODERATORS

MASTER THESIS

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To Institute of Social Sciences,

The study titled **"Association of Rclationship Obscssivc-Compulsivc Symptoms with Depression, Anxiety and Stress: Marriage and Child Related Factors as Moderators"**, which belongs to **Elif PARLAPAN BAŞ**, was certified as fully adequate in scope and quality, and as a **thesis for the degree of Master of Science** by the examining committee members.

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PREFACE

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ABSTRACT

ASSOCIATION OF RELATIONSHIP OBSESSIVE-COMPULSIVE SYMPTOMS WITH DEPRESSION, ANXIETY AND STRESS: MARRIAGE AND CHILD RELATED FACTORS AS MODERATORS

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This study was conducted to investigate the moderator role of child-focused obsessive-compulsive symptoms and variables related to marital life in relationship between partner-focused obsessive-compulsive symptoms with depression, anxiety, and stress. For this purpose, firstly, the psychometric properties of the Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC), which assesses the child-related obsessive-compulsive symptoms, were evaluated by adapting it to Turkish. Then, the relationships between the variables were evaluated by using separate hierarchical regression analyses. With this purpose, the data were collected from 268 individuals who were married and had a child living in Turkey. The results of the validity and reliability study showed that the Turkish version of PROCSI-PC had a four-factor structure, unlike the original form. In addition, the results revealed that PROCSI-PC had concurrent and predictive validity and has high internal consistency. In the second stage, moderation analyses showed that parent-child focused OC symptoms played a moderator role between partner-focused obsessive-compulsive symptoms and depression and stress. In addition to this, among the marriage-related factors, marital

satisfaction played a moderator role between partner-focused OC symptoms and anxiety and stress.

Key words: PROCSI-PC, Partner Focused ROCD, Parent-Child Focused ROCD, Depression, Anxiety, Stress, Marriage Related Factors

ÖZET

İLİŞKİSEL OBSESİF KOMPULSİF SEMPTOMLARIN DEPRESYON, ANKSİYETE VE STRESLE İLİŞKİSİ: MODERATÖR OLARAK EVLİLİK VE ÇOCUKLA İLGİLİ FAKTÖRLER

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Bu araştırma partner odaklı obsesif kompulsif semptomların depresyon, anksiyete ve stres ile olan ilişkisinde, çocuk odaklı obsesif kompulsif semptomların ve evlilik yaşamıyla ilgili değişkenlerin düzenleyici rolünü incelemek amacıyla gerçekleştirilmiştir. Bu amaç doğrultusunda, ilk olarak çocuk temalı obsesif-kompulsif semptom şiddetinin ölçülmesine olanak tanıyacak Çocuğa İlişkin Obsesif Kompulsif Belirti Ölçeği (ÇİOKBÖ) Türkçe'ye uyarlanarak psikometrik özellikleri incelenmiş, daha sonra ayrık hiyerarşik regresyon analizleri kullanılarak söz konusu değişkenler arasındaki ilişkiler değerlendirilmiştir. Bu amaçla evli, en az bir çocuk sahibi ve Türkiye'de yaşayan 268 yetişkin bireyden veri toplanmıştır. Yapılan geçerlilik ve güvenirlik çalışmasının sonuçları, PROCSI-PC'nin Türkçe versiyonunun faktör yapısının, orijinalinden farklı olarak dört faktörlü bir yapıya sahip olduğunu göstermiştir. Buna ek olarak sonuçlar, PROCSI-PC'nin eş zaman geçerliliği ve yordayıcı geçerliliğe sahip olduğunu ve yüksek iç tutarlılığının olduğunu göstermiştir. İkinci aşamada, araştırmanın asıl amacı olan düzenleyicilik analizleri yapılmış ve çocuk odaklı obsesif kompulsif semptomların partner odaklı obsesif kompulsif belirtiler ile depresyon ve stres arasında düzenleyici rol oynadığı sonucuna ulaşılmıştır. Buna ek

olarak evlilikle ilgili faktörlerden evlilik doyumunun da partner odaklı obsesif kompulsif belirtiler ile anksiyete ve stres arasında düzenleyici rol oynadığı görülmüştür.

Anahtar kelimeler: ÇİOKBÖ, Eş Odaklı İOKB, Ebeveyn-Çocuk odaklı İOKB, Depresyon, Anksiyete, Stres, Evlilikle İlgili Faktörler

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ABBREVIATION LIST

PROCSI **:** Partner Related Obsessive Compulsive Symptom Inventory

PROCSI-PC **:** Parent-Child Related Obsessive Compulsive Symptom Inventory

DASS **:** Depression Anxiety Stress Scale

DAS **:** Dyadic Adjustment Scale

MLS **:** Marital Life Scale

CHAPTER I

1. INTRODUCTION

Obsessive-Compulsive Disorder (OCD) is one of the frequently encountered disorders in clinical area which has been raising awareness in terms of the disturbances it creates in variety of settings from family dysfunction to the general standards of living of a client (Martis et al. 2004: 87). This being the case, understanding the complex and comprehensive structure of this disorder in multiple aspects comes into prominence.

The relationship of OCD with depression, anxiety and stress has been emphasized by researchers for many years. In the recent years, one of the topics researchers focused on OCD is the romantic relations. In this study, it was aimed to examine the moderator role of child-focused obsessive-compulsive symptoms (OC symptoms) and variables related to marital life, in the relationship of partner-focused OC symptoms with depression, anxiety and stress. In this section, firstly the literature findings related to OCD, then phenomenological findings of partner oriented and child oriented obsessive-compulsive symptoms will be mentioned. Then, the literature findings related to the phenomenological properties of OCD, type of obsessions and compulsions, cognitive behavioral models of OCD and relationship focused, partner focused and parent child focused OC symptoms will be presented. Then, OCD and marriage related factors, depression, anxiety, stress and their relation to OCD will be given. Finally, the aim of the research and the hypothesis of the study will be given.

1.1. Classification of Obsessive-Compulsive Disorder and Phenomenological Properties

Providing the definitions of the basic components of OCD such as obsessions and compulsions are a convenient point to start describing the disorder. Obsessions are simply defined as thoughts or images that are recurrent, intrusive disruptive and usually provoke distress and anxiety in the client (Soomro 2012: 1004). These thoughts or images are often found to be difficult to have a control over, as well as self-generated and senseless by most of the clients (Clark 2007; Soomro 2012). Compulsions, on the other hand, are the behaviors which are triggered by obsessive thoughts or images, and which have the motivation to prevent a certain kind of hazardous situations that are thought to be caused by the obsessions (Soomro 2012: 1004). Fulfillment of the compulsions generally reduces the anxiety derived from the obsessions so that the client has an irresistible urge to perform these ritualistic and stereotyped behaviors or mental acts (Clark 2007; Soomro 2012).

In obsessive-compulsive disorder both obsessions and compulsions can be seen together at the same time in a client, with the neutralizing function of the compulsions over the obsessions, however, there are cases in which only either of them is encountered (Butchler, Mineka and Hooley 2013). The symptomatic features of OCD in diagnostic criteria may help us contour our knowledge on this disorder in a more concrete way.

In the last version of Diagnostic Manual of Mental Disorders (DSM-V) (APA 2013), OCD appears under the category of “obsessive-compulsive and related disorders” which shows differences from DSM-IV in which the disorder was under the section of anxiety disorders. In the diagnostic criteria, the definitions of obsessions and compulsions are provided in the frame of the basic features which is mentioned above with a further emphasis on the compulsions being unrealistically linked with what they are intended to neutralize or prevent. Moreover, the necessary duration of the obsessions or compulsions are stated as one hour or more in a day without mentioning of the duration in a weekly or monthly basis, with stressing the malfunctioning in various life

contexts (APA, 2013). Furthermore, when giving an OCD diagnose, it is obliged to rule out possible substance or medication-related conditions that lead to obsessions and compulsions and also considering other disorders which may explain the symptoms in a client better than OCD. Additionally, specifications criteria about the level of insight are identified in DSM-V as "with good or fair insight", "with poor insight" and "with absent insight/delusional beliefs" in addition to the specification whether there is a "tic-related" condition in the client (APA 2013).

The changes between DSM-IV and DSM-V are seemed to be mostly occurred due to the debate on whether OCD is an anxiety disorder or not, thus the section of OCD in DSM-IV is changed from anxiety disorders to obsessive-compulsive and related disorders in DSM-V as it is mentioned previously (Thomsen 2013: 23). The other changes are generally in the frame of insight specifications such as excluding some criteria or differences in the word selections, with an extra caution for the children which identifies that the children cannot be expected to express the aims of their compulsions (APA 2013).

In ICD-10 criteria, OCD is under the section of "neurotic, stress related and somatoform disorders". In these criteria the duration of the obsessions or compulsions specified as at least 2 weeks and the most important exclusion criteria is about the condition that obsessions and compulsions should not be related to any schizophrenia-related and affective disorders (WHO 1993).

Looking at the diagnostic criteria, OCD is a disorder that possibly has some overlapping symptomatic features with other disorders. Therefore, to reach the most appropriate diagnosis in a client, it is crucial to differentiate OCD with other disorders having OCD-like symptoms but departs from it with some critical characteristics.

1.1.1. Type of Obsessions and Compulsions

OCD is a disorder characterized by recurrent obsessions and compulsions. Obsessions are defined as ego-dystonic thoughts, images, or impulses that

unintentionally appear in the mind, leading to serious problems or concerns in individuals (APA 2013; WHO 2015). Compulsions are repetitive and ritualistic voluntary behaviors to reduce the anxiety caused by obsessions or to prevent the occurrence of feared events (APA 2013). These obsessions and compulsions can be in a variety of forms.

Fear of contamination is one of the most common fears among the clients with OCD which is seen in between 55% and 58% of the cases (Abramowitz, McKay and Taylor 2008). It is characterized by avoiding situations, such as using public restrooms, which has the possibility to get microbes and viruses, and characterized by compulsions such as hand washing and cleaning (Leckman et al. 2010: 507).

Controlling compulsions, such as recurrently switching the electric lights, locking and unlocking the doors again and again to control whether they are actually turned off or locked without being sure of it in most of the time are the typical rituals which can generally be called as controlling compulsions (Abramowitz, McKay and Taylor 2008). Doubts and uncertainty usually underlie these types of rituals. Here, the clients' motivation is usually to prevent future dreadful, catastrophic events whereas there is no actual harm or hazardous signals in the environment (Abramowitz, McKay and Taylor 2008). In some cases, these ritualistic behaviors become so time consuming that most of the time the client ends up with a physical, emotional and economical breaking down. These compulsions are found to be related to some traits such as pathological suspicion, indecision, perfectionism and intolerance to uncertainty (Abramowitz, McKay and Taylor 2008).

Sorting, counting and organizing compulsions are related to symmetry obsessions and the feelings of doubt and insufficiency. Counting and repeating behaviors can show up in various ways such as images or objects, sounds, tactile or proprioceptive ways (Abramowitz, McKay and Taylor 2008). The clients usually try to organize their environment by arranging their items in a symmetrical way and their anxiety level increases in the case of disorganization and dissymmetry but this feeling

of anxiety turns into sense of insufficiency and the thought of “there are some things not going well on their way” (Abramowitz, McKay and Taylor 2008).

The other frequently encountered obsessions can be harming impulsions in which the individual has thoughts or images of harming a close one. Sexual obsessions can occur as thoughts or images of harassing someone sexually; and the obsessions against religious beliefs can occur like thoughts of swearing in a sacred place (Abramowitz, McKay and Taylor 2008).

1.1.2. Epidemiology

According to the DSM-V, in the United States, the 12-month prevalence of OCD is 1.2% which is not very different from the international prevalence that is in between 1.1% and 1.8% (APA, 2013). In addition, more than 90% of the OCD cases were found to have both obsessions and compulsions together and the onset of OCD usually occurs about late adolescence and early adulthood (Butchler, Mineka and Hooley 2013). Moreover, while females are seemed to be more affected from OCD in adulthood, conversely, males are more commonly affected from the disorder in their childhood (APA 2013).

According to the DSM-5 statistics, 76% of the cases with OCD have also other anxiety disorders such as panic disorder, social anxiety disorder, specific phobia and generalized anxiety disorder. On the other hand, the comorbidity between affective disorders and OCD seems also high, which is 63% for any depressive or bipolar disorder, and 41% for only depressive disorders (APA 2013). There is an essential point to mention about the comorbidity of depressive disorders and anxiety disorders with OCD that is while OCD mostly follows anxiety disorders, depressive disorders may occur after OCD (APA 2013). Furthermore, it was found that while between 23% and 32% of the OCD cases can have obsessive-compulsive personality disorder, 30% of them have a tic disorder in lifetime period which is most common in males with the onset in childhood (Thomsen 2013: 23). In children, tic disorder, attention deficit/hyperactivity disorder and OCD is frequently seen together. Additionally, there

is also comorbidity between OCD and other related disorders like body dysmorphic disorder, hair-pulling disorder, skin-picking disorder and the oppositional defiant disorder because of the component of impulsivity in this disorder. Lastly, it was found that the 12% of OCD cases can also be diagnosed with schizophrenia and schizoaffective disorder (APA 2013).

Identification of possible causes and risk factors of OCD also has a crucial role to understand more about the prognosis, prevention and treatment of the disorder. In the next section of this paper, the risk factors are examined in a biopsychosocial-cultural perspective with some cognitive vulnerability specific to OCD.

1.1.3. Etiology

1.1.3.1. Biological Factors

In most of the studies which were conducted with twins and families, the results demonstrated the importance of the genetic factors in OCD. In a twin study, it was found that, OCD was more frequent in identical twins compared to fraternal twins (Hanna 1999: 74, Van Grootheest et al. 2007: 1635); and in a family study, among first degree relatives, OCD was 3 to 12 times more frequent than normal prevalence (Grabe et al. 2006: 1986). In addition, the findings showed that in early onset of OCD genetics had more effect on the occurrence of the disorder than in later onset of OCD (Grisham et al. 2008: 107).

The studies investigating the role of brain functions in OCD led to the similar results. Studies with brain imaging methods demonstrated that the individuals with OCD generally had some abnormalities in subcortical structures such as basal ganglia, and excessive activation in orbitofrontal cortex and cingulate frontal cortex which are parts of the limbic system. As a matter of fact, these structures of brain are mostly responsible from some primitive behaviors such as sexuality, aggression and cleaning (Butchler, Mineka and Hooley 2013).

The abnormalities in the serotonergic system were identified to be related to OCD which refer mostly to the decreased level of serotonin or because of some brain structures that are highly sensitive to serotonin (Butchler, Mineka and Hooley, 2013). Besides serotonergic system, dysregulation of glutamate and disturbances in dopaminergic system were also found to have a role on OCD (Pittenger, Bloch, and Williams 2011: 314; Butchler, Mineka and Hooley 2013).

1.1.3.2. Psychosocial Factors

Early life experiences, attachment and parenting styles, stressful life events, familial and personality factors seem to have a precipitating impact on the onset of OCD according to the recent studies.

In a study conducted with OCD patients (Benedetti et al.,2014: 298), it was found that adults' negative experiences in their childhood such as being exposed to both physical and emotional abuse, and neglect, were associated with treatment seeking behaviors or early applications to the consultant.

In another study conducted by Doron and his colleagues (2012), insecure attachment in adulthood was found higher among people with OCD, even depression was controlled. Rezvan et. al. (2012) found that insecure attachment style in childhood and poor communication between parents and children contributed to the childhood onset of OCD. Related with parenting styles, Timpano and her colleagues (2010) supported the protective factor of positive and warm relationships between parents and child by suggesting that authoritarian parenting style was significantly related with OCD symptoms in the adulthood. In another study, perceived maternal overprotectiveness in childhood was found to be significantly related with obsessive compulsive symptoms in adulthood (Haciomeroglu and Karanci 2014: 641). In addition, Clark and Beck (2010) drew attention to the stressful life events as possible triggers on the onset of the OCD, specifying the important changes in life course such as pregnancy, childbirth or traumatic events; however they also mentioned that many cases did not report any particular triggering event.

A study conducted by Murphy and Flessner (2015) supported the point about the impact of family environment on OCD suggesting a powerful relationship between childhood onset OCD and negative family functioning such as depression and anxiety symptoms seen in parents, feelings of guilt in parents and family accommodation.

A study investigated the associations between 5-factor personality traits and OCD symptoms, found that conscientiousness revealed the most significant relationship with OCD (Inchausti et al. 2015: 254).

1.1.3.3. Cognitive Factors

As in the famous example, requesting of “not thinking about the white bear” generally ends up thinking of it more, suppressing the obsessive thoughts also makes them stronger and increases their frequency of thoughts in individuals with OCD, since they generally find their obsessions unacceptable and try to suppress them consequently (Butchler, Mineka and Hooley 2013).

Another cognitive related phenomenon in OCD is evaluating one’s responsibility in his or her obsessive thoughts in an exaggerated way as if assuming that even the thought of engaging in an action is morally equals to actually doing it or thought of committing a negative action increases the possibility of committing it actually (Butchler, Mineka and Hooley 2013). This phenomenon also called as “thought-action fusion” that triggers compulsive behaviors which are carried on preventing “harmful” events (Butchler, Mineka and Hooley 2013).

A group of researchers called the Obsessive Compulsive Cognitions Working Group (OCCWG 1997) identified six major belief domains which have etiological importance for the development and maintenance of OCD: inflated responsibility, overimportance of thoughts, overestimation of threat, importance of controlling thoughts, intolerance of uncertainty and perfectionism. Inflated responsibility was defined as the belief that the individual has specific powers to prevent or elicit subjectively crucial negative consequences. Overimportance of thoughts was defined as

the belief that mere presence of a thought is important. Overestimation of threat was defined as an exaggeration of the probability and severity of harm. Importance of controlling thoughts was defined as over-evaluation and application of full control over intrusive thoughts, images and impulses. Intolerance of uncertainty was defined as beliefs about inability to cope with unpredictable changes, the necessity of certainty, and the difficulty in functioning in ambiguous situations. And finally, perfectionism was defined as the belief that everything must be perfect, that there is always a perfect solution to every problem, and that even small mistakes will have serious consequences (Clark 2004: 112).

1.1.3.4. Cultural Factors

OCD symptoms show some differences across different cultures. For instance, contamination and dirt obsessions seem to be more frequent in the sample which comprise of Indian individuals than the obsessions about sex, religion and religious obsessions might be more common in cultures that impose strict religious rules (Clark 2007). There are also studies examining the effects of religion on obsessions and compulsions in different cultures. A research with highly religious Muslim and Christian students living in Turkey and Canada showed that Muslim students had fear of God's punishment and exhibit more compulsive symptoms. Highly religious Christian and Muslim students reported more obsessionality, guilt and maladaptive beliefs about responsibility and control of intrusive thoughts compared to low religious students (Inozu, Clark and Karanci 2012: 190; Inozu, Karanci et al. 2012: 959). In another study conducted in Canada and Turkey samples, both groups showed different responses to OC symptoms. While Turkish participants were more likely to use worry and thought suppression, Canadian participants tended to use self-punishment more often (Yorulmaz, Gencoz and Woody 2010: 110). According to another study conducted by Yorulmaz and Işık (2011) with Turkish and Western samples, it was found that thought-action fusion in the field of morality was more related with OCD symptoms in Turkish participants than Western participants.

