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INTERGENERATIONAL TRANSMISSION OF RELATIONSHIP-RELATED OBSESSIVE COMPULSIVE SYMPTOMS: ROLES OF INSECURE ATTACHMENT STYLES AND PERFECTIONISM

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INTERGENERATIONAL TRANSMISSION OF RELATIONSHIP-RELATED OBSESSIVE COMPULSIVE SYMPTOMS: ROLES OF INSECURE ATTACHMENT STYLES AND PERFECTIONISM

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ABSTRACT

INTERGENERATIONAL TRANSMISSION OF
RELATIONSHIP-RELATED OBSESSIVE COMPULSIVE SYMPTOMS:
ROLES OF INSECURE ATTACHMENT STYLES AND PERFECTIONISM

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December, 2023

Looking through literature, it has been determined that there are numerous studies on Obsessive-Compulsive Disorder (OCD), but relatively few on Relationship-Related OCD (ROCD) symptoms which have been added to the literature in a decade , and there are even no studies on the intergenerational transmission of relationship-related OCD symptoms. Therefore, the aim of this study is to examine the mediating role of insecure attachment styles and perfectionism in the transmission of relationship-related obsessive-compulsive symptoms from mothers to offspring. The participants in the study consist of 139 late adolescents and mother dyads. The results revealed that both anxious attachment style and perfectionism, as well as avoidant attachment style and then perfectionism, played a serial mediating role in the relationship between parent-child-focused obsessive-compulsive symptoms and relationship-focused obsessive-compulsive symptoms. On the other hand, while the avoidant attachment style and then perfectionism had a serial mediating role in the relationship between parent-child-focused obsessive-compulsive symptoms and partner-focused obsessive-compulsive symptoms, it was found that anxious attachment style and perfectionism did not have a serial mediating effect on this relationship. The findings of the study were discussed through empirical data obtained from the literature. Based on attachment theory and techniques related to perfectionist tendencies, several

recommendations for therapeutic treatments aimed at the familial transmission of relationship-related obsessive-compulsive symptoms have been made.

Keywords: Obsessive Compulsive Disorder, Relationship-Related Obsessive Compulsive Symptoms, Romantic Relationships, Insecure Attachment Styles, Perfectionism, Intergenerational Transmission

ÖZET

YAKIN İLİŞKİ ODAKLI OBSESİF KOMPULSİF BELİRTİLERİN
KUŞAKLARARASI AKTARIMI:
GÜVENSİZ BAĞLANMA STİLLERİ VE MÜKEMMELİYETÇİLİĞİN ROLÜ

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Alanyazına bakıldığında obsesif kompulsif bozukluk (OKB) üzerine birçok çalışma yapıldığı, ancak alanyazına son yıllarda kazandırılan yakın ilişki odaklı OKB semptomları üzerine çalışmaların az olduğu, yakın ilişki odaklı OKB semptomlarının kuşaklararası aktarımına ilişkin çalışmanın ise olmadığı saptanmıştır. Bu nedenle, bu araştırmanın amacı yakın ilişki odaklı obsesif kompulsif belirtilerin anneden çocuğa aktarımında güvensiz bağlanma stilleri ve mükemmeliyetçiliğin rolünü incelemektir. Araştırmanın örneklemini 139 genç yetişkin ve anne çifti oluşturmaktadır. Sonuçlar sırasıyla hem kaygılı bağlanma stili ve mükemmeliyetçiliğin hem de kaçıngan bağlanma stili ve mükemmeliyetçiliğin ebeveyn-çocuk odaklı obsesif kompulsif belirtiler ile romantik ilişki odaklı obsesif kompulsif belirtiler arasındaki ilişkide seri aracı rolü olduğunu ortaya koymuştur. Diğer yandan, ebeveyn-çocuk odaklı obsesif kompulsif belirtiler ile partner odaklı obsesif kompulsif belirtiler arasındaki ilişkide kaçıngan bağlanma stili ve mükemmeliyetçilik seri aracı rolü oynarken, kaygılı bağlanma stili ve mükemmeliyetçiliğin bu ilişkide seri aracılık etkisi olmadığı saptanmıştır. Çalışmanın bulguları alan yazındaki ampirik bulgular temelinde tartışılmış ve yakın ilişki odaklı obsesif kompulsif belirtilerin ailesel aktarımını hedef alan terapötik uygulamalara yönelik bağlanma kuramı ve mükemmeliyetçi eğilimlere ilişkin teknikler temelinde çeşitli önerilerde bulunulmuştur.

Anahtar Kelimeler: Obsesif Kompulsif Bozukluk, Yakın İlişki Odaklı Obsesif Kompulsif Belirtiler, Romantik İlişkiler, Güvensiz Bağlanma Stilleri, Mükemmeliyetçilik, Kuşaklararası Aktarı

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For those who believe that the sun will rise again…

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OCD	Obsessive-Compulsive Disorder
ROCD	Relationship-Related Obsessive-Compulsive Disorder
RF-OC	Relationship-Focused Obsessive-Compulsive
PF-OC	Partner-Focused Obsessive-Compulsive
PC-OC	Parent-Child-Focused Obsessive-Compulsive
PROCSI-PC	Parent-Child Related Obsessive Compulsive Symptom Inventory
ROCI	Relationship Obsessive–Compulsive Inventory
PROCSI	Partner-Related Obsessive–Compulsive Symptoms Inventory
F-MPS	Frost-Multidimensional Perfectionism Scale
ECR-R	Experiences in Close Relationships-Revised

CHAPTER 1

INTRODUCTION

Relationships have profound impacts on human life. Starting from birth we bond with others and need their company. We also relate with others in many different ways and these relationships carry different meanings and functions across lifespan. As babies, we begin to form relationships with our caregivers so that our fundamental needs may be fulfilled, and we can feel protected (Bowlby, 1982). The construction of mental representations of others and us dates back to these times. On the other side, our need for social, emotional, and physical proximity emerges, particularly during adolescence (Erikson, 1968). The relationships we establish during this time are critical for identity development and our integration into the society we live in. Expanding on these theories about relationships, researchers, particularly in the field of clinical and developmental psychology, have carried out numerous studies and obtained comprehensive findings. While clinical research has mostly focused on the impact of relationships on mental disorders, developmental research has focused on the impact of relationships on the physical, cognitive, moral, social, and emotional development of humans.