1.1.4. Cognitive-Behavioral Models of OCD

1.1.4.1. Behavioral Learning Theory

Behavioral learning theory is simply based on classical and operant conditioning principles based on theory of Two Process Theory of Avoidance Learning (Mowrer 1947). Related with how obsessions and compulsions nourish each other, this theory claims that individuals connect neutral stimuli from outside with their early fearful thoughts or experiences, therefore being exposed to that neutral stimuli leads to anxiety in the individual as time progresses (Butchler, Mineka and Hooley 2013). Since the compulsions reduce the anxiety, they function as negative reinforces. For instance, when the individual somehow associates hand shaking behavior (a neutral stimulus at first) with contamination (thinking to get germs from someone's hand), inevitably he or she engages in the hand washing behavior which reduces fear or anxiety of being contaminated. The reduction of the anxiety reinforces the hand-washing behavior as a result and this reinforcement increases the possibility of recurrence of this behavior in the future as well, which is a very resistant cycle to be modified, or weakened (Butchler, Mineka and Hooley 2013).

1.1.4.2. Cognitive Models of OCD

The cognitive model which was proposed by Beck (1976) emphasized that responses to the stimuluses are caused by negative automatic thoughts (NAT). Emotional responses are determined by the content of negative automatic thoughts. For example, thoughts of loss are associated with depression and thoughts of danger are associated with anxiety. Salkovskis and Warwick (1985) suggested that the cognitive component of obsessions was more comprehensive than intrusive thoughts. They considered the question of how the negative automatic thoughts associated with obsessions differs from those associated with depression and anxiety. They suggested that thoughts about being responsible for possible harms for themselves or others could explain the characteristics of obsessive disorders (Salkovskis 1985). According to Salkovskis's model, individuals exhibit neutralization behavior to protect

themselves/others from harm, and this behavior is accompanied by a sense of relief because it leads to a reduction in perceived responsibility. All these factors strengthen negative automatic thoughts and increase the likelihood of exhibiting neutralization. Neutralizing also decreases anxiety / discomfort but maintains obsessive thoughts and beliefs in being responsible for harm (Salkovskis and Warwick 1988).

Rachman (1997) proposed that normal unwanted intrusive thoughts become obsessions when misinterpreted as a personally important and threatening phenomenon. Rachman's cognitive theory begins with the premise that unwanted intrusive thoughts, images, or impulses are universally experienced, as in Salkovskis's inflated responsibility model. But Rachman argues that a number of key cognitive concepts and processes play a role in elevating "normal" unwanted intrusive thoughts to highly persistent clinical obsessions (Rachman, 2003). In addition, which intrusive thought will become obsessed depends on whether it is "important in the patient's system of values". Rachman presented misinterpretations of significance of thoughts in five dimensions.
These are Importance (*"The cognitive intrusion is viewed as meaningful, not trivial, because it reveals something about the person."*), Personalized (*"The significance of the intrusive thought is personal in that it is "my own thought of particular importance to me.""*), Ego-alien (*"The content or theme of the intrusion is "unlike me, uncharacteristic of me.""*), Potential consequences (*"The cognitive intrusion is viewed as having potential consequences, no matter how unlikely."*) and Serious consequences (*"The perceived consequences associated with the intrusion are considered serious, usually involving some intolerable degree of threat, harm, or danger."*) (Clark 2004: 101).

1.1.4.3. Metacognitive Model of OCD

Metacognition is a phenomenon which refers to the complex structures of cognitions that organize and evaluate other simpler cognitions, in another words, metacognitive beliefs of an individual are simply about what does the person think about his/her own thoughts (Wells 1995: 301). In the perspective of OCD, metacognitive model suggests that the metacognitive thoughts have a more crucial role

than the thoughts themselves (Wells and Papageorgiou 1998: 899). According to Myers, Fisher and Wells (2009) there are three types of metacognitive thoughts which are "thought-action fusion", "metacognitive beliefs on performing the rituals" and "metacognitive beliefs on the signal to terminate these ritualistic behaviors", and they also claim that studying on these metacognitive beliefs in the first place will also have a significant benefit to the therapy process.

Three types of fusion have been proposed in this model. The first one is Thought-Action Fusion (TAF) which is the belief that a thought alone can cause a person to act, or that thought can be equivalent to action. The second one is Thought-Event Fusion (TEF), the belief that having a thought means it can cause an event or actualize an event. The third one is Thought-Object Fusion (TOF) which is the belief that thoughts or emotions can be transferred to objects (Myers, Fisher and Wells 2009).

Another suggestion of the model is metacognitive beliefs on performing the rituals. These beliefs have two components: "(1) declarative beliefs about the need to carry out rituals (e.g., "I need to perform my rituals otherwise I will never have peace of mind", (2) a plan or program for monitoring and controlling action. Part of this plan is a target which is indicated by a stop signal or stop criterion. (Myers, Fisher and Wells 2009).

The next step proposed by the model is "metacognitive beliefs on the signal to terminate these ritualistic behaviors". According to the model, individuals with OC symptoms need certain criteria and idiosyncratic rules to cessation of their rituals. For example, a person with an obsession with microbes can wash their hands repeatedly. However, as microbes cannot be seen, this person can use a certain number of hand washes and a feeling of rightness as a signal. (Myers, Fisher and Wells 2009).

Up to this point, general information about OCD, diagnostic critters, epidemiological and etiological factors and cognitive behavioral models have been explained. Next, a new type of OCD, Relationship Obsessive Compulsive Disorder

(ROCD), which was introduced by a group of researchers (Doron et al. 2012) will be explained.

1.2. Relationship Obsessive Compulsive Disorder

In the literature, a lot of studies have been carried out in order to examine the effects of romantic relationships on the psychological well-being of individuals or the effects of psychopathology on close relationships, However, OC symptoms related to partner or relationship have not attracted the attention of researchers until recently. Doron et al. (2012a; 2012b), based on their clinical observations and experiences, have proposed two different structures that are relationally centered as new symptom types of OCD: relationship centered OCD symptoms (ROCD type I; Doron, Derby and Szepsenwol 2012a) and partner focused OCD symptoms (type II; Doron, Derby, Szepsenwol and Talmor 2012b).

1.2.1. Relationship Focused (Type I) OCD Symptoms

In relationship centered OCD symptoms, individual's anxiety, doubts and the compensatory behaviors are characterized at three domains: individual's feelings towards partner in relationship, the partner's feelings towards oneself, and the 'rightness' of the experience of relationship (Doron et al., 2012a: 16). It was stated that the mind of the individuals who have this type of obsessions are busy with the thoughts, such as whether they love their partner enough, whether their partners love them enough and whether the current relationship is the right relationship for them. These considerations may be accompanied by compulsions such as checking, comparing, reassurance seeking and neutralizing (Doron et al. 2012a: 16).

Doron and colleagues (2012a) have hypothesized that relationship focused OCD symptoms' primary focus is the relationship itself, and that OCD symptoms effect the relationship in a very direct way. Even though in close relationships the couples' ambivalent and conflicting attitudes are perceived as normal (Clark 2004), relationship

focused OCD symptoms, are hypothesized to be significantly apart from normal relationship doubts and anxiety through being ego-dystonic, intrusive and causing impairments at functionality. Also, when compared to a normal relationship anxiety, relationship focused intrusive thoughts are less desirable and more unacceptable impulses. These impulses are generally against the relationship (e.g. “I know he loves me but I should control it”) and for that reason it seems to be more incongruent with self, compared to normal relationship anxiety. As in other forms of OCD, these intrusive impulses cause irrational reactions in individual's thought flow and actions and immediately after, results in extreme anxiety and recurrent neutralization (compensation) behaviors (i.e. search for control and safety) that cause extreme disruptions at individual's daily life and relationship quality.

Doron and colleagues (2012a), have developed an instrument, the Relationship Obsessive-Compulsive Inventory (ROCI), to measure their hypothesis related to relationship focused OCD symptoms. This instrument measures the level of obsessive-compulsive behaviors on 3 relationship domain: a) individual's feelings towards partner (“I constantly evaluate whether I love my partner”), b) partner's feelings towards oneself (“I constantly doubt my partner's love towards me”) and c) the integrity of the relationship (“I constantly evaluate whether my relationship feels right”). The instrument is translated and adapted into Turkish by Trak and Inözü (2017).

1.2.2. Partner Focused (Type II) OCD Symptoms

In partner focused OCD symptoms, individual's occupation is about perceived flaws in their partner. Individuals have obsessive thoughts about their partner's morality, sociability, emotional stability, competency, appearance or intelligence. It was also stated that these obsessive thoughts may be accompanied by compulsions such as checking, comparison, reassurance seeking and neutralizing (Doron et al. 2012a: 16). For example, some people significantly focus on the perceived flaws on their partners to the point which can be time consuming and significant source of stress. According to Doron and colleagues (2012b) partner focused obsessive compulsive symptoms can be about physical traits (e.g. he/she has a very big nose), social skills (e.g. he/she is not

sociable enough, he/she, does not have what it takes to be successful) or personality traits like morality, intelligence and emotional stability (e.g. he/she is not smart enough).

Doron and colleagues (2012b) have developed another instrument, the Partner Related Obsessive Compulsive Symptom Inventory (PROCSI), to measure this construct and its effects on close relationships and emotional state. The inventory, measures obsessions and compulsions about individual's perceived flaws on their partners on six aspects; physical traits, sociability, morality, emotional stability, intelligence and competence. Translation and adaptation to Turkish of the inventory is conducted by Trak and Inözü (2017).

Even though the relationship and partner focused obsessions are often in the form of thoughts and images, they may also occur in the form of urges (Doron et al. 2014), and the intrusive thoughts are often expressed as ego-dystonic (Doron et al. 2014). These thoughts are generally against individual's subjective experiences (e.g., "I love her, but I can't stop questioning my feelings") or personal values (e.g., "appearance should not be important in selecting a relationship partner"). Such intrusive thoughts are often perceived as disturbing and unacceptable and may lead to feelings of shame and guilt.

The age of onset of ROCD is not known exactly, but based on their clinical experience researchers suggested that it may begin in early adulthood (Doron et al. 2014). ROCD symptoms may occur when the individuals are in a romantic relationship, as well as when they end the relationship. Individuals may think that their previous partner is the only right person for them, and they have lost him/her. Such obsessions may be accompanied by compulsions such as continuous comparison of old and new partners. In addition, ROCD symptoms may also occur in commitment-related romantic decision situations (e.g., getting married, having children).

Recent studies which focus on the factors that can be associated with Relationship Obsessive Compulsive Disorder, suggested that ROCD can be related to

attachment representations, parenting and family environment, relational and sexual satisfaction, social anxiety, personality and societal factors (Doron et al., 2014). Research on ROCD shows that both relationship-centered OC symptoms and partner-focused OC symptoms are associated with low relationship satisfaction when controlled of OCD, mood symptoms, low self-esteem, and attachment anxiety (Doron et al, 2012a: 16; 2012b: 234). A study, conducted with 538 adults, investigated the association between relationship-centered OC symptoms and anxious attachment style and partner-contingent self-worth, and it was concluded that anxious attachment style has a mediator role in the relationship between high parental overprotection and the relationship-centered OC symptoms. Besides, partner-contingent self-worth has a moderator role in the relationship between attachment anxiety and relationship-centered OC symptoms (Trak and Inozu 2019: 121).

Another study showed that sexual satisfaction decreased with increasing ROCD symptoms (Doron, Mizrahi, Szepsenwol and Derby 2014: 2218). In a study that investigated the relationship between ROCD and depression, anxiety and stress, both the relationship-centered OC symptoms and the partner-focused OC symptoms were found to be moderately correlated with depression, anxiety and stress symptoms (Doron et al. 2012a; 2012b). In addition, the relationship between ROCD and OCD in both clinical and nonclinical samples was found to be a moderately correlated. These findings indicate that ROCD might be a sub-dimension of OCD (Doron, Derby, Szepsenwol, Nahaloni and Molding 2016; Doron et al. 2012a, 2012b).

In addition to relationship and partner focused OC symptoms, Doron and colleagues (2014) have recently presented a new construct: Parent-Child ROCD. It is an additional presentation of ROCD where symptoms focus on children.

1.2.3. Parent-Child Focused OCD Symptoms

Recently, Doron and colleagues (2014) have suggested that the principles that manage ROCD symptoms' form and its effects on romantic relationships can be generalized to the relationship between parent and child. According to the researchers

(Doron, Derby and Szepsenwol 2017), parents can have obsessive anxieties about their children's flaws similar to the perceived flaws in their partners, therefore, they suggested that there could be another form of obsessive compulsive symptoms named parent-child related obsessive compulsive symptoms.

Parent-child related OC symptoms include parents' obsessive preoccupation related to perceived flaws on their children and the compulsive behaviors that ease the distress caused by this preoccupation (Doron, Derby and Szepsenwol 2017). Parents can experience unwanted thoughts (e.g. Is my child smart enough?) or memories (a specific memory of an instance that the child is unsuccessful) relevant to perceived flaws of their children that contradict their values (e.g. All children must be accepted no matter what their flaws are), or personal experiences (e.g. I know my child is successful at school but I can't stop questioning his/her intelligence). By this way, these kind of unwanted thoughts cause parents to feel guilt and shame.

Parent-child focused relationship OC symptoms can include certain compulsions, such as comparing the child constantly with other children including siblings, controlling the child's behavior and assurance seeking about child's abilities and perceived flaws (Doron, Derby and Szepsenwol 2017).

Recently, Doron and colleagues (2017) has developed an inventory called Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC) to measure parent-child focused ROCD symptoms. This inventory includes certain areas where parents focus about their children's perceived flaws; intellectual flaws (e.g.: The idea that my child is not smart enough bothers me), appearance flaws (e.g. My thoughts about the flaws on my child's physical appearance bothers me), personality flaws (e.g. My constant doubts about my child's morality bother me), psychological flaws (e.g. I constantly keep checking if my child is behaving odd), flaws on social functionality (e.g. The thoughts about my child's poor functioning on social situations bother me) and poor competence (e.g. I keep searching for proofs regarding my child's potential vocational success). The Turkish translation and adaptation of the scale was conducted within the scope of this study.

1.3. OCD and Marriage Related Factors

It has been argued that OCD is a disorder that effects the people close to patients as much as it effects the patients themselves. A study conducted by Mataix-Cols and his colleagues (2013), suggested the importance of environmental factors, such as family environment, on OCD. They suggested that there is a high risk of OCD also for relatives with no biological connections such as spouses. OCD patients report problems on relational dimensions such as lower marriage rates, and increased marital stress, adjustment and communication problems compared to general population (Abramowitz et al., 2013; Belus et al. 2014; Emmelkamp, de Haan, and Hoogduin 1990; Riggs, Hiss, and Foa 1992). In a study conducted by Rigs and colleagues (1992), it was shown that almost half of spouses have high marital stress and after a three weeks behavioral therapy, 42% of participants with marital stress have significantly reduced levels of marital stress. Besides, it was predicted that disappointments due to partner's ritualistic behaviour (i.e. repeated control or hand washing) and the persistence to attend OCD rituals might increase the conflict in relationships (Koran 2000: 509).

In the literature, factors such as marital satisfaction, burnout, and perceived spousal support were emphasized related to the relationship between individuals with OCD and people close to them. In a study comparing burnout level and life satisfaction, in 40 individuals with OCD and 47 individuals close to them, and 40 healthy individuals and 45 individuals close to them, results showed that the families of individuals with OCD experienced more burnout and had lower life quality compared to families of healthy individuals (Çiçek et al. 2013: 253).

OCD has cognitive, behavioral and emotional components which also effect married individuals' relationship satisfaction. In a study with 33 couples including people with OCD diagnosis, there was a significant relationship between daily anxiety levels of women with OCD and couples perceived relationship quality. Also it was found that anxiety related support had a moderator effect, indicating that individuals with OCD who had spouses supporting them with their anxiety were more content with their relationship (Zaider, Heimberg and Lida 2010: 163).

In another study (Remmerswaal et al. 2016: 56) conducted with 353 adult OCD patients, the quality of life and the relationship satisfaction were examined. According to the results, it was found that the quality of life of the OCD patients was low and the relationship satisfactions were moderate. In addition, perceived criticism, impulsivity, irritation and the lack of emotional support were associated with decreased relationship satisfaction.

Families of OCD patients and their relatives sometimes participate in obsessive compulsive symptoms and organize their personal and family routines according to OCD individuals (i.e. taking off dirty work clothes, keeping knives locked, checking devices and locks for patients, doing extra house works, etc.) (Calvocoressi et al. 1995: 441). This scenario is called as family accommodation. In a study which evaluated the effects of family accommodation on symptoms of family stress, functioning, and family reaction to the patient, it was found that the families of 30 (88.2%) individuals showed family accommodation behaviors and family accommodation was associated with poor family functioning, a refusal attitude towards the patient and family stress in various forms (Calvocoressi et al. 1995: 441). This study also suggested that families could show the accommodation behaviors to reduce the anxiety and anger which was directed to them by the patients.

In another study, it was found that the spouses of individuals with OCD reported negative relationship between self-reported accommodation behaviors (e.g., controlling sockets and locking for spouses) which were conducted to prevent and soothe partners' anxieties and relationship satisfaction (Boeding et al. 2013: 316).

In the study by Amir and colleagues (2000), the relationship between the response of family members to the illness of OCD patients, OCD symptoms, depression and anxiety levels of patients were examined. According to the results, family stress and accommodation or rejection were found to be related with depression and anxiety symptoms of the family members (Amir, Freshman and Foa 2000: 209).

There has been a very limited study that examined the symptoms of ROCD and relational factors. Mizrahi and colleagues (2014) found that ROCD symptoms were found to be associated with decreased sexual satisfaction besides increased depression, general anxiety, OCD and attachment anxiety. In addition, it was showed that the relationship between the symptoms of ROCD and low sexual satisfaction was mediated by relationship satisfaction. In another study, it was found that relationship-centered obsessive-compulsive symptoms were associated with relationship dissatisfaction even though comorbid OCD symptoms, mood symptoms, low self-esteem, attachment anxiety, and relational instability were controlled (Doron et al. 2012a: 16). Moreover, in another study, partner-focused obsessive-compulsive symptoms were found to be associated with relationship satisfaction when controlled for all variables mentioned above and relationship-centered obsessive-compulsive symptoms. Furthermore, both relational and partner-focused obsessive-compulsive symptoms were found to be related with decreased relationship satisfaction (Doron et al. 2012b: 134).

1.4. Depression, Anxiety, Stress and Their Relation to OCD and Marriage Related Factors

Depression, anxiety and stress are important indicators of general mental health of people. Large number of researchers has investigated many variables which possibly related to depression, anxiety and stress. In this section, literature review related to the associations between OCD and marriage related factors with depression, anxiety and stress will be examined.

1.4.1. Depression

Major depressive disorder is a serious mood disorder which is one of the most widespread mental disorders. It is often experienced with symptoms of a depressive feeling, loss of interest in activities once enjoyed, feeling guilty or worthless, and sleep and appetite problems (APA 2013). According to the Global Burden of Disease study published in 2013, depression is one of the most common mental health problems in the

world and results in loss of functioning in daily life (Vos, et al. 2013: 746). It also contributes to the increase in mortality and disability rates along with the risk of suicide and heart attack, therefore has an impact on quality of life both directly and indirectly (Ferrari et al. 2013: 5).

According to DSM-V, depressive disorders are grouped under seven headings: (i) disruptive mood dysregulation disorder, (ii) major depressive disorder, (iii) persistent depressive disorder/dysthymia, (iv) premenstrual dysphoric disorder, (v) substance/medication-induced depressive disorder, depressive disorder due to another medical condition, (vi) other specified depressive disorder, and (vii) unspecified depressive disorder (APA 2013).

According to the National Comorbidity Survey, the lifetime prevalence of major depressive disorder, as the most common mental disorder, was 16.6% in adults (Kessler et al. 2005: 595). In another systematic review, it was determined that the prevalence of depression in adults varied between 4.6% and 9.3%, and depressive disorders were distributed in an average of 17.1% (Luppa et al. 2012: 215).

According to DSM-IV classification, the comorbidity of major depressive disorder with any Axis I disorder is 60%, and posttraumatic stress disorder, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder and social phobia are the disorders which commonly comorbid with depression (Brown et al. 2011: 588).

1.4.1.1. Depression, OCD and Marriage Related Factors

Many studies from past to present have revealed the relationship between depression and Obsessive-Compulsive Disorder (Brown et al. 2001; Ruscio et al. 2010: 57). According to the study of Ruscio and colleagues (2010: 57) the highest comorbidity with Obsessive Compulsive Disorder, following anxiety disorders, is Mood Disorders with a rate of 63.3%. Among the sub-dimensions of Mood Disorders, it is concluded that Major Depressive Disorder has the highest comorbidity with OCD with 40.7%.

Torres and colleagues (2016) recently examined the relationship between symptom dimensions of OCD and comorbid psychiatric disorders with 1001 OCD patients. When the relationships between OCD symptom subtypes and Major Depressive Disorder were examined, and it was found that the sub-dimensions of harm-aggression, sexual-religious, symmetry-ordering and hoarding except contamination-cleaning were related to major depression.

The high rate of comorbidity of depression and OCD led researchers to understand the reasons of this comorbidity. In a study conducted with 382 OCD patients in the Netherlands, the effect of cognitive and interpersonal mediators on the relationship between depression and OCD was investigated. The results of the study showed that the OCD level predicted the depression in the 2-year follow-up period but there was no significant relationship in the 4-year period. Moreover, no significant finding was found in the opposite direction. In addition, only secure attachment style has a moderator effect on the relationship between OCD and depression (Tibi et al. 2017: 76).

Generally, the presence of comorbid depression has been shown to cause a negative effect on the treatment of OCD patients (Abramowitz, Franklin, Street, Kozak and Foa 2000: 517). Similarly, significant decreases in depression levels of patients during the treatment process are associated with decreased severity of OCD symptoms (Leonard, Jacobi, Riemann, Lake and Luhn 2014: 95).

Depressive symptoms or depression are frequently examined issues in researches that focus on the factors that effect the relationship of couples. Researches in both Western and Asian cultures suggested that factors such as marital satisfaction or adjustment are negatively associated with depression levels of couples. In a meta-analysis, (Whisman 2001: 3), based on the data of the 26 studies, it was found that dissatisfaction in the marriage accounted for 18% of depression in women (N = 3700) and 14% in men (N = 2700).

The results of a study with 203 Chinese couple (Cao, Zhou, Fang and Fine 2017: 775), in which marital satisfaction, instability, closeness and commitment factors were investigated, indicated that both wives' and husbands' perceived marital satisfaction and marital commitment levels were associated negatively with their own depression levels. Also, both wives' and husbands' marital instability levels were associated positively with their depression levels. In a review conducted by Rehman, Gollan and Mortimer (2008: 181) which compared the interactions of depressed couples and non-depressed couples, it was found that the interactions between the depressive couples were associated with negative communication behaviors such as verbal aggression, withdrawal and blaming.

1.4.2. Anxiety

Although anxiety is a natural and adaptive reaction to the stress, it is accepted as a symptom of a mental disorder if this natural reaction becomes persistent, severe and longer than six months. Anxiety disorders are classified in DSM-V as Separation Anxiety Disorder, Specific Phobia, Social Anxiety Disorder (Social Phobia) Panic Disorder, Panic Attack (Specifier), Agoraphobia, Generalized Anxiety Disorder, Selective Mutism etc. (APA 2013).

According to the results of National Comorbidity Survey study, lifetime prevalence of any anxiety disorder (classified by DSM-IV) was indicated as 28.8% (Kessler et al. 2005: 595). In the same study the most common anxiety disorders were listed as specific phobia (12.5%), social phobia (12.1%), posttraumatic stress disorders (6.8%), generalized anxiety disorder (5.7%), separation anxiety disorder (5.2%), and obsessive-compulsive disorder (1.6%) which is now a distinct class of disorder. Additionally, anxiety disorders were found to be more common in younger women than other age groups (Stansfeld et al. 2016).

1.4.2.1. Anxiety, OCD and Marriage Related Factors

Obsessive Compulsive Disorder was categorized as one of anxiety disorders in the previous versions of DSM. However, in the latest version (DSM-V) it found its place inside Obsessive-Compulsive and Related Disorders which is a new separate diagnostic category together with some other disorders such as Body Dysmorphic Disorder and Hoarding Disorder (APA 2013: 235).

OCD shows comorbidity with many psychopathologies (Ruscio et al. 2010: 57), and one of the most common of them is anxiety disorders with a rate of 75.8%. Considering comorbidity of the anxiety disorders with OCD, 43.5% of them is social phobia, 42.7% is specific phobia, 37.1% is separation anxiety disorder, 20% is panic disorder, 19.1% is posttraumatic stress disorder, and 8.3%isgeneralized anxiety disorder and 7.8% is agoraphobia without panic disorder (Ruscio et al. 2010: 57). Although there is a high comorbidity between OCD and anxiety disorders and anxiety is the major component of OCD, it has been accepted as a different diagnosis in terms of neurological mechanisms, compulsivity and other phenomenological and epidemiological indicators (e.g. childhood onset, chronic course etc.) (Krzanowska and Kuleta 2017: 8).

Studies showed that marital life has a significant role on the mental health problems of individuals. In a cross-sectional study (Scott et al. 2010: 1495) with 34493 people from 15 different countries, it was observed that the risk of having a mental disorder was higher in both men and women who had never been married compared to married individuals.

Considering the relationship between marital satisfaction and anxiety disorders, it was suggested that marital satisfaction levels of partners may have a triggering role in the beginning and maintenance of anxiety disorders (Kasalova et al. 2017: 555) or it can be interpreted that the level of dissatisfaction experienced by spouses might be the result of anxiety disorder. In a study conducted with 774 married couples, the relationship between the psychopathology of individuals and their spouses with marital satisfaction

was evaluated. The findings showed that marital satisfaction was predicted by the level of anxiety and depression of the individual (i.e., actor effects) and the depression level of the spouse (i.e., partner effects) (Whisman, Uebelacker and Weinstock 2004: 830). Also, a study examined the empirical and theoretical publications from 1970 to 2009 on the relationship between marriage and sexual functioning, depression and anxiety, showed that marital treatment not only improves sexual and marital functioning but also can reduce psychological symptoms (Trudel and Goldfarb 2010: 137). Another study conducted to examine the relationship between marital adjustment and anxiety with 45 married couples indicated that husbands' anxiety can predict the marital adjustment of themselves and their wives. But, wives' anxiety did not predict their own and their husband's marital adjustments (Dehle and Weiss 2002: 328).

1.4.3. Stress

Stress means a pressure and distracting environmental factor or emotional response for normal people (Ogden 2016: 290). In a study which is known the largest study (*N*=4,619) in UK (Mental Health Foundation's 2018 study), 74% of the participants reported that they felt so stressed and overwhelmed or unable to cope with stress. In a17 years longitudinal study with 968 men and women with the mean age 56, it was found that being exposed to stressful life events was positively associated with the 17- years mortality rate even if controlled for potential risk factors (Philips et al. 2008: 647).

Both cross-sectional and longitudinal studies indicated that stressful life events may increase the possibilities of illness. Although it is not completely clear that stress effects cardiovascular disease, vulnerability and resilience factors has a moderate role in this effect (Dimsdale 2008: 1237). Ogden (2016: 290) summarized the possible factors that play critical roles in the relationship between stress and illness. Such as behavioral changes (such as smoking, alcohol use, eating and exercise behaviors, accidents etc.), physiological changes (sympathetic and HHA activity), psychoneuroimmunology (Ogden 2016: 290) and the role of chronic and acute psychological process (Johnston and Johnston 2002: 55) are the possible factors. Studies also indicated that chronic

stress is more powerfully associated with depressive symptoms than acute stress (McGonagle and Kessler 1990: 685).

1.4.3.1. Stress, OCD and Marriage Related Factors

It is strongly suggested by different researchers that environmental stressors are important risk factors for the onset of OCD. For example, children with OCD reported more life events as well as more negative life events compared to non-OCD children (Gothelf et al. 2004: 192). In a study conducted with adult OCD patients (*N*= 449), it was stated that the history of familial psychiatric diagnosis was associated with the chronicity of OCD and stressful life events was one of the factors that moderate this relationship (Goldberg et al. 20015: 129).

Brain imaging studies also indicated that OCD patients who are exposed to stressful life events at the beginning of the disease have different imagining results. In the study by Real et al. (2013: 175) conducted with 124 OCD patients and healthy control group (*N*= 112), gray matter volumes in right putamen and the anterior cerebellum were significantly differentiated in the patient group exposed to stressful life events. In another study in which the same data was used, gray matter volumes in the bilateral dorsal putamen and the central tegmental tracts of the patients with OCD who were less exposed to stressful life events were significantly higher than those compared to the control groups. In addition, patients exposed to stressful life events exhibited an increased gray matter volume in the right anterior cerebellum. In summary, the findings suggest that OCD patients exhibit neurological differences to stressful life events prior to disease (Real et al. 2016: 366).

When the relationship between stress factors and OCD is examined in detail, before the onset of OCD experiencing negative life events such as illness of a family member, personal physical illness and loss of a loved object was found to be significantly associated with symmetry obsessions, repeating, ordering/arranging, counting, and checking compulsions (Rosso et al. 2012: 259). In addition, in another study, reporting of at least one stressful life event prior to OCD disease was associated

with problems in pregnancy and contamination / cleaning symptoms (Real et al. 2011: 367).

As previously mentioned, stress has a critical role on the onset of medical illness. From this point, it is also expected that stress might be a destructive factor on marital life such as reduced marital satisfaction, partner cohesion or quality of life. According to a study conducted with 810 adults (Pittman and Llyods (1988: 53) stress, especially in home and financial stress had a larger effect on quality of family life.

In the relationship between different types of stressors and marital life factors, gender seems to have a different role. In a recent study with infertile couples, although the stress perceived by both men and women had significant actor effects on marital satisfaction, there was no significant partner effect of men's perceived stress on woman's marital satisfaction (Maroufizadeh et al. 2019: 68).

Studies also indicated that in the relationship between daily life stress and marital strain, previous negative childhood life events have an amplifier effect in both same-sex marriages and different-sex marriages (Donnelly, Umberson and Kroeger 2018: 2095). On the other hand, some factors such as social support and increased communication between partners might be improving factors in that relationship (Abbas et al. 2019: 234; Vazhappilly and Reyes 2018: 85). Additionally, OCD is a critical disorder which effects the quality of life of individuals and marital status (Eisen et al. 2006: 274). A treatment study indicated that after a behavioral oriented OCD treatment, marital distress significantly reduced (Riggs, Hiss and Foa 1992: 588).

1.5. Aim of the Present Study

As seen in the literature mentioned above, there are various studies which focus on the relationship between individuals with OCD and their partners or people they are in close relationship with. However, it appears that there are limited studies which examine the associations between individuals with ROCD and their partners in the

context of relational factors. Additionally, even though a relationship was found between parent-child focused ROCD and partner focused ROCD, the findings are limited to the Doron, Derby and Szepsenwol (2017).

In addition to these, although the relationship between OCD symptoms and depression, anxiety and stress has been frequently investigated in previous studies, there is not enough study which examine the relationship between depression, anxiety and stress with ROCD, which is suggested as a new symptom type of OCD. Studies are limited to the work of Doron and colleagues (Doron et al. 2012b; Doron et al., 2014; Doron et al. 2016; Doron, Derby and Szepsenwol, 2017). Since the ROCD is a quite new topic, there are not enough studies in the literature.

Based on these limitations in the literature, this research has two main objectives. The first aim of the study was to examine the psychometric properties of the Turkish form of Parent-Child Related Obsessive Compulsive Symptom Inventory. The second aim of the study is to examine the moderator role of child-focused OC symptoms and variables related to marital life in the relationship between partner-focused OC symptoms and depression, anxiety and stress.

1.6. Hypotheses of the Present Study

The hypotheses created for the purposes of the research are as follows:

Hypothesis 1: The Turkish version of the Parent-Child Related Obsessive Compulsive Symptom Inventory will have statistically acceptable validity and reliability.

Hypothesis 2: There will be a significant positive relationship between partner focused OCD and parent-child focused OCD.

Hypothesis 3: There will be a significant negative relationship between partner focused OCD and marriage related factors.

Hypothesis 4: There will be a significant negative relationship between child focused OCD and marriage related factors.

Hypothesis 5: There will be a significant positive relationship between partner focused OCD and depression, anxiety and stress.

Hypothesis 6: There will be a significant positive relationship between child focused OCD and depression, anxiety and stress.

Hypothesis 7: There will be a significant negative relationship between marriage related factors and depression, anxiety and stress.

Hypothesis 8: In the relationship between partner focused OCD and depression, anxiety and stress, child focused OCD and marriage related factors will have a moderation role.

In the light of the hypotheses of the study, the proposed model was depicted in Figure 1.1

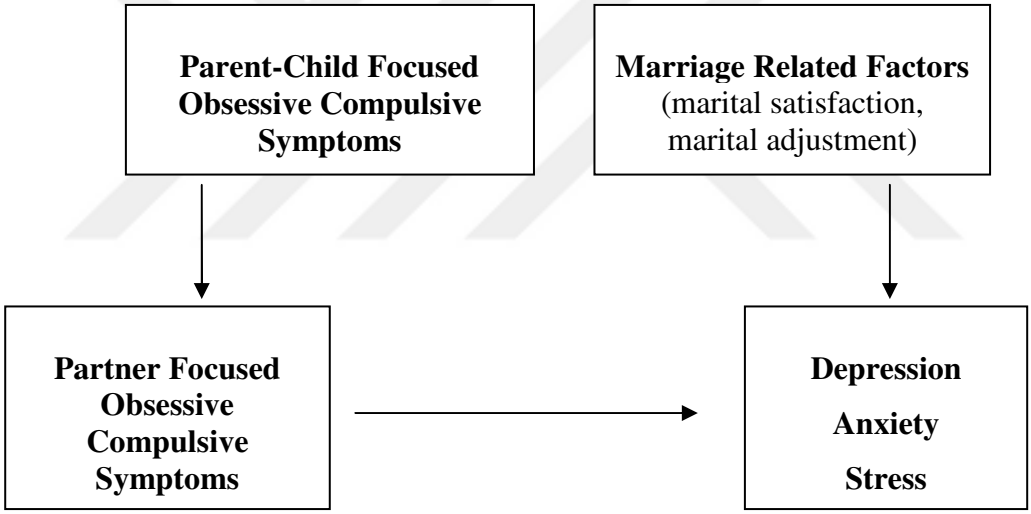

Figure 1.1: A proposed model of moderation effect

CHAPTER II

2. METHOD

2.1. Participants

The population of the study was married adults having a child and living in Turkey. The sample of the study consisted of a total of 268 married individuals with children living in different cities of Turkey such as İzmir, Bolu, Ankara, İstanbul, Kırıkkale, Mardin, Samsun etc. Participants' age range was between 22 and 64, and the average age of participants was 37.46 (SD =8.1). 77.2% of the participants were female (N=207) and 22.8% of them were male (N=61). Female participants' age range was between 22-61with a mean age of 36.78, and male participants' age range was between 27-64 with a mean age of 39.77.

Participants' educational background was as follows: 1,1% primary school graduate (N=3), 2,6% secondary school graduate (N=7), 12,3% high school graduate (N=33), 56,0% college graduate (N=150) and 28,0% post graduate (N=75).

All of the participants were married and had at least one child 100% (N =268). Additionally, while 60.4% of the participants had one child (N = 162), 32.5% of them had two children (N = 87), 5.6% of the participants had three children (N = 15) and 1.5% of the participants had four or more children (N = 4). Table 2.1 shows the demographical characteristics of the participants in detail.

Table 2.1: Demographic characteristics of the participants

Variables		**M**	**SD**	**N**	**%**
Age		37.46	8.19	268	100
Gender					
	Woman			207	72.2
	Man			61	22.8
Education					
	Primary School			3	1.1
	Secondary School			7	2.6
	High School			33	12.3
	University			150	56.0
	Master/PhD			75	28.0
Marital Status					
	Married			268	100
Number of Child					
	1			162	60.4
	2			87	32.5
	3			15	5.6
	4 and more			4	1.5
Income(TL)					
	1000-2000			9	3.4
	2001-3000			19	7.1
	3001-4000			29	10.8
	4001-5000			37	13.8
	5001 and more			174	64.9
Professional					
	Housewife			30	11.2
	Worker			5	1.9
	Retired			1	.4
	Self-employment			4	1.5
	Officer			24	9.0
	Teacher/Lecturer			89	33.2
	Architect/Engineer			20	7.5
	Tradesman			2	.7
	Technician			8	3.0
	Director			11	4.1
	Healthcare Personnel			20	7.5
	Psychologist			26	9.7
	Sociologist			2	.7
	Social Worker			1	.4
	Lawyer			1	.4
	Banker			4	15
	Pharmacist			2	.7
	Graphic Design			2	.7
	Chemist			2	.7
	Accountant			3	1.1
	Student			2	.7
	Writer			2	.7

This study was conducted in a non-clinical sample because although ROCD has been accepted as a sub-dimension of OCD (Doron et al., 2016; Doron et al., 2012a, 2012b), it has not been considered as a disorder in the last diagnostic evaluation systems

such as DSM V and ICD 11. Because of that, ROCD clinical sample cannot be diagnosed but the symptoms can be evaluated by valid and reliable scales. In addition, OCD is a disorder that is widely studied in non-clinical samples and OCD symptom contents are also reported by majority of the non-clinical samples (Clark, 2004: 210), but the severity and intensity of the symptoms vary in clinical samples compared to non-clinical samples.

2.2. Instruments

In order to collect the data, a booklet of inventory composed of the Demographical Information Form, Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC), Partner Related Obsessive Compulsive Symptom Inventory, Dyadic Adjustment Scale (DAS), Marital Life Scale (MLS), Spouse Support Scale (SSS) and Depression Anxiety Stress Scales (DASS-21), was used.