As mentioned above, social, emotional, and physical interactions with others such as parents, romantic partners, friends, or other important figures have a significant impact on identity development during adolescence (Erikson, 1968; Furman & Shaffer, 2003). In this time of lifespan, interest in relating to others shifts from parental figures to peers (Josselson, 1988) and romantic relationships become pivotal, especially during late adolescence (Furman & Wehner, 1994). Supporting this, several studies indicated a significant association between feelings of belonging to someone romantically and the psychological well-being of an individual (Baumeister & Leary, 1985; Brabeck & Guzmán, 2009), underlining the protective role of close relationships against strains (Røsand et al., 2012). However, individuals with mental disorders may experience particular challenges in close relationships such as poor interpersonal communication (Chen et al., 2023) and sexual or relationship dissatisfaction (Doron et al., 2014b) due to the burden of symptoms caused by their mental disorders. One of those mental disorders is obsessive-compulsive disorder (OCD) which impairs the

quality of life and affects an individual's well-being, and social, family, and professional relations adversely (Coluccia et al., 2016; Schwartzman et al., 2017). Accumulating evidence has shown that the presence of OCD symptoms in a romantic relationship may disrupt the quality of romantic relationships (Angst et al., 2004; Abbey et al., 2007; Remmerswaal et al., 2016). Excessive controlling behaviors and communication problems, jealousy issues that emerge as a result of insecure attachment patterns, and compromised intimacy are some of the challenges that individuals with OCD and their partners face in their romantic relationships (Kasalova et al., 2020). Another area in which individuals with OCD have a lower quality of life is in their familial relationships (Coluccia et al., 2016). Likewise, individuals with OCD most commonly complain about symptoms that disrupt relations in the family context (Subramaniam et al., 2012). In addition to communication problems within the family, it has been determined that factors such as not being able to emotionally support each other and feelings of guilt disrupt the psychological and social functionality of both the individuals with OCD and their family members (Cicek et al., 2013). These findings lead researchers to consider children whose caregivers have the disorder and who can regulate their emotions and behaviors through interactions with their caregivers (Lincoln et al., 2017). In this regard, researchers begin to address the development and maintenance of OCD within the family system. A growing body of research has investigated how OC symptoms are transmitted from parent to offspring. Although limited in number, existing research revealed that obsessive beliefs are transmitted through genetic and environmental factors (Coppola et al., 2020; Hasani et al., 2021), yet the psychosocial mechanisms accounting for such transmission are still not well-defined.

Considering the debilitating impacts of OCD in close relationship issues, Relationship-related OCD (ROCD) also caught the attention of researchers. ROCD, which has specific symptoms being manifested in several relational contexts, briefly refers to obsessions associated with relationships and compulsions performed to relieve the distress caused by relational obsessions (Doron et al., 2012a; Doron et al., 2012b). Although it is a newly studied subject and the preliminary findings are inadequate, it has been proposed that the psychological processes in the development of ROCD might be similar to the ones that play a role in the genesis of OCD (Doron

et al., 2012b; Doron et al., 2014a). Nevertheless, despite the studies on the etiology of ROCD and its relationship with other psychosocial variables, no research has been conducted so far investigating the intergenerational transmission of ROCD symptoms.

Referring to this gap in the literature, the current study aimed to enlarge ROCD literature by examining two psychosocial mechanisms (i.e., attachment styles and perfectionism) that may account for the intergenerational transmission of ROCD symptoms from mothers to offspring. Accordingly, in the following section, OCD was conceptualized, and etiological factors were mentioned. Then, different subtypes of ROCD symptoms were introduced, and current studies in the literature on ROCD were explained. Grounding on the studies investigating the familial transmission of other psychopathologies, research on how OCD is transmitted across generations was discussed. Afterward, the theoretical framework of attachment styles and perfectionism which were hypothesized as possible psychosocial mechanisms that may be associated with the intergenerational transmission of ROCD was given. Lastly, the hypotheses of the study were presented with the proposed models.

1.1 Conceptualization of Obsessive Compulsive Disorder (OCD)

Obsessive-compulsive disorder (OCD) is an anxiety disorder characterized by disturbing thoughts (i.e., obsessions) and repetitive behaviors (i.e., compulsions) that the individual feels compelled to do, causing distress, and interfering with age-appropriate functionality (American Psychiatric Association, 2013). Although contamination and control-related intrusions are the most common types (McKay et al., 2004), OCD can be manifested through different thought contents and subsequent behavioral patterns including symmetry/order, fear of harming oneself and others, sexuality, religion, and contamination (Abramowitz et al., 2011). Obsessions cause individuals to suffer from significant anxiety, which are usually relieved by repetitive compulsive behaviors that coexist with intrusive thoughts (Clark, 2004). Compulsions are usually performed