2.2.1. Demographical Information Form

The Demographic Information Form included questions regarding gender, age, educational background, income, mental health, age of the individuals when they married, marriage style (marriage arranged by others or self-arranged marriage), duration of marriage, whether it is 1st, 2nd, or etc. marriage, and number of children. This form is available in Appendix A.

2.2.2. Parent-Child Related Obsessive Compulsive Symptom Inventory (PROCSI-PC)

It was developed by Doron et al. (2017) to measure parent-child focused ROCD symptoms. The instrument is a 28 items 5-point Likert type scale (1: Not at all, 5: All the time). However, items 1, 4, 16 and 24, which are control items, were not included in the analysis. The scale includes areas where parents perceive their children's flaws such as intellectual flaws, physical trait flaws, character flaws, psychological flaws, flaws in

social functionality and low competence. The scale consisted of 5 factors (appearance, intelligence, competence, morality, sociability and emotional stability). High scores from the scale indicate that parent-child focused ROCD symptoms are increased. Doron et al. (2017) reported that the Cronbach Alpha coefficient for internal consistency of the whole scale was .94 and .83 for the Morality subscale, .84 for the Sociability and Emotional Stability subscale, .84 for the Competence subscale, .89 for the Appearance subscale and .75 for the Intelligence subscale. The Turkish translation and adaptation of the scale was conducted within the scope of this study. The findings indicated that the PROCSI-PC is a valid and reliable measurement tool. The detailed results obtained from the adaptation study of the scale will be given in the results section. The PROCSI-PC is available in Appendix E.

2.2.3. Partner Related Obsessive Compulsive Symptom Inventory (PROCSI)

Doron and colleagues (2012b) developed the Partner Related Obsessive Compulsive Symptom Inventory to measure obsessions and compulsions related to perceived flaws on partner (appearance, intelligence, competence, morality, sociability and stability). It is a 24 item, 5-point Likert type scale (1: Not at all, 5: All the time). High scores obtained from the scale indicate the elevated levels of partner focused obsessive-compulsive symptoms. The scale consisted of 6 factors; appearance, intelligence, competence, morality, sociability and stability subscales. Cronbach alpha coefficients for the internal consistency was .95 for the whole scale, .89 for the Morality subscale, .84 for the Sociability subscale, .84 for the Emotional Stability subscale, .87 for Competence subscale, .83 for the Appearance subscale and .83 for the Intelligence subscale. Also, in order to assess the validity of the scale, the Obsessive-Compulsive Inventory (OCI-R) (Foa et al., 2002), the Obsessive Beliefs Questionnaire (OBQ) (Molding et al, 2011), the DASS-21 (Lovibond and Lovibond, 1995), the short form of the Experiences in Close Relationships scale (ECR-12) (Wei et al., 2007) and the Relationship Assessment Scale (RAS) (Hendrick, 1998) were used and moderate correlations between total and subscale scores of the PROCSI and other scales scores were found. The Turkish translation of the scale and the adaptation study was conducted by Trak and Inözü (2017). For the Turkish version of the scale, the Cronbach alpha

coefficients were .94 for the whole scale, .88 for the Morality subscale, .77 for the Sociability subscale, .85 for the Emotional Stability subscale, .83 for Efficacy subscale, .88 for the Appearance subscale, and .71 for the Intelligence subscale. In this study, the Cronbach alpha coefficient was .90 for the whole scale. The PROCSI is available in Appendix C.

2.2.4. Dyadic Adjustment Scale (DAS)

Dyadic Adjustment Scale was developed by Spanier (1976) to determine relational adjustment between married couples. The DAS is a Likert type scale comprising of 32 items. Items 1-22 are rated on 6 point, items 23 and 24 are rated on 5 point, and items 25-28 are rated on 6-point Likert-type scale. The last two items (31 and 32) answered as yes/no. The scores for total scale range between 0-151 and the higher the total adjustment score, the higher the marital adjustment. The adaptation of the scale into Turkish culture and its reliability and validity analysis were conducted by Fışıloğlu and Demir (2000). Internal consistency coefficient (Cronbach's Alpha) of the Turkish form of the scale is .92 and split-half reliability coefficient is .86 (Fışıloğlu and Demir, 2000: 214). Cronbach α internal consistency coefficients of the subscales included in the scale were as follows: dyadic satisfaction (α = .83), dyadic cohesion (α = .75), dyadic consensus (α = .75), affectional expression (α =. 80). Also, Locke-Wallace Marital Adjustment Test (Locke and Wallace, 1959) was used for the criterion validity of the scale. The correlation between the DAS and the Locke-Wallace Marital Adjustment Test was .82. A Principal Component Analysis was used for construct validity. The results were confirmed for 4 factors explaining 45.5% of the total variance. In this study, the Cronbach alpha coefficient was .95 for the whole scale (See Appendix D).

2.2.5. Marital Life Scale (MLS)

The Scale was developed by Tezer (1986) to evaluate the marital satisfaction of the individuals. The MLS is a 10 item, 5-point Likert type scale: (1) "I absolutely disagree", (2) "I do not agree", (3) "I am undecided", (4) "I agree", (5) "I absolutely agree". The total score ranges between 10-50. Higher scores on the scale indicate that

the marital satisfaction level of the individual is high. Test-retest reliability of the scale was 0.85 (Pearson Correlation Coefficient) and the internal consistency coefficient (Cronbach's Alpha) was found to be 0.91 in the first group (N= 50) and 0.89 in the second group (N= 208). In order to evaluate the construct validity of the marital life scale, the scores of the married and divorced couples were analyzed by t test. The t-value was found to be 6.23 ($p<.01$). In this study, the Cronbach alpha coefficient was .93 for the whole scale (See Appendix B).

2.2.6. Depression Anxiety Stress Scale (DASS 21)

The Depression Anxiety Stress Scale, developed by Lovibond and Lovibond (1995), was used to measure depression, anxiety and stress levels of individuals. The DASS consists of 42 items rated on 4-point scale: (0) "Never", (1) "Sometimes", (2) "Very Often" and (3) "Always". The short version of the scale consists of 21 items which measure the three factors (Henry and Crawford, 2005). The scale was translated into Turkish by Uncu et al. (2006) and psychometric properties were evaluated by Bilgel and Bayram (2010). In the study of Bilgel and Bayram (2010), the Cronbach Alpha coefficients were .92 for the Depression Scale, .89 for the Anxiety scale and .93 for the Stress Scale. In order to evaluate the convergent validity of the scale, Pearson Correlation Coefficients were investigated between Hospital Anxiety and Depression (HAD) Scale and DASS. The DASS depression and anxiety scale correlated significantly with HAD depression ($r = 0.64$; $p < 0.01$) and HAD anxiety ($r = 0.58$; $p < 0.01$). Also, correlations between the DASS stress scale and the HAD scales were moderate ($r = 0.45$; $p < 0.01$ and $r = 0.59$; $p < 0.01$) In this study, the Cronbach alpha coefficients were .90 for the Depression scale, .85 for the Anxiety scale and .86 for the Stress scale (See appendix F).

2.3. Procedure

Prior to the study, ethical approval was obtained from the Ethics Committee of Abant Izzet Baysal University. Then, in the first part of the study, the PROCSI-PC was

translated from English to Turkish by two clinical psychologists who had studies on OCD and had fluent Turkish and English. The translations were compared by the researcher and her thesis supervisor with the items of the original scale. After the detailed examination, necessary corrections were made, and the first Turkish version of the scale was created. In the second stage, subjects outside the field were asked to fill out both the Turkish and the English scales. In accordance with the feedbacks received from the participants, items that were not clear enough were edited. Finally, the Turkish version of the scale was re-translated into English by a specialist who was professional in both languages and the scale was sent to the author who developed the original scale and the approval was obtained.

After the translation process of the scale was completed, the data collection phase started. The Informed Consent Form and the scales prepared for the research were entered in surveys.google.com online survey site. Participants were reached through social media and email groups by snowball method. All participants filled out online survey version of the scales and the forms. The purpose of the study was explained in the Consent form and it was reported that participation was entirely voluntary. The participants who were referred to the questionnaire via the link shared by the researcher were asked to approve the informed consent form first. Participants who accepted to participate in the study completed the scale set and after the sufficient sample size was obtained the data collection process was finalized.

2.4. Analyses

Firstly, factor structures of the PROCSI-PC were examined by confirmatory factor analysis. AMOS 23.0 (Airbuckle, 2014) software was used for confirmatory factor analysis. In addition, correlations of the PROCSI-PC with demographic variables were examined. Correlations between PROCSI-PC, PROCSI and DASS were investigated for concurrent validity. In order to evaluate the predictive validity of the PROCSI-PC scale, hierarchical regression analysis was used. Cronbach Alpha coefficients were calculated to determine the internal consistency levels of the total

PROCSI-PC and subscales. SPSS 23.0 (IBM Corp., Armonk, NY) software was used for all analyzes except confirmatory factor analysis.

Pearson correlation analysis was performed to examine the relationships between the main variables. The method recommended by Aiken and West (1991) was used to investigate the moderating effects of marriage-related factors and child-focused obsessive-compulsive symptoms in the relationship between obsessive-compulsive symptoms of married individuals for their partners and depression, anxiety and stress levels.

CHAPTER III

3. RESULTS

In this section firstly the results related to the adaptation study of the Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC) will be reported. In this respect, the results of confirmatory factor analysis used to determine the factor structure of the scale, the results of correlation analyses conducted to test concurrent validity and also the results of hierarchical regression analyses used to evaluate the predictive validity will be given. Moreover, the Cronbach Alpha coefficients calculated to evaluate the reliability of the scale will be presented.

In the second part of the results section, Pearson correlation coefficient values of the variables and the findings of the moderation analysis will be reported. In the moderation analysis using PROCESS (Hayes, 2013), a macro modeling procedure; the moderating effect of the PROCSI-PC and relationship-related factors (MLS and DAS) on the relationship between PROCSI and DASS will be investigated.

3.1. Validity and Reliability Results of the Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC)

3.1.1. Validity Results of the Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC)

3.1.1.1. Factor Structure of the Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC)

In order to test the five-factor structure of the Turkish form of the scale, Confirmatory Factor Analysis was conducted by using AMOS program (Analysis of Moment Structures). However, the obtained values showed that the fit indices (X^2 / *sd* = 3.83, *TLI* =.73, *CFI* = .77, *NFI* = .71, *RMSEA* = .10, p <.001) were not acceptable.

In the literature, it has been stated that for the χ2/sd ratio of the fit indices that are used to evaluate if the model indicates a good fit, should be equal to 3 or lower than 3 (Schreiber, Nora, Stage, Barlow and King, 2006). The χ2/sd ratio, which was found to be 3.82 in this study, was not acceptable for a good fit. AGFI, GFI, CFI and NFI fit indices are expected to be higher than .90 in order to be able to mention a good fit (Schreiber et al., 2006). In this study, AGFI, GFI, CFI and NFI fit indice values were found to be lower than the expected levels. Finally, the RMSEA fit indices was examined and the RMSEA value was found to be above the range of .06-10 (Hu and Bentler, 1999; Browne and Cudeck, 1993), which was considered as good fit.

For this reason, to view the structure of unique factors in the Turkish sample, exploratory factor analysis was conducted. Principal Component Analysis with direct oblimin rotation was conducted to assess the construct validity of the scale. The Kaiser-Meyer Olkin (KMO) index was found as .89 and The Barlett's was found as 3076.38 (p<.001). These values showed that the data was suitable for factor analysis. Unlike the original form, the findings in this study indicated a 4 factor structure with eigenvalues greater than 1. This 4-factor structure of the scale explained 56.19% of the cumulative variance.

When the distributions of the items were examined, 5 items of the scale (8,10,11,12,13) loaded on the Intelligence factor, 7 items (2,3,21,24,25,27,28) to the Competence factor, 8 items (5,6,7, 15,17,18,20,22) to the Morality factor, and 4 items (9,14,19,26) loaded onto the Appearance factor.

Factor I accounted for 35.9%, factor II accounted for 8.1%, factor III accounted for 6.5% and factor IV accounted for 5.7% of the cumulative variance. However, inconsistent with the original form, items 2,3,5,7,10,12,18,21,22 and 24 loaded on different factors. Differently from the original factor structure of the scale, item 10 with a standardized loading of 0.74 loaded onto the Intelligence factor instead of Competency factor. Item 12 with a standardized loading of 0.69 loaded onto the Intelligence factor instead of Emotional Stability factor.

In terms of Competency factor, item 2 with a standardized loading of 0.70 and item 21 with a standardized loading of 0.49 loaded onto the Competency factor instead of Sociability factor. Moreover, Item 3 which was loaded on to Intelligence factor in the original scale, loaded on to Competency factor with a standardized loading of 0.60. Finally, item 24 with a standardized loading of 0.62 loaded onto the Competency factor instead of Emotional Stability factor.

When considering Morality factor, item 5 with a standardized loading of 0.48 and item 18 with a standardized loading of 0.56 loaded onto the Morality factor instead of Sociability. Lastly, item 7 with a standardized loading of 0.65 and item 22 with a standardized loading of 0.73 which were loaded on to Emotional Stability in the original scale loaded on to Morality scale.

In the next stage, the 4-factor structure of the scale, which was determined by using exploratory factor analysis, was re-tested by using confirmatory factor analysis. The analyzes were performed using the AMOS program. Some of the proposed modification indices were applied to increase the fit of the model. The error scores of item 8 and 10 of Intelligence factor, item 2 and 3 of Competence factor, item 5 and 6, 7 and 22, 17 and 18, 5 and 18 of Morality factor, and finally item 9 and 26 of Appearance

factor were matched. In this way, the fit indices of the model have reached the acceptable values. The fit indexes (X^2 / *sd* = 2.59, *TLI* = .85, *CFI* = 0.87, *NFI* = 0.81, *RMSEA* = .08, p<.001) were found to be acceptable. The results of confirmatory factor analyses shown in Figure 3.1. The results of these two models are shown in Table 3.1.

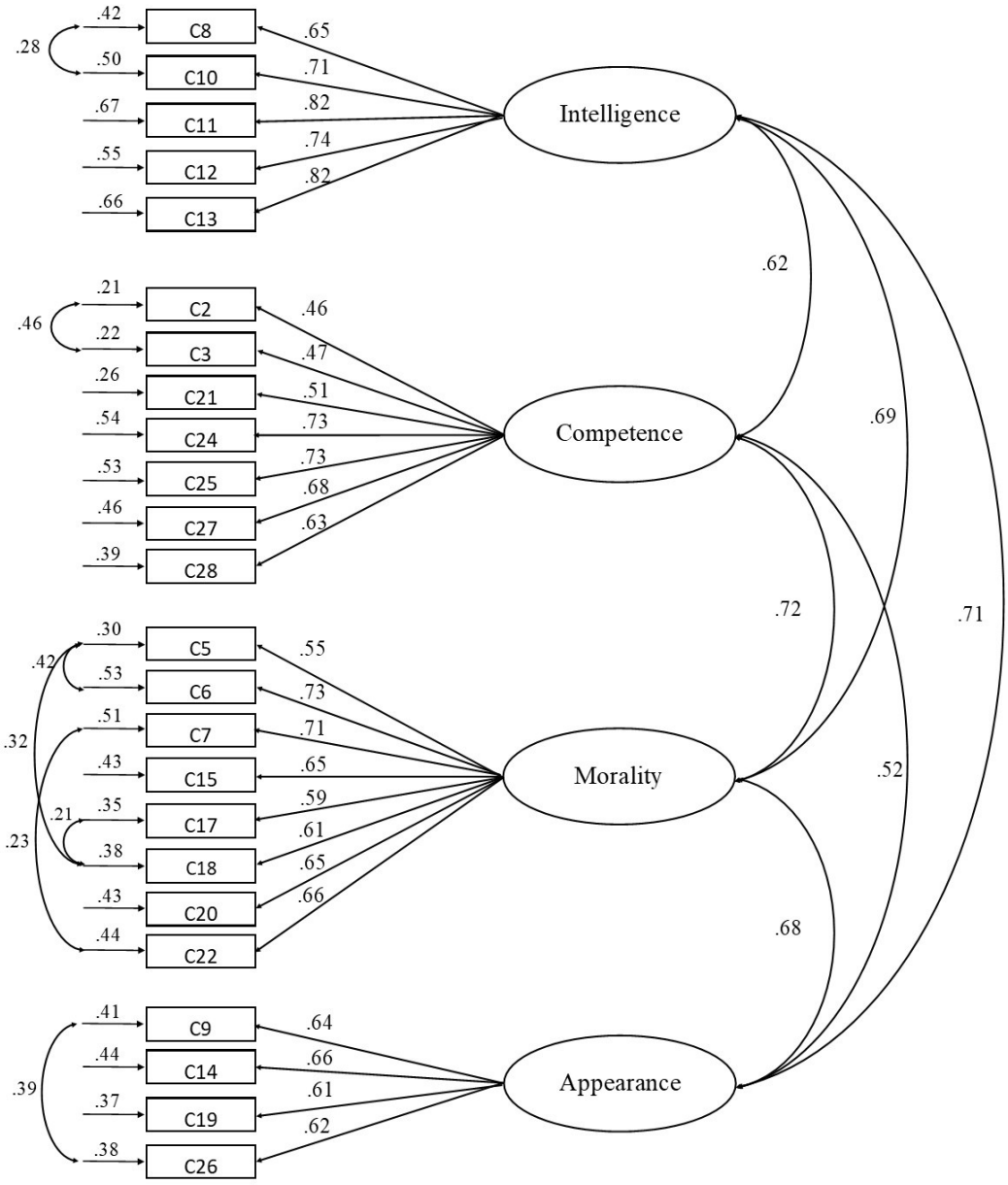

Figure 3.1: The results of confirmatory factor analyses

Table 3.1: Fit indices of models related the PROCI-PC's factor structure.

	X^2	sd	X^2/sd	p	TLI	CFI	NFI	RMSEA
Model 1	912.24	238	3.83	.000	.73	.77	.71	.10
Model 2	618.01	239	2.59	.000	.85	.87	.81	.08

Note: Model 1: The model for five factor structure. Model 2: The model for four factor structure.

3.1.1.2. Concurrent Validity of Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC)

The relationship between the scores on the PROCSI-PC and the PROCSI and DASS were examined as a test of concurrent validity.

When considered the relationship between the PROCSI-PC and the PROCSI scores, it was found that PROCSI-PC total scores were significant and positively correlated with the PROCSI total (r = .46, p <.01), and its subscales of the Morality (r = .33, p <.01), Sociability (r = .25, p <.01), Emotional Stability (r = .40, p <.01), Competence (r = .43, p <.01), Appearance (r = .38, p <.01), and Intelligence (r = .35, p <.01). Similarly, PROCSI total scores were significantly and positively correlated with subscales of Morality (r = .33, p <.01), Competence (r = .38, p <.01), Appearance (r = .49, p <.01), and Intelligence (r = .43, p <.01) of the PROCSI-PC.

Finally, the relationships between total scores of PROCSI-PC and DASS were examined and it was found that PROCSI-PC total score significantly and positively correlated with Depression (r = .38, p <.01), Anxiety (r = .44, p <.01) and Stress (r = .40, p <.01) subscales. Moreover, the DASS depression scores were found to be significantly correlated with all subscales of PROCSI-PC: Morality (r = .34, p <.01), Competence (r = .31, p <.01), Appearance (r = .26, p <.01), and Intelligence (r = .30, p <.01). The DASS anxiety scores were found to be significantly correlated with all subscales of the PROCSI-PC: Morality (r = .39, p <.01), Competence (r = .37, p <.01), Appearance (r = .36, p <.01), Intelligence (r = .31, p <.01). Lastly, the DASS Stress scores were found to be significantly correlated with all subscales of the PROCSI-PC: Morality (r = .32, p <.01), Competence (r = .39, p <.01), Appearance (r = .29, p <.01) and Intelligence (r = .27, p <.01). The correlation coefficients between the subscales were given in detail in Table 3.2.

Table 3.2: Correlations for concurrent validity

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1	**PROCSI-PC Total**		.88**	.86**	.63**	.77**	.46**	.33**	.25**	.40**	.43**	.38**	.35**	.38**	.44**	.40**
2	**PROCSI-PC Morality**			.60**	.52**	.61**	.33**	.28**	.16**	.29**	.29**	.25**	.25**	.34**	.39**	.32**
3	**PROCSI-PC Competency**				.38**	.52**	.38**	.26**	.21**	.34**	.34**	.30**	.28**	.31**	.37**	.39**
4	**PROCSI-PC Appear**					.55**	.49**	.27**	.25**	.36**	.45**	.57**	.40**	.26**	.36**	.29**
5	**PROCSI-PC Intelligence**						.43**	.29**	.24**	.37**	.42**	.32**	.32**	.30**	.31**	.27**
6	**PROCSI Total**							.66**	.73**	.78**	.82**	.74**	.84**	.48**	.50**	.43**
7	**PROCSI Morality**								.29**	.47**	.42**	.46**	.45**	.29**	.32**	.23**
8	**PROCSI Sociability**									.47**	.53**	.35**	.56**	.32**	.32**	.33**
9	**PROCSI Emotional Stability**										.51**	.54**	.55**	.42**	.46**	.39**
10	**PROCSI Competency**											.57**	.71**	.39**	.40**	.37**
11	**PROCSI Appearance**												.57**	.35**	.38**	.30**
12	**PROCSI Intelligence**													.41**	.42**	.34**
13	**DASS Depression**														.76**	.80**
14	**DASS Anxiety**															.76**
15	**DASS Stress**															

**: p< .01

Note: PROCSI: Partner Related Obsessive Compulsive Symptom Inventory
PROCSI-PC: Parent-Child Related Obsessive Compulsive Symptom Inventory
DASS: Depression Anxiety Stress Scale

3.1.1.3. The Predictive Validity of the Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC)

A three-step hierarchical regression analysis in which the PROCSI total score is the dependent variable was performed to determine the predictive validity of the PROCSI-PC. In the first step of the analysis, DASS depression, anxiety and stress scores were entered. In the second step, the DAS and the MLS total scores were entered and in the third step, the total score of the PROCSI-PC was entered in the analysis. The results of the regression analysis were summarized in Table 3.3.

Table 3.3: The results of hierarchical regression analysis

	Predictors in set	F for set	t for w/in set Predictors	df	Beta (β)	Model R^2
A. Dependent Variable: PROCSI						
I.	DASS	33.49***		3, 264		.276
	Depression		2.37*	264	.23	
	Anxiety		3.8***	264	.33	
	Stress		.02	264	.002	
II.	Relationship Variables	32.39***		5, 262		.382
	MLS		-.74	262	-0.06	
	DAS		-4.41***	262	-0.38	
III.	*PROCSI-PC*	38.20***	6.48***	6		.468
				261	.33	

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

The hierarchical regression analysis that was performed using the Enter method in the first step showed that depression (β = .23, t = 2.37, p<.05) and anxiety (β = .33, t = 3.8, p<.001) subscales of DASS made a significant contribution to the regression model (F [3, 264] = 33.49, p<.001) and explained 28% of the variance in the PROCSI score. In the second step, only the DAS scores (β = -0.38, t = -4.41, p<.001) significantly predicted the PROSCI total score and significantly contributed to the model (F [5, 262] = 32.39, p< .001) and resulted with an increase of 11% in the explained variance. In the third step, the PROCSI-PC total score (β = .33, t = 6.48, p<.001) significantly predicted the PROCSI total score and contributed significantly to the model (F [6, 261] = 38.20, p<.001) and resulted with a 9% increase in the explained variance. Thus, the results showed that when the DASS, MLS and DAS scores were controlled, the PROCSI-PC score significantly predicted the PROCSI total score.

3.1.2. The Reliability Results of the Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC)

The reliability of the scale was examined via internal consistency analysis. The Cronbach Alpha coefficient of the Parent-Child Related Obsessive Compulsive Inventory (*M* = .56, *SD* = .54) was found as .91 for the total scale, .85 for Morality (*M*=.42, *SD*=.66), .80 for Competence (*M* = 1.14, *SD* = .85), .74 for Appearance (*M*= .13, *SD*= .39) and .85 for Intelligence (*M*= .32 *SD*= .58) subscales (See Table 3.4).

Table 3.4: Reliability values of the PROCSI-PC

	PROCSI-PC	**Morality**	**Competence**	**Appearance**	**Intelligence**	**Sociability ve Stability**
Turkish Scale (*N*= 268)						
M	.56	.42	1.14	.13	.32	
SD	.54	.66	.85	.39	.58	
α	.91	.85	.80	.74	.85	
Original Scale (*N*= 350)						
α	.94	.83	.84	.89	.75	.89

Note: PROCSI-PC: Parent-Child Related Obsessive Compulsive Symptom Inventory

3.2. Correlations between PROCSI-PC and Demographical Variables

To evaluate the relationship between child and partner focused OC symptoms and demographic variables, Pearson correlation coefficients were calculated between the PROCSI-PC and PROCSI scores and gender, age, education level, education level of the spouse, marriage type (marriage arranged by others or self-arranged marriage), age at marriage, spouse's age at marriage and number of children were calculated.

Table 3.5: Corelations between the PROCSI, PROCSI-PC and demographical variables

	PROCSI	PROSI-PC
Age	.02	-.01
Gender	-.04	.07
Education	-.03	-.11
Education of Spouse	-.11	-.16**
Type of Marriage	-.16*	-.15*
Marriage Age	-.05	-.08
Marriage Age of Spouse	-.06	-.16*
Number of Child	.03	.08

*p< .05, **p < .01
Note: PROCSI: Partner Related Obsessive Compulsive Symptom Inventory
PROCSI-PC: Parent-Child Related Obsessive Compulsive Symptom Inventory

As seen in Table 3.5, the level of partner focused obsessions and compulsions was significantly correlated with the type of marriage (r = -.16, p <.05). The level of obsessions and compulsions were lower in self-arranged married couples than marriage arranged by others couples.

Child-focused obsessions and compulsions were negatively correlated with the educational status of the spouse (r = -.16, p <.01), the type of marriage (r = -.15, p <.05) and the marital age of the spouse (r = -.16, p < .05). Thus, as the education level of spouse decreased, and the marriage age of spouses increased, the obsessions and compulsions related with children increased. In addition, child-focused symptoms were negatively correlated with type of marriage (r = -.15, p <.05). Symptoms were higher in marriages arranged by others compared to self-arranged marriages.

3.3. Descriptive Statistics for the Major Variables of the Study

In order to see the descriptive information for the variables used in the study, the standard deviations and the means of the measures were computed, which were shewed in Table 3.6.

Table 3.6: Means and Standard Deviations of the Major Variables of the Study

	N	M	SD	Range		Possible Range
PROCSI	268	.42	.47	0	2.67	0 - 4
PROCSI-PC	268	.56	.54	0	2.75	0 - 4
PROCSI-PC_ Competence	268	1.14	.85	0	4.00	0 - 4
PROCSI-PC_ Morality	268	.42	.66	0	3.63	0 - 4
PROCSI-PC_ Appearance	268	.13	.39	0	2.75	0 - 4
PROCSI-PC_ Intelligence	268	.32	.58	0	3.20	0 - 4
Depression	268	.63	.67	0	3.0	0 - 3
Anxiety	268	.48	.54	0	2.43	0 - 3
Stress	268	.89	.62	0	3	0 - 3
MLS	268	3.73	.92	1	5	1 - 5
DAS	268	3.32	.72	.63	4.44	0 - 5

Note: PROCSI: Partner Related Obsessive Compulsive Symptom Inventory
PROCSI-PC: Parent-Child Related Obsessive Compulsive Symptom Inventory
MLS: Marital Life Scale
DAS: Dyadic Adjustment Scale

3.4. Correlations among the Main Variables of the Study

Correlation analysis indicated that partner focused OC symptoms were significantly and positively correlated with the depression (r = .48, p <.01), anxiety (r = .50, p <.01) and stress (r = .43, p <. 01) scores (Table 3.6). As the partner focused OC symptoms scores increased, the depression, anxiety and stress symptom scores also increased. Similarly, parent-child OC symptoms scores were positively correlated with depression (r = .38, p <.01), anxiety (r = .44, p <.01) and stress scores (r = .40, p <.01).

When considered the relationship between marriage related factors and depression, anxiety, and stress levels, negative correlations were found. Secondly, marital satisfaction was found to be negatively correlated with depression (r = -.55, p <.01), anxiety (r = -.41, p <.01) and stress (r = -.50, p <.01) scores. Finally, the dyadic adjustment scores were negatively correlated with depression (r = -.63, p <.01), anxiety (r = -.51, p <.01) and stress (r = -.56, p <.01) scores, indicating that as the accordance between partners increased, depression, anxiety and stress levels decreased (See Table 3.6).

Table 3.7: Correlations among the main variables

		1	2	3	4	5	6	7	8	9	10	11	12	13
1	MLS	1	.79**	-.46**	-.01	-.16**	-.13	-.16**	-.21**	-.11	-.16	-.55**	-.41**	-.50**
2	DAS		1	-.56**	-.04	-.18**	-.17**	-.19**	-.18**	-.14	-.19**	-.63**	-.51**	-.56**
3	PROCSI_Total			1	.29**	.29**	.44**	.41**	.49**	.36**	.46**	.48**	.50**	.43**
4	PROCSI-PC_Morality				1	.61**	.70**	.52**	.41**	.58**	.82**	.26**	.32**	.25**
5	PROCSI-PC_Sociability					1	.59**	.57**	.39**	.61**	.82**	.34**	.35**	.37**
6	PROCSI-PC_Stability						1	.60**	.54**	.60**	.85**	.32**	.39**	.35**
7	PROCSI-PC_Competence							1	.45**	.58**	.81**	.34**	.39**	.36**
8	PROCSI-PC_Appearance								1	.45**	.63**	.26**	.36**	.29**
9	PROCSI-PC_Intelligence									1	.80**	.27**	.28**	.27**
10	PROCSI-PC_Total										1	.38**	.44**	.40**
11	DASS_Depression											1	.76**	.80**
12	DASS_Anxiety												1	.76**
13	DASS_Stress													1

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

Note. PROCSI: Partner Related Obsessive Compulsive Symptom Inventory, PROCSI-PC: Parent-Child Related Obsessive Compulsive Symptom Inventory, MLS: Marital Life Scale, DAS: Dyadic Adjustment Scale, DASS: Depression, Anxiety Stress Scale

3.5. Results of the Moderation Analyses

Separate hierarchical regression analyses were conducted for the prediction of depression, anxiety and stress. The method recommended by Aiken and West (1991) was used to test the possible moderation roles of the PROCSI-PC and marital life variables in relationship between the PROCSI and depression, anxiety and stress.

3.5.1. Moderator Roles of the PROCSI-PC and Marital Life Variables (MLS and DAS) in Relationship between the PROCSI and Depression

The moderation analysis was conducted to examine whether the influence of partner focused OC symptoms on the depression scores depends on the degree of parent-child OC symptoms, marital satisfaction and relational adjustment between married couples. A hierarchical regression analysis was performed to examine whether the interaction of partner focused and parent-child focused OC symptoms; partner focused OC symptoms and marital satisfaction; partner focused OC symptoms and marital adjustment would predict total depression scores above and beyond the main effects of partner focused OC symptoms, parent-child focused OC symptoms and marital life variables (MLS and DAS).

To specifically test the research hypotheses, all variables were entered as blocks in five separate steps in the regression analysis. After controlling for the effects of demographical variables (gender, age, marriage age, marriage age of the spouse, duration of the marriage, education, education of the spouse), the PROCSI was entered in the equation at the second step. The PROCSI-PC was entered at the third step and marital life variables (MLS and DAS) were entered at the fourth step. At the last step, the interaction of partner focused and parent-child focused OC symptoms; partner focused OC symptoms and marital satisfaction; partner focused OC symptoms and marital adjustment were entered.

Table 3.7 presents the results of the hierarchical regression analysis with total depression scores as the dependent variable. In the first step, control variables (gender,

age, age of marriage, marriage age of spouse, duration of marriage, education, education of spouse) were analyzed by stepwise method but none of them were found as significant predictors. PROCSI was the second variable entered into the equation, and explained 23% of the variance (F [1,266] = 79.09, p<.001), and the PROCSI (pr = .48, β = .48, t [266] = 8.89, p< .001) had a significant association with total depression scores. In the third step, the PROCSI-PC scores was entered into the equation and 3% contributed to the explained variance (F [1,265] = 11.30, R^2 = .26, p < .001), and the PROCSI-PC (pr = .20, β = .20, t [265] = 3.36, p< .001) had a significant association with total depression scores. In the fourth step, the MLS and the DAS scores were entered into the equation and 21% contributed to the explained variance (F [2,263] = 52.09, R^2 = .46, p < .001), and MLS (pr = -.12, β = -.14, t [263] = -1.97, p< .05) and DAS (pr = -.33, β = -.44, t [263] = -5.59, p< .001) had a negative significant association with total depression scores. Finally, on the last step, interaction of partner focused and parent-child focused OC symptoms scores; partner focused OC symptoms and marital satisfaction scores; partner focused OC symptoms and marital adjustment scores were entered into the equation and 3% contributed to the explained variance (F [3,260] = 4.25, R^2 = .48, p < .01) and only interaction of partner focused and parent-child focused OC symptoms (pr =.16, β =.16, t [260] = 2.64, p< .01) scores significantly predicted total depression scores. All these variables totally accounted for 48% of the variance.

Table 3.8: Results of hierarchical regression analysis for depression

Variables	β	t	Pr	R^2 change	(df)	F
Depression						
Step 2						
PROCSI	.48	8.89***	.48	.23	(1,266)	79.09***
Step 3						
PROCSI-PC	.20	3.36***	.20	.03	(1,265)	11.30***
Step 4						
MLS	-.14	-1.97*	-.12	.21	(2,263)	52.09***
DAS	-.44	-5.59***	-.33			
Step 5						
PROCSIxPROCSI-PC	.16	2.64**	.16	.03	(3,260)	4.25**
PROCSI x MLS	.16	1.74	.11			
PROCSI x DAS	-.03	-.32	-.02			

* p < .05 ** p < .01 *** p < .001

To better understand the nature of this significant interaction between partner focused OC symptoms and child focused OC symptoms, the procedure outlined by

Aiken and West (1991) was followed. According to this procedure, simple regression lines for moderated variables are plotted for significant interaction effects by using centered data. The inspection of Fig. 3.1 suggests that partner focused OC symptoms affected individuals differently depending on their level of parent-child focused OC symptoms for determining depression symptoms. To better understand the pattern of this interaction, whether the slopes of these two regression lines significantly differed from zero was tested (Aiken and West, 1991).

Simple slopes analysis revealed a significant positive association between partner focused OC symptoms and depression symptoms among participants with both high (simple slope β = .96, t [264] = 8.14, p < .001) and low (simple slope β = .47, t [264] = 5.58, p < .001) parent-child focused OC symptoms. These probes revealed that for subjects with high parent-child focused OC symptoms, depression symptom severity was higher among those with high partner focused OC symptoms compared to those with low partner focused OC symptoms. Besides, similar findings were found for subjects with low parent-child focused OC symptoms.

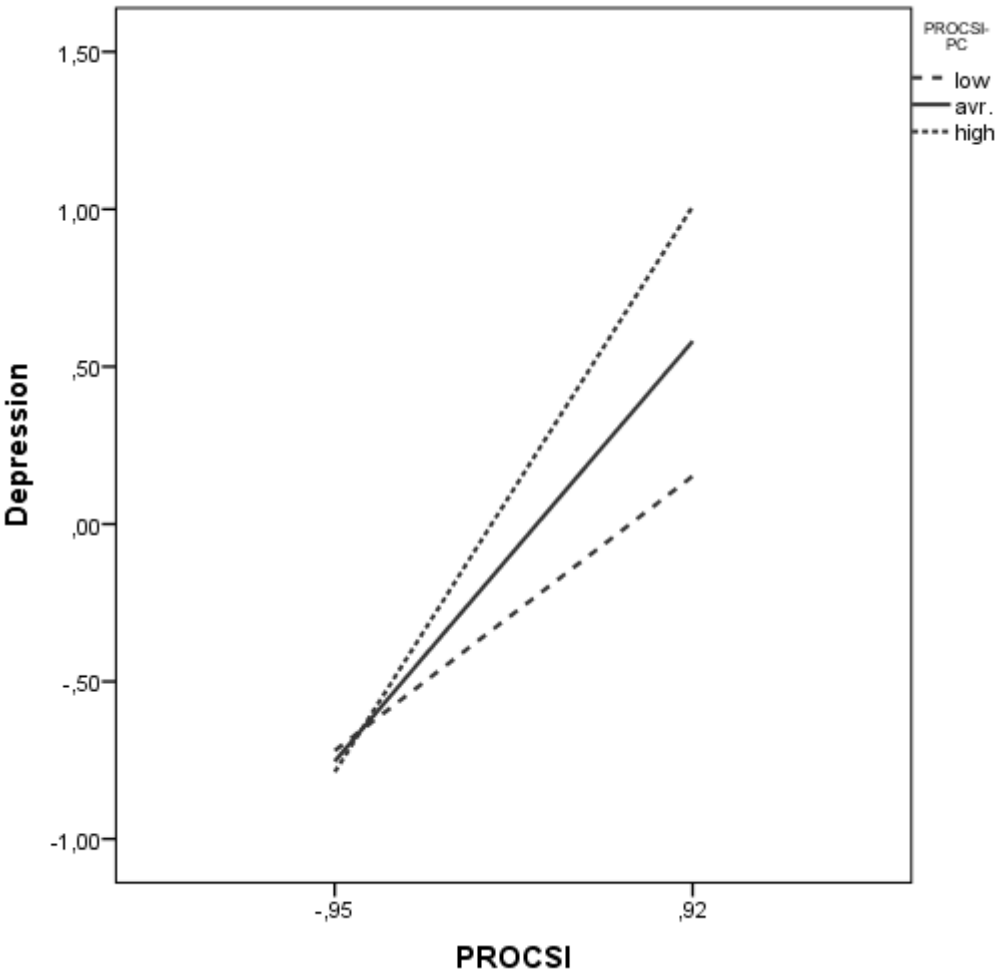

Figure 3.2: Interaction between partner focused and child focused OC symptoms in the prediction of depression symptoms

Note: PROCSI: Partner Related Obsessive Compulsive Symptom Inventory PROCSI-PC: Parent-Child Related Obsessive Compulsive Symptom Inventory

3.5.2. Moderator Roles of the PROCSI-PC and Marital Life Variables (MLS, DAS) in Relationship between the PROCSI and Anxiety

A separate hierarchical multiple regression analysis was performed in order to examine the impact of partner focused OC symptoms, parent-child focused OC symptoms, marital life variables and their interaction on anxiety. The regression analysis was performed to examine whether the interaction of partner focused and child focused OC symptoms; partner focused OC symptoms and marital satisfaction; partner focused OC symptoms and marital adjustment would predict total anxiety scores above

and beyond the main effects of partner focused OC symptoms, parent-child focused OC symptoms and marital life variables (MLS and DAS).

To specifically test the research hypotheses, all variables were entered as blocks in five separate steps in the regression analysis. After controlling for the effects of demographical variables (gender, age, marriage age, marriage age of the spouse, duration of the marriage, education, education of the spouse), the PROCSI was entered in the equation at the second step. The PROCSI-PC was entered at the third step, and marital life variables (MLS and DAS) were entered at the fourth step. At the last step, the interaction of partner focused and parent-child focused OC symptoms; partner focused OC symptoms and marital satisfaction; partner focused OC symptoms and marital adjustment were entered.

Table 3.8 presents the results of the hierarchical regression analysis with total anxiety scores as the dependent variable. In the first step only education of spouse (pr = .20, β = .20, t [266] = 3.29, p< .001) and marriage age (pr = .12, β = .12, t [265] = 1.98, p < .05) had a significant association with total anxiety scores. While education of spouse explained 4% of the variance (F [1,266] = 10.82, p <.001), marriage age increased the total variance to 5% (F [1,265] = 3.90, R^2 = .05, p < .05).

In the second step, the PROCSI scores was entered into the equation and 23% contributed to the explained variance (F [1,264] = 85.46, R^2 = .28, p < .001), and PROCSI (pr = .50, β = .49, t [264] = 9.25, p < .001) had a significant association with total anxiety scores. In the third step, the PROCSI-PC scores was entered into the equation and 5% contributed to the explained variance (F [1,263] = 17.58, R^2 = .32, p < .001), and PROCSI-PC (pr = .25, β = .24, t [263] = 4.19, p < .001) had a significant association with total anxiety scores. In the fourth step, the MLS and DAS scores were entered into the equation and 8% contributed to the explained variance (F [2,261] = 18.60, R^2 = .40, p <.001). While the MLS (pr = .00, β = .00, t [261] = -.01, p >.05) did not have a significant association with anxiety scores, the DAS (pr = -.26, β = -.35, t [261] = -4.26, p < .001) had a negative significant association with total anxiety scores. Finally, on the last step, interaction of partner focused and parent-child focused OC

symptoms scores; partner focused OC symptoms and marital satisfaction scores; partner focused OC symptoms and marital adjustment scores were entered into the equation and 3% contributed to the explained variance (F [3,258] = 4.37, R^2 = .42, p < .01), and only interaction of partner focused OC symptoms and marital satisfaction (pr =.14, β =.23, t [258] = 2.30, p < .05) scores significantly predicted total anxiety scores. All these variables totally accounted for 42% of the variance.

To better understand the nature of this significant interaction between partner focused OC symptoms and marital satisfaction, the procedure outlined by Aiken and West (1991) was followed. According to this procedure, simple regression lines for moderated variables are plotted for significant interaction effects by using centered data. The inspection of Fig. 3.2 suggests that partner focused OC symptoms affected individuals differently depending on their level of marital satisfaction for determining anxiety symptoms. To better understand the pattern of this interaction, whether the slopes of these two regression lines significantly differed from zero was tested (Aiken and West, 1991).

Simple slopes analysis revealed a significant positive association between partner focused OC symptoms and anxiety symptoms among participants with high (simple slope β= .54, t [264] = 7.70, p< .001) marital satisfaction. On the other hand, there were not significant associations between partner focused OC symptoms and anxiety symptoms for those with low marital satisfaction (simple slope β = .20, t [264] = 1.93, p=.06). These probes revealed that for subjects with high marital satisfaction and high partner focused OC symptoms, anxiety symptom severity was higher compared to those with low partner focused OC symptoms and low marital satisfaction.

Table 3.9: Results of hierarchical regression analysis for anxiety

Variables	*β*	*t*	Pr	R^2 *change*	(d.f)	*F*
Anxiety						
Step 1						
Education Of Spouse	.20	3.29***	.20	.4	(1,266)	10.82***
Marriage Age	.12	1.98*	.12	.05	(1,265)	3.90*
Step 2						
PROCSI	.49	9.25***	.50	.23	(1,264)	85.46***
Step 3						
PROCSI-PC	.24	4.19***	.25	.5	(1,263)	17.58***
Step 4						
MLS	.00	-.01	.00			
DAS	-.35	-4.26***	-.26	.8	(2,261)	18.60***
Step 5						
PROCSIxPROCSI-PC	.06	.99	.06			
PROCSI x MLS	.23	2.30*	.14	.3	(3,258)	4.37**
PROCSI x DAS	-.04	-.36	-.02			

* p < .05 ** p < .01 *** p < .001

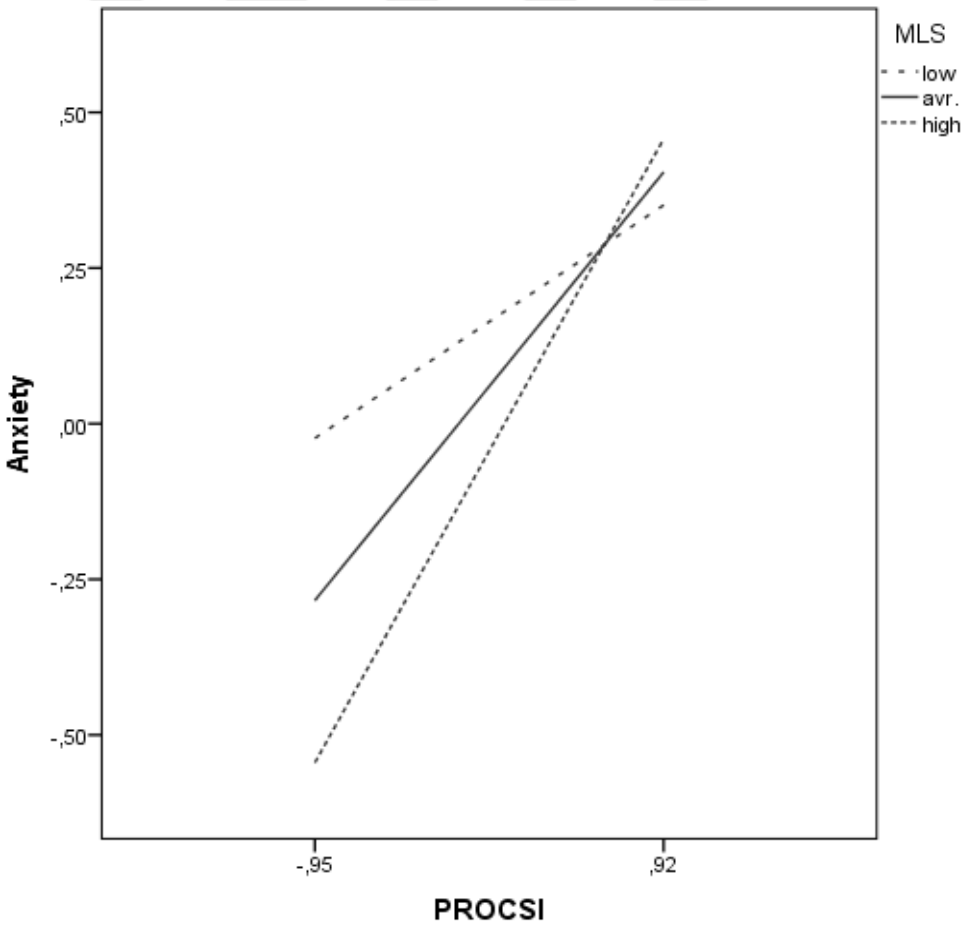

Figure 3.3: Interaction between partner focused OC symptoms and MLS in the prediction of anxiety symptoms

Note: MLS: Marital Life Scale

3.5.3. Moderation Roles of the PROCSI-PC and Marital Life Variables (MLS, DAS) in Relationship between the PROCSI and Stress

Another hierarchical multiple regression analysis was performed in order to examine the impact of partner focused OC symptoms, parent-child focused OC symptoms, marital life variables and their interaction on stress. The regression analysis was performed to examine whether the interaction of partner focused and child focused OC symptoms partner focused OC symptoms and marital satisfaction; partner focused OC symptoms and marital adjustment would predict total stress scores above and beyond the main effects of partner focused OC symptoms, parent-child focused OC symptoms and marital life variables (MLS and DAS).

To specifically test the research hypotheses, all variables were entered as blocks in five separate steps in the regression analysis. After controlling for the effects of demographical variables (gender, age, marriage age, marriage age of the spouse, duration of the marriage, education, education of the spouse), the PROCSI was entered in the equation at the second step. The PROCSI-PC was entered at the third step and marital life variables (MLS and DAS) were entered at the fourth step. At the last step, the interaction of partner focused and parent-child focused OC symptoms; partner focused OC symptoms and marital satisfaction; partner focused OC symptoms and marital adjustment was entered.

Table 3.9 presents the summary statistics for the hierarchical regression analysis with total stress scores as the dependent variable. In the first step, control variables (gender, age, age of marriage, marriage age of spouse, duration of marriage, education, education of spouse) were analyzed by stepwise method but none of them were found as significant predictors. The PROCSI was the second variable entered into the equation, and explained 19% of the variance (F [1,266] = 61.73, p <.001), and the PROCSI (pr = .43, β = .43, t [266] = 7.86, p< .001) had a significant association with total stress scores. In the third step, the PROCSI-PC scores was entered into the equation and 5% contributed to the explained variance (F [1,265] = 17.95, R^2= .23, p< .001), and the PROCSI-PC (pr = .25, β = .26, t [265] = 4.24, p< .001) had a significant association

with total stress scores. In the fourth step, the MLS and the DAS scores were entered into the equation and 17% contributed to the explained variance (F [2,263] = 38.57, R^2 = .40, p < .001), and the MLS (pr = -.13, β = -.17, t [263] = -2.17, p< .05) and DAS (pr = -.26, β = -.36, t [263] = -4.40, p< .001) had a negative significant association with total stress scores. Finally, on the last step, interaction of partner focused and parent-child focused OC symptoms scores; partner focused OC symptoms and marital satisfaction scores; partner focused OC symptoms and marital adjustment scores were entered into the equation and 3% contributed to the explained variance (F [3,260] = 4.88, R^2 = .43, p <.01), and interaction of partner focused and parent-child focused OC symptoms scores (pr =.18, β =.18, t [260] = 2.93, p< .01) and interaction of partner focused scores and marital satisfaction (pr =.16, β =.26, t [260] = 2.68, p< .01) scores significantly predicted total stress scores. All these variables totally accounted for 43% of the variance.

Table 3.10: Results of hierarchical regression analysis for stress

Variables	*β*	*t*	Pr	R^2 *change*	(d.f)	*F*
Stress						
Step 2						
PROCSI	.43	7.86***	.43	.19	(1,266)	61.73***
Step 3						
PROCSI-PC	.26	4.24***	.25	.5	(1,265)	17.95***
Step 4						
MLS	-.17	-2.17*	-.13	.17	(2,263)	38.57***
DAS	-.36	-4.40***	-.26			
Step 5						
PROCSIxPROCSI-PC	.18	2.93**	.18	.3	(3,260)	4.88**
PROCSI x MLS	.26	2.68**	.16			
PROCSI x DAS	-.16	-1.53	-.09			

* p < .05 ** p < .01 *** p < .001

To better understand the nature of these significant interactions the procedure outlined by Aiken and West (1991) was followed. According to this procedure, simple regression lines for moderated variables are plotted for significant interaction effects by using centered data. The inspection of Fig. 3.3 suggests that partner focused OC symptoms affected individuals differently depending on their level of parent-child focus OC symptoms for determining stress symptoms. To better understand the pattern of this interaction, whether the slopes of these two regression lines significantly differed from zero was tested (Aiken and West, 1991). Simple slopes analysis revealed a significant

positive association between partner focused OC symptoms and stress symptoms among participants with both high (simple slope β = .79, t [264] = 7.02, p < .001) and low (simple slope β = .34, t [264] = 4.33, p < .001) parent-child focused OC symptoms.

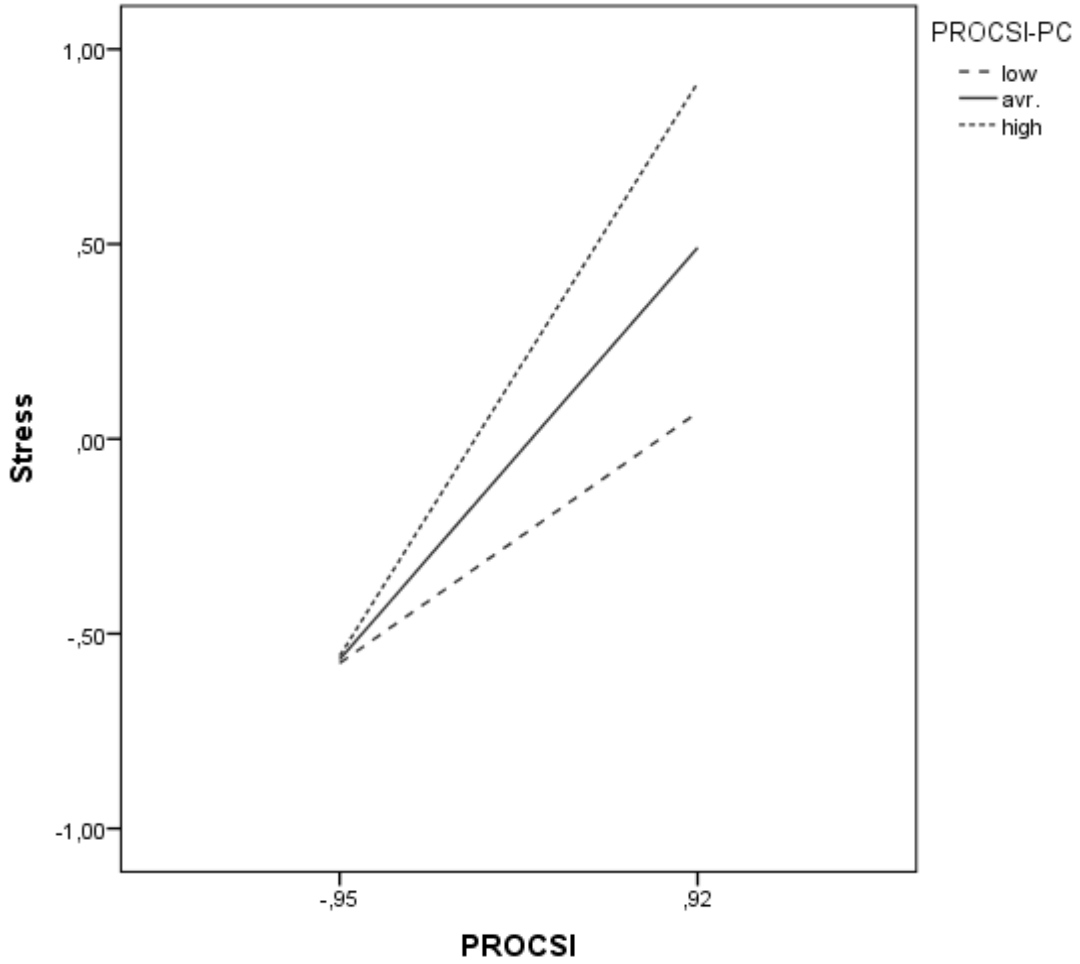

Figure 3.4: Interaction between partner focused and child focused OC symptoms in the prediction of stress symptoms

The inspection of Fig. 3.4 suggests that partner focused OC symptoms affected individuals differently depending on their level of marital satisfaction symptoms for determining stress symptoms. To better understand the pattern of this interaction, whether the slopes of these two regression lines significantly differed from zero was tested (Aiken and West, 1991).

Simple slopes analysis revealed a significant positive association between partner focused OC symptoms and stress symptoms among participants with high (simple slope β = .79, t [264] = 7.02, p < .001) marital satisfaction. On the other hand, there were not significant associations between partner focused OC symptoms and stress symptoms for those with low marital satisfaction (simple slope β = .15, t [264] = 1.28, p = .20). These probes revealed that for subjects with high marital satisfaction and high partner focused OC symptoms, stress symptom severity was higher compared to those with low partner focused OC symptoms and low marital satisfaction.

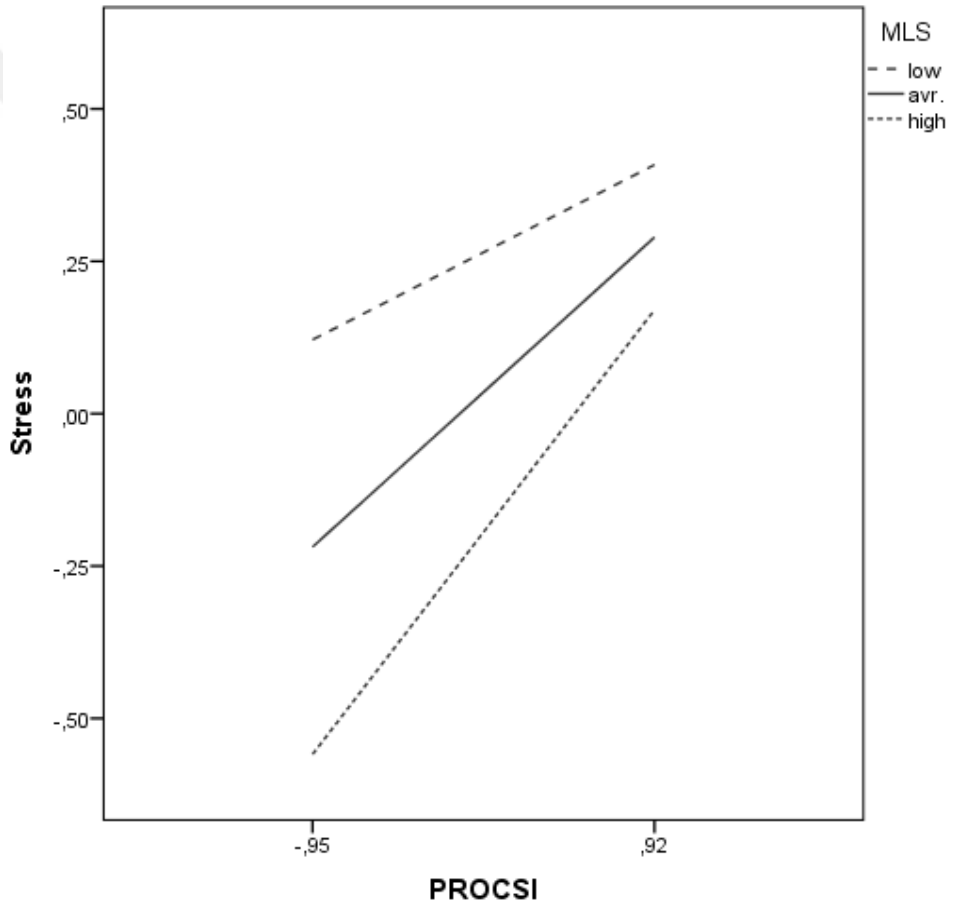

Figure 3.5: Interaction between partner focused OC symptoms and MLS in the prediction of stress symptoms.

CHAPTER VI

6. DISCUSSION

This study was conducted to investigate the moderator role of child-focused OC symptoms and variables related to marital life in the relationship between partner-focused OC symptoms with depression, anxiety, and stress. For this purpose, firstly, the psychometric properties of the Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC) which assesses the child-related OC symptoms were evaluated by adapting it to Turkish. Then, the proposed relationships between the variables were evaluated by using separate hierarchical regression analyses. In this section, firstly the validity and reliability results of the Turkish version of the PROCSI-PC will be discussed. Then, the results of the analyses that examined the relationships between the variables will be evaluated in accordance with the hypotheses of the research. After words, the limitations of the study and suggestions for future research will be included and finally the clinical implications of the research will be discussed.

6.1. Discussion of Psychometric Properties of the PROCSI-PC

For the validity and reliability study of the Turkish version of the PROCSI-PC, first the factor structure of the scale was evaluated. To understand whether the PROSCI-PC exhibits the same original 5 factor construct in the Turkish population parallel to the original form, confirmatory factor analysis and exploratory factor analysis were conducted. Principal Component Analysis with direct oblimin rotation was conducted to assess the construct validity of the scale. The obtained values showed that the data were suitable for factor analysis. Unlike the original form, the findings in this study indicate 4 factor structure with eigenvalues greater than 1. The 4-factor structure of the

scale, which was determined by using exploratory factor analysis, was re-tested by using confirmatory factor analysis. The fit indexes were found to be acceptable.

When the items of PROCSI-PC are examined in detail, it is seen that the items loaded to the factors of Emotional Stability and Sociability in the original scale distributed to the factors of Intelligence, Morality and Competence. Considering the items in detail and the structure of the Turkish language, which is able to interpreted in many different ways, it is thought that the expressions which belong to the concepts of Emotional Stability and Sociability might be perceived by Turkish participants as the concepts of Intelligence, Morality and Competence. For example, the item “I keep trying to compensate for my child’s social deficiencies” which is in the Sociability factor in the original scale loaded to Competency factor in this study. It is clearly seen that the expression of “social deficiencies” in the item was perceived as a competency situation by the participants. In addition, the item “I am bothered by doubts about my child’s emotional stability”, which loads to the factor of Emotional Stability in the original scale, loaded to morality factor in our study. Here, it is thought that parents might associate emotional instability with the morality of their children. Also in the item 12, parents compare their children's emotional reactions to other children's emotional reactions. It is possible that the parents may associate this situation with the intelligence level of their children (“I find it difficult to control my tendency to compare my child’s emotional responses to those of other children”). Similar explanations are also possible for other items. The items loaded to the factor of Appearance are about the physical characteristics of the child (e.g. When I am with my child, her / her physical flaws) which include more concrete expressions and are not easily interpreted in different ways, so they did not load to any other factors. Additionally, none of the items of Emotional Stability and Sociability factors loaded to Appearance factor.

For concurrent validity of the PROCSI-PC scale, correlations between the PROCSI-PC, PROCSI and DASS scales were investigated. The PROCSI-PC and its subscale scores showed significant but not high correlations with the PROCSI and DASS. This indicated that the PROCSI-PC was correlated to a certain extent with the PROCSI and DASS but still measures a different and independent concept.

In order to evaluate the predictive validity, hierarchical regression analysis was performed in which the DASS, MLS, DAS and PROCSI-PC scores predicted the PROCSI total score. The PROCSI-PC scores significantly predicted partner focused OC symptoms when controlled for all other variables (marital satisfaction and dyadic adjustment as well as depression, anxiety and stress). These findings indicate that the parent-child focused OC symptoms have an impact on the partner-focused OC symptoms beyond the effects of general mental health, marital satisfaction, and marital adjustment measures.

As a result of the reliability analysis, the PROCSI-PC and its subscales were found to have high internal consistency coefficients in parallel with the values of the original study. These findings indicated that the PROCSI-PC had acceptable reliability. In summary, the results of the study indicated that the Turkish version of the PROSC-PC which was developed to better understand the nature of the parent-child focused obsessions and compulsions, had satisfactory reliability and validity values.

Adaptation of the PROCSI-PC into Turkish will enable to conduct future studies which will contribute to a better understanding of OCD. As stated before OCD is a disorder with heterogeneous symptom profile, one of which is parent-child related OC symptoms. Both partner related and parent-child related OC symptoms are the recently focused symptom types in the OCD literature. Therefore, the Turkish version of the PROCSI-PC will allow new studies to be conducted on parent-child centered OC symptoms in Turkey, and also allow to make reliable comparisons in cross cultural studies. However, in the current study validity and reliability analyses were performed using non-clinical sample. In order to increase the generalizability of the current study findings to clinical sample, the study should be repeated with OCD patients who complain about parent-child focused OC symptoms.

6.2. Discussion of the Associations between the Main Variables and the Moderation Effects

Based on the hypotheses of the study, it was tested whether there is a relationship between partner focused OCD symptoms and parent-child focused OCD symptoms. The results of the correlation analysis showed that there was a significant positive relationship between partner focused OCD symptoms and parent-child focused OCD symptoms. In the study conducted to develop the PROCSI-PC scale, Doron, Derby and Szepsenwol (2017) predicted that parents being engaged in obsessions with their children and being obsessed with the defects of their romantic partners might reflect a similar problem and might be evaluated in a similar way. The results obtained from this study supported the suggestions of Doron, Derby and Szepsenwol (2017). When the results of the current study were examined, it has seen that if the individuals have obsessive thoughts about their partner, this situation can be transferred to their children. This finding can be explained by the general obsessional tendency of the individual about the people whom the person is in close relationship. More specifically, this situation can also be interpreted as a reflection and transfer of individuals' obsessional thoughts about the deficiencies in their partners to their children. It is known that parents' attitudes and genetic predispositions play an important role in the development of children. Considering these, it is possible that the spouse who has beliefs related to the insufficiency of his/her partner's intelligence, appearance, morality, sociability and so on, might also has a belief that these flaws are transferred to their children by genetically or by child rearing styles.

In this study, one of the hypotheses was that there would be a relationship between marriage-related factors (marital satisfaction and adjustment) and partner focused OCD. Marital satisfaction and marital adjustment were evaluated as marriage-related factors in this study. These concepts are generally used to describe the quality of marriage (Akar et al., 2005: 39). Marriage satisfaction is defined as the perceptions and the expectations of the individuals from the marital relationship and the degree to which their needs are met (Tezer, 1996). Marital adjustment is defined as a marriage away from conflict, where spouses agree on important issues, enjoy the same leisure

activities, and show emotional affinity to each other (Spanier, 1972). In addition, according to Spanier (1972), highly compatible couples are defined as mature, balanced, concordant and coherent individuals from unproblematic families. Therefore, in this study, it was proposed that there would be an association between partner focused OC symptoms and marriage satisfaction and marital adjustment, and the findings of the study supported this hypothesis. As the partner focused OC symptoms increase, marital satisfaction and adjustment decrease. These results are consistent with the previous findings in the literature (Doron et al., 2012b: 234), which indicated that the relationship satisfaction and partner focused OCD symptoms were related with each other. Since this finding only reflects the correlational relationship between the two variables, it is very possible to interpret these results in two different ways. Firstly, if the individuals have obsessive thoughts about their spouses' deficiencies, as these obsessive thoughts increase some problems in the marriage might emerge and decrease the perceived satisfaction from their partner and disrupt the harmony between them. Secondly, if the individuals do not get enough satisfaction from marital relationship, and if there is no agreement between them, individuals may exhibit partner-focused obsessive-compulsive symptoms. These two conditions can be the triggers of each other.

In the current study, it was also investigated whether there was a relationship between parent-child focused OCD symptoms and marital factors (marital satisfaction and adjustment). Correlation analysis showed a significant negative correlation between parent-child focused OCD symptoms and marriage-related factors. Individuals who are dissatisfied with marital relationships and cannot achieve the necessary harmony with their partner can show parent-child focused OC symptoms as well as partner focused OC symptoms. This may be a way of reflecting the dissatisfaction with their spouses to their children who are also part of their partner.

In addition, Doron et al. (2014) emphasized that ROCD is associated with "self-related processes". They stated that self-vulnerabilities can be important factors in the development of ROCD. Therefore, it is considered that the ROCD symptoms might be higher especially in cases where the person's value depends on the perceived value of the partner and the children. From this point of view, self-related processes should also

be considered while discussing the relationships between partner focused OC symptoms, child focused OC symptoms and the factors related to marital life.

As one of the most important hypotheses of the study, it was proposed that parent-child focused OC symptoms and marriage related factors would have moderator effects in the relationship between partner focused OC symptoms and depression, anxiety and stress (See Figure 1.1 for the proposed model).

In order to test the proposed moderator model, first of all, it was investigated whether there was a relationship between partner focused OC symptoms and depression, anxiety and stress. The findings of the regression analyses revealed that partner focused OC symptoms significantly and positively predicted depression, anxiety and stress. These findings supported the findings of Doron et al. (2012b) who also emphasized that there was a moderate significant relationship between the PROCSI and depression, anxiety and stress. These findings supported that the partner-focused OC symptoms have negative effects on the general mental health of the individuals. Therefore, it can be interpreted that such obsessive thoughts and behaviors related to partner might have a significant role in the levels of depression, anxiety and stress.

Secondly, it was examined whether there was a relationship between parent-child focused OC symptoms and depression, anxiety and stress. The findings of the regression analyses revealed that parent-child focused OC symptoms significantly and positively predicted depression, anxiety and stress. The results were consistent with the findings in the literature (Doron, Derby and Szepsenwol, 2017: 106), which indicate that depression, anxiety and stress symptoms are related with parent-child focused OC symptoms. These findings emphasized the possible negative effects of parent child ROCD symptoms on parents' mental health. Such obsessive parental attitudes for their children can disrupt the parent-child relationship and attachment bond between them, this can contribute to the increased levels of depression, anxiety and stress in both parents and children. In addition, parent-child ROCD symptoms can prevent enjoyable parenting experience with children, which may cause increased stress day by day.

Doron and Kyrios (2005) have revealed the relationship between OCD and self-worth based on the theory of Harter (1982, 1996). Harter's (1982, 1996) theory revealed that professional competence, academic competence, appearance, morality, athletic competence are important areas for individuals' self-worth. Doron and Kyrios (2005) have suggested that there are sensitive self-areas that are important in terms of self-worth and help individuals to identify themselves. Each individual's self-worth may be dependent on different areas. A study by Doron, Molding, Kyrios and Nedeljkovic (2008) showed that the self-worth of the individuals with OCD was dependent more on the areas of morality and business success than the other areas. In addition, studies have shown that partner-focused OC symptoms are associated with perceived partner-value contingent self-worth (Doron and Szepsenwol, 2015: 173). This self-vulnerability can be identified as individuals' over-reliance on the perceived value of their partners. Similarly, it has been suggested that child-centered OC symptoms may also be related to child-value contingent self-worth (Doron, Derby and Szepsenwol, 2017: 106). This self-vulnerability can be identified as parents' over-reliance on the perceived value of their child. From this point of view, the self-worth of some individuals might be effected by the perceived failures or defects of their partners or children.

As presented above, the findings of this study suggested that both partner and child focused OC symptoms are associated with depression, anxiety and stress. When these findings are evaluated in terms of partner and child-value contingent self-worth, individuals whose self-values are dependent on their partner/children might be preoccupied with the defects and failures in their partners/children. When they perceive their partners/children as defective and unsuccessful, their self-values might be damaged depending on the value of their partners/children and therefore they may exhibit symptoms of depression, anxiety and stress.

Moreover, the relationship between marriage-related factors and depression, anxiety and stress were investigated. The findings of the regression analyses revealed that marital satisfaction and adjustment significantly and negatively predicted depression, anxiety and stress in accordance with the research hypothesis. There are similar findings in the field which shows significant associations between marital

adjustment and satisfaction and depression, anxiety and stress levels (Abbas et al., 2019: 234). The findings of the current study supported that the general mental health of the individuals was affected by the problems in their marital relationship. When individuals cannot achieve the necessary harmony with partner in their marriages, this situation can cause a constant conflict between them and the peace in the home can be disturbed. In such a situation where the restlessness is dominant, it is quite normal for individuals to have negative effects on general mental health. In relationships which become tainted, the spouses do not agree on the important issues, do not like the same leisure activities and do not show emotional affinity with each other (Spanier, 1972). All of these factors might damage the relationship between them and might contribute to the increase in the symptoms of depression, anxiety and stress. In addition to marital adjustment, marital satisfaction, which is defined as the perceptions of individuals about their expectations and needs from the marriage (Tezer, 1996), also effects the general mental health of the individuals. The individuals who experience problems related to marital satisfaction or do not meet their expectations might also experience emotional problems and their general mental health might be adversely affected.

One of the most important findings of the study was the moderator effect of parent-child focused OC symptoms in the relationship between partner focused OC symptoms and depression and stress. The results of the regression analysis indicated that there was an interaction between partner focused OC symptoms and parent-child focused OC symptoms. The increase in the obsessive thoughts of the individuals towards their partners was related to the increase in depression and stress levels, when they have obsessive thoughts towards their children. Partner and child focused OC symptoms can single handedly elevate individuals' depression and stress levels. Beyond the main effects, the partner and child focused OC symptoms further elevate individuals' depression and stress levels when they are seen together. As it was explained before, individuals may identify their self-values with the values of their partners and their children (partner and child-value contingent self-worth), therefore individuals who perceive defects in both their partners and their children may see themselves as worthless because of the defects of their partners and their children. It is

understandable that, individuals who perceive themselves worthless, exhibit symptoms of depression and stress.

However, there were no moderator effect of parent-child focused OC symptoms in the relationship between partner focused OC symptoms and anxiety. Although both partner-focused OC symptoms and parent-child focused OC symptoms were significantly associated with anxiety symptoms, the interaction effect of these two variables was not significant. The OCD is inherently an anxiety disorder, although it has been subtracted from the sub-domain of anxiety disorders in the DSM-V. For this reason, it is thought that the partner and parent-child focused OC symptoms alone are sufficient to explain the anxiety level of the participants. Also, when the items of anxiety subscale of DASS-21 are examined, it is clear that anxiety symptoms are inherently more physical (e.g. “I was aware of dryness of my mouth”, “I experienced trembling (e.g. in the hands)” or “I was aware of the action of my heart in the absence of physical exertion” etc.). Therefore, the anxiety subscale of the DASS, might not represent the anxiety levels of the individuals in all aspects. In addition, considering the mean scores of the parent-child focused OC symptoms and the explained variance given above, it was thought that the parent-child focused OC symptoms did not significantly provide a contribution beyond the partner-focused OC symptom on the anxiety symptoms.

In terms of marriage related factors, marriage satisfaction plays a moderator role in the relationship between partner-focused OC symptoms and anxiety and stress. When individuals' marital satisfaction is low, the increase or decrease in obsessive thoughts towards their partners do not affect their anxiety and stress levels. Individuals have already showed symptoms of anxiety and stress due to low marital satisfaction. However, when individuals' marital satisfaction is high, anxiety and stress levels increase as the obsessive thoughts towards their partners’ increase. This is a very important finding of the current study that pointed out the interactional effects of the variables. Marriage satisfaction is defined as the perceptions of the expectations of the individuals from the marital relationship and the degree to which their needs are met (Tezer, 1996). The findings of the current study related to moderation effect indicated

that, having obsessive thoughts towards the partner causes more anxiety and stress for the individuals when the individuals' expectations of marital relationships are met and their satisfaction is high. Doron et al. (2014) emphasized that the intrusive thoughts of individuals towards their partners are ego dystonic and generally against individual's subjective experiences (e.g., "I love her, but I can't stop questioning my feelings"). For this reason, these unwanted thoughts can cause feelings like shame and guilt (Doron et al., 2014: 169). Our findings also supported this situation. Individuals may think that "these thoughts are coming to my mind even though I am happy in my marriage" and they may experience more shame and guilt. Moreover, the intrusive, uncontrollable and unwanted nature of these obsessional thoughts might increase the anxiety and stress symptoms of the individuals who are satisfied in their relationship.

However, there was no moderator effect of marital satisfaction in the relationship between partner-focused OC symptoms and depression although the main effects of both partner-focused OC symptoms and marital satisfaction on depression were significant. These results indicated that individuals' obsessive thoughts about their partners' flaws were important factors in explaining the level of depressive symptoms. Moreover, the decrease in the individuals' marital satisfaction also explained the depressive symptoms. However, the decrease in marital satisfaction does not lead a further increase in depressive symptoms beyond the effect of partner focused OC symptoms on depression.

In addition, there was no moderator effect of marital adjustment which was another hypothesized variable. Even though the study sample was normally distributed, the research hypothesis might work better in future research samples with higher representativeness, Since the sample was a nonclinical one, the means of the main variables were quite low, therefore the unsupported hypothesis should be investigated in future studies with clinical samples.

6.3. The Strengths and Limitations of the Study and Suggestions for the Future Research

This research was the first one in which Parent-Child Related Obsessive Compulsive Inventory (PROCSI-PC) was translated and adapted into Turkish. In addition, even though Doron et al. (2012b) pointed to the similarity between parent-child focused OC symptoms and partner-focused OC symptoms, to our knowledge the current study was the first one which investigated the relationship between partner focused and parent-child focused OC symptoms.

Another contribution of this study to the literature was that even though there were studies that showed the relationships between partner focused and parent-child focused OCD with depression, anxiety and stress (Doron, 2012b; Doron et al., 2017), in this study, it is the first time that in married couples with children, the moderator effect of parent-child focused OCD and marital factors in the relationship between partner focused OCD and depression, anxiety and stress were examined.

The most important finding of the study is that marriage satisfaction, which is generally considered to be a protective factor in the relationships, may have a different effect depending on the symptom type of the individuals. Anxiety and stress symptoms were found to be increased in individuals with obsessive thoughts towards their partners, although they were satisfied with their marital relationships. It was thought that this situation might be related with the feelings of guilt and shame as well as the unwanted and intrusive nature of the obsessions. With this respect, the findings of the moderational effects of the current study make an important contribution to the literature.

However, the research has also a number of limitations as well as contributions to the literature. The first limitation of the study was the non-clinical sampling. Doron et al. (2017) stated that participants with parent-child focused OCD might be different in terms of symptom-related impairment from non-clinical sample. This limits the generalizability of the findings to the clinical population. It will be more beneficial to

conduct future studies with individuals who are complaining about partner focused and parent-child focused OC symptoms. Even though the collection through online surveys has made it easier to reach participants from various cities in Turkey, it only allowed the data to be collected from users with digital literacy, thus this may be considered both as an advantage and a disadvantage. In the future studies, it would be more representable to collect the data both as an online survey and as a hard copy.

Another limitation of the study was that there was no measurement to evaluate the children in terms of the areas that the parents have concerns (e.g. academic achievement, psychopathology, mental or physical disability, etc.). The assessment of the children would be important in evaluating the realism of parents' concerns. Doron et al. (2017) also suggested that it would be useful to evaluate the relationships between parent-child ROCD symptoms and children's well-being and psychopathology. As indicated by Doron (2017) parent-child ROCD symptoms are thought to negatively affect the well-being and mental health of children. In future research, it would be beneficial to investigate the relationship between parent-child ROCD symptoms and well-being and mental health of children.

Finally, in this study data were collected only from one of the partners. However, data collection from both partners at the same time and the analysis of these data with dyadic analysis method would give more detailed information about the results.

6.4. Clinical Implications of the Research

The results of the study revealed some important findings that should be taken into account in the treatment of partner focused and/or parent-child focused OC symptoms. First of all, the results revealed a close relationship between partner-focused OCD and parent-child focused OCD. Therefore, if an individual expresses obsession related to individuals with whom he/she is in close relationship (partner or children), the therapist should consider the reflection of these obsessions to other people in the family.

Especially, individuals who report having obsessive thoughts about their spouses should be evaluated in detail whether they have similar obsessive thoughts related with their children. Moreover, the effect of having obsessive thoughts about the partner or child on general mental health of the individual should also be examined. Parent-child and partner-focused OC symptoms were also found to be related with depression, anxiety and stress, therefore the individuals with these types of obsessions should be evaluated in terms of their emotional state and general mental health. Depression, anxiety and stress have different kinds of etiological factors and intervention strategies. Therefore, the intervention strategies should be arranged if depression, anxiety and stress symptoms of the individuals are related with their obsessional thoughts. It would be more effective to follow strategies involving partners and children if individuals have obsessive thoughts towards their partner and children. If the obsession is towards both the partner and the children, the intervention strategies must be carried out in both ways. Finally, another important point is that marital satisfaction always thought to be a protective factor in the relationships. The findings of the current study pointed out that marital satisfaction is not actually a protective factor in individuals that have the partner-focused OC symptoms, in fact, it causes more anxiety and stress on individuals. Even though individuals are satisfied with their marriages, they blame themselves and feel the shame for having obsessive thoughts towards their partners. Therefore, in such cases, individual's feelings of guilt and shame should be studied and the uncontrollable, unwanted and intrusive nature of the obsessions should be explained to the patient.

In case of depressive symptoms, it was found that low marital satisfaction was alone effective on depression and stress symptoms of individuals. Therefore, addition of strategies to increase marital satisfaction and marital adjustment will be effective in alleviating the general mental health status of the individuals.

Finally, another important issue to be considered is partner and child-value contingent self-worth. If the self-value of individuals depends on their spouses and children, it is also important to work on the self-value of the patient during the therapy process.

6.5. Conclusion

The findings of the current study contributed to a better understanding of the limited etiology of the ROCD, which is a new emerging symptom type of OCD. Within the scope of this study, the adaptation study of the PROCSI-PC was conducted and it was concluded that the scale is a valid and reliable measurement tool. By this measurement tool, it would be possible to investigate the parent child focused OCD symptoms in Turkish samples in future studies, and to make cross cultural comparisons. Moreover, it was found that partner-focused OC symptoms have a relation with both parent-children focused OC symptoms and depression, anxiety and stress. Also, parent-children focused OC symptoms and marriage related factors have moderator roles in this relationship. To sum up, the findings of the current study revealed important results which contributes to the literature which has limited studies related to ROCD's etiology and the development of new treatments.

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APPENDICES

Appendix A: Demographic Information Form

Katılımcı Kodu: _____

Tarih: _____

Sizden, diğer ölçekleri cevaplandırmadan önce öncelikle aşağıda kişisel bilgilerinizle ilgili olan soruları cevaplandırmanızı rica ediyoruz.

1. Cinsiyetiniz: ☐ Kadın ☐ Erkek

2. Yaşınız:……

3. Evlenme Yaşınız:……

4. Eşinizin Evlenme Yaşı: ……

5. Nasıl evlendiniz? ( )Görücü usulü/ isteyerek ( ) Görücü usulü/ istemeyerek
( )Severek (anlaşarak) ( ) Diğer ……

6. Eşinizle beraberlik sürelerinizi aşağıdaki seçeneklerin karşısına yazınız:
a) Arkadaşlık süresi: _____ b) Flört süresi: _____
c) Nişanlılık süresi: _____ d) Evlilik süresi: _____

7. Bu sizin kaçıncı evliliğiniz?..... 8. Eşinizin kaçıncı evliliği: ……..

9. Çocuğunuz var mı? ( ) Yok Var ( ) 1 ( ) 2 ( ) 3 ( ) 4 ve üstü

10. Eğitim durumunuz: ☐ Okuryazar değil ☐ Okuryazar ☐ İlkokul mezunu
☐ Ortaokul mezunu ☐ Lise mezunu ☐ Üniversite mezunu ☐ Lisanstüstü

11. Eşinizin eğitim durumu: ☐ Okuryazar değil ☐ Okuryazar ☐İlkokul mezunu
☐ Ortaokul mezunu ☐ Lise mezunu ☐ Üniversite mezunu ☐ Lisanstüstü

Appendix B: Marital Life Scale (MLS)

Examples of Items

1. Evlilikten beklediklerimin çoğu gerçekleşti.

( )	( )	( )	( )	( )
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

2. Evliliğimizdeki engellerin aşılamaz olduğunu düşünüyorum.

( )	( )	( )	( )	( )
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

3. Evliliğimizi çok anlamlı buluyorum.

( )	( )	( )	( )	( )
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

4. Evliliğimizde giderek eksilen heyecan beni rahatsız ediyor.

( )	( )	( )	( )	( )
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

5. Evliliğimiz zaman zaman bana bir yük gibi geliyor.

( )	( )	( )	( )	( )
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

6. Huzurlu bir ev yaşamım var.

( )	( )	( )	( )	( )
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

Appendix C: Partner Related Obsessive Compulsive Symptom Inventory (PROCSI)

Aşağıda insanların romantik ilişkilerinde yaşayabilecekleri deneyimlere ilişkin ifadeler yer almaktadır. Sizin yakın ilişkilerinizde neler yaşadığınızı değerlendirmek istiyoruz. Lütfen aşağıdaki ifadelerin yakın ilişkilerinizde deneyimlediğiniz düşünce ve davranışları ne ölçüde yansıttığını belirtiniz. "Partner" ifadesiyle romantik ilişki içinde olduğunuz kişi (eş, sevgili, nişanlı, sözlü vb.) kastedilmektedir.

Rakamlar aşağıda görülen sözlü ifadelere denk gelmektedir:

Bana hiç uygun değil.	Bana biraz uygun.	Bana orta düzeyde uygun.	Bana oldukça uygun.	Bana çok uygun.
0	1	2	3	4

Examples of Items

1.	Partnerimin sahip olduğu ahlak düzeyinden memnunum.	0	1	2	3	4
2.	Partnerimin sosyal becerilerini tekrar tekrar gözden geçiririm.	0	1	2	3	4
3.	Partnerimin yeterince akıllı ve derinlik sahibi biri olup olmadığını sürekli sorgularım.	0	1	2	3	4
10.	Partnerimin hayatta "bir şey başarma" becerisini sürekli diğer kadın/erkeklerinkiyle karşılaştırırım.	0	1	2	3	4
15.	Her gün, partnerimin "iyi ve ahlaklı" bir insan olmadığı düşüncesinden rahatsız olurum.	0	1	2	3	4
16.	Partnerimin zeka seviyesinden memnunum.	0	1	2	3	4
18.	Partnerimin sosyal konulardaki beceriksizliğine ilişkin düşünceler beni her gün rahatsız eder.	0	1	2	3	4
20.	Partnerimin ahlak düzeyini sürekli incelerim.	0	1	2	3	4
25.	Zihnim partnerimin hayatta başarılı olup olmayacağını değerlendirmekle çok meşguldür.	0	1	2	3	4
27.	Partnerimi düşündüğümde, modern dünyada başarılı olabilecek türden biri olup olmadığını merak ederim.	0	1	2	3	4
28.	Sürekli, partnerimin iş hayatındaki başarısına dair kanıt ararım.	0	1	2	3	4

Appendix D: Dyadic Adjustment Scale (DAS)

İlişikte, çiftler hakkında bazı cümleler bulunmaktadır. Size uyan seçeneğe (x) işareti koyunuz. Hiç bir cümle için uzun uzun düşünmeyiniz. Mümkün olduğu kadar çabuk ve samimi cevaplar veriniz Kararsızlığa düşerseniz, aklınıza gelen ilk seçenek doğrultusunda hareket ediniz. Lütfen, her cümleyi cevapladığınızdan emin olunuz.

Examples of Items

	Her zaman anlaşırız	Hemen her zaman anlaşırız	Arada bir anlaşamayız	Sıkça anlaşamayız	Hemen hiç anlaşamayız	Hiç anlaşamayız
1. Aile gelirinin idaresi						

	Her zaman	Çoğu zaman	Yeterince	Ara sıra	Nadiren	Hiçbir Zaman
16. Boşanmayı, ayrı yaşamayı veya ilişkinizi sonlandırmayı ne sıklıkta tartışıyor veya düşünüyorsunuz?						
22. Eşinizle ne sıklıkta birbirinizi sinirlendirecek şeyler yaparsınız?						

	Her Gün	Hemen her gün	Ara sıra	Nadiren	Hiçbir zaman
23. Eşinizi öper misiniz?					

	Hepsini	Çoğunu	Bazılarını	Çok azını	Hiç birini
24. Eşinizle ev dışındaki meraklarınızın ne kadarını birlikte gerçekleştirirsiniz?					

Aşağıdakilerin siz ve eşiniz arasında ne sıklıkta olduğunu söyleyebilir misiniz?

	Hiçbir zaman	Ayda birden az	Ayda bir veya iki defa	Haftada bir veya iki defa	Günde bir defa	Günde birden fazla
25. Heyecan verici, keyifli fikir alışverişleri						
28. Bir konu üzerinde beraber çalışma						

Appendix E: Parent-Child Related Obsessive Compulsive Symptom Inventory (PROCSI-PC)

Examples of Items

Bana hiç uygun değil 0	Bana biraz uygun 1	Bana orta düzeyde uygun 2	Bana oldukça uygun 3	Bana çok uygun 4

1.	Çocuğumun sahip olduğu ahlak düzeyinden memnunum.	0	1	2	3	4
2.	Çocuğumun sosyal becerilerini tekrar tekrar gözden geçiririm.	0	1	2	3	4
7.	Çocuğumun duygusal olarak dengesiz olduğu fikrini zihnimden uzaklaştırmakta zorlanırım.	0	1	2	3	4
8.	Çocuğumun yeterince zeki olup olmadığı konusunda çevremdeki insanlardan (arkadaşlarımdan, ailemden vs.) sık sık onay ararım.	0	1	2	3	4
9.	Çocuğumla birlikteyken onun fiziksel kusurlarını görmezden gelmekte zorlanırım.	0	1	2	3	4
10.	Çocuğumun hayatta "bir şey başarma" becerisini sürekli olarak diğer çocuklarınkiyle karşılaştırırım.	0	1	2	3	4
11.	Çocuğumun zekâ seviyesini sürekli olarak diğer çocuklarınkiyle karşılaştırırım.	0	1	2	3	4
12.	Çocuğumun duygusal tepkilerini diğer çocuklarınki ile karşılaştırma eğilimimi kontrol etmekte zorlanırım.	0	1	2	3	4
19.	Çocuğum aklıma her geldiğinde görünüşündeki kusurları düşünürüm.	0	1	2	3	4
20.	Çocuğumun ahlak düzeyini sürekli incelerim.	0	1	2	3	4
21.	Sürekli, çocuğumun sosyal yetersizliklerini telafi etmeye çalışırım.	0	1	2	3	4
22.	Çocuğumun duygusal olarak dengesiz olduğuna ilişkin şüpheler beni rahatsız eder.	0	1	2	3	4
26.	Çocuğumun fiziksel kusurlarını diğer çocuklarınki ile karşılaştırma konusunda kontrol edemediğim bir dürtü hissederim.	0	1	2	3	4
27.	Çocuğumu düşündüğümde, modern dünyada başarılı olabilecek türden biri olup olmadığını merak ederim.	0	1	2	3	4
28.	Sürekli, çocuğumun iş hayatındaki potansiyel başarısına dair kanıt ararım.	0	1	2	3	4

Appendix F: Depression Anxiety Stress Scale (DASS)

Examples of Items

NO	SON 1 HAFTADAKİ DURUMUNUZ	Hiçbir zaman	Bazen ve ara sıra	Oldukça sık	Her zaman
1 S	Gevşeyip rahatlamakta zorluk çektim	0	1	2	3
2 A	Ağzımda kuruluk olduğunu farkettim	0	1	2	3
3 D	Hiç olumlu duygu yaşayamadığımı farkettim	0	1	2	3
4 A	Soluk almada zorluk çektim *(örneğin fizik egzersiz yapmadığım halde aşırı hızlı nefes alma, nefessiz kalma gibi)*	0	1	2	3
5 D	Bir iş yapmak için gerekli olan ilk adımı atmada zorlandım	0	1	2	3
6 S	Olaylara aşırı tepki vermeye meyilliyim	0	1	2	3
7 A	Vücudumda *(örneğin ellerimde)* titremeler oldu.	0	1	2	3
8 S	Sinirsel enerjimi çok fazla kullandığımı hissettim	0	1	2	3
9 A	Panikleyip kendimi aptal durumuna düşüreceğim durumlar nedeniyle endişelendim.	0	1	2	3
10 D	Hiçbir beklentimin olmadığı hissine kapıldım	0	1	2	3
11 S	Kışkırtılmakta olduğumu hissettim	0	1	2	3
12 S	Kendimi gevşetip salıvermek zor geldi	0	1	2	3
13 D	Kendimi perişan ve hüzünlü hissettim	0	1	2	3
14 S	Herhangi bir şekilde *geciktirildiğimde (asansörde, trafik ışıklarında, bekletildiğimde)* sabırsızlandığımı hissettim	0	1	2	3
15 A	Panik haline yakın olduğumu hissettim	0	1	2	3
16 D	Neredeyse her şeye karşı olan ilgimi kaybettiğimi hissettim	0	1	2	3
17 D	Birey olarak değersiz olduğumu hissettim	0	1	2	3
18 S	Alıngan olduğumu hissettim	0	1	2	3
19 A	Fizik egzersiz söz konusu olmadığı halde kalbimin hareketlerini hissettim *(kalp atışlarımın hızlandığını veya düzensizleştiğini hissettim)*	0	1	2	3
20 A	Geçerli bir neden olmadığı halde korktuğumu hissettim	0	1	2	3
21 D	Hayatın anlamsız olduğu hissine kapıldım	0	1	2	3

Appendix G: Informed Consent Form

Bu araştırma Psikolog Elif PARLAPAN BAŞ tarafından, Abant İzzet Baysal Üniversitesi Sosyal Bilimler Enstitüsü Psikoloji Bölümü Klinik Psikoloji Ana Bilim Dalı Yüksek Lisans Tezi olarak Doç. Dr. Müjgan İNÖZÜ danışmanlığında yürütülmektedir. Çalışmaya katılmaya karar vermeden önce çalışmanın neden ve nasıl yapılacağını anlamanız oldukça önemlidir. Bu nedenle lütfen biraz zaman ayırarak aşağıdaki bilgileri dikkatlice okuyunuz ve isterseniz başkalarıyla tartışınız. Açık olmayan bir bölüm varsa veya daha ayrıntılı bir bilgiye ihtiyaç duyarsanız lütfen bizimle iletişime geçiniz. Bu araştırmaya katılmayı kabul etmeniz durumunda sizden partneriniz/eşiniz ve çocuklarınız ile aranızdaki ilişkinin niteliğine yönelik bazı soruları cevaplandırmanız istenecektir. Ölçek setinde yer alan soruların cevaplandırılması yaklaşık 30 dakika alacaktır. Çalışmaya katılım gönüllülük esasına dayalıdır. Tüm veriler, size verilecek bir katılımcı kodu ile saklanacak, hiçbir yerde kimliğinize ilişkin herhangi bir bilgi kullanılmayacaktır. Ayrıca, isminizi veya imza gibi kimliğinizi belirtecek herhangi bir bilgiyi bu onam formu dışındaki hiçbir yazılı forma yazmamalısınız. Onam formları sadece araştırmanın yürüttücüsü tarafından ulaşılabilen kapalı bir yerde muhafaza edilecektir. Ölçeklerde istemediğiniz sorulara cevap vermek zorunda değilsiniz, ancak araştırmada sağlıklı veriler toplanabilmesi için mümkün olduğu kadar eksik soru bırakmamanız ve sorulara içtenlikle cevap vermeniz önemlidir. Eğer araştırma ile ilgili şimdi, ölçekleri doldururken veya görüşme sırasında herhangi bir soru aklınıza gelirse lütfen bunu araştırmacı ile paylaşınız. Sorduğunuz bütün sorular araştırmacı tarafından büyük bir içtenlikle cevaplandırılacaktır. Ayrıca bu çalışmadan herhangi bir neden belirtmeksizin, istediğiniz an çekilebilirsiniz. Çalışmadan çekilmeniz durumunda herhangi bir yaptırımla karşılaşmayacaksınız. Bu çalışmaya katılımınızdan dolayı hiçbir fiziksel, psikolojik, sosyal, ekonomik vb. risk ya da rahatsızlık yaşamayacağınız öngörülmektedir. Ancak, katılım sırasında sorulardan veya başka bir nedenden dolayı kendinizi kötü hissederseniz çalışmayı yarıda bırakma hakkına sahipsiniz. Ayrıca bu çalışmanın size rahatsızlık verme durumunda bu rahatsızlığı gidermekle yükümlüyüm. Bu çalışma sonunda elde edilen bilgiler sadece bilimsel amaçla kullanılacak ve hiçbir kimlik bilginiz paylaşılmayacaktır. Eğer siz de bu çalışmanın sonuçları hakkında bilgilendirilmek isterseniz bilgiler sizinle de

paylaşılacaktır. Bu araştırmaya katılımınız için sizden bir ücret istenmeyecektir. Size de bu katılımınızdan dolayı bir ücret ödenmeyecektir. Araştırma sonuçları, İstatistiksel Yöntemlerle analiz edip, işlenecek ve bunun sonucunda elde edilen bilgiler rapor edilip, Tez Jürisine sunulacaktır. Kabul görmesi halinde bulgular alan yazına kazandırılacaktır. Bu araştırma Abant İzzet Baysal Üniversitesi Araştırma Etik Komisyonu tarafından incelenmiş ve onaylanmıştır. Bu çalışma ile ilgili herhangi bir endişeniz veya sorunuz olursa tez danışmanı Doç. Dr. Müjgan İnözü (0312-2976323, mujganinozu@hacettepe.edu.tr) veya Psikolog Elif Parlapan Baş (elifprlpn@gmail.com, 507 012 0350) ile iletişim kurabilirsiniz.

Araştırmamıza vermiş olduğunuz destek ve yardım için şimdiden teşekkür ederiz.

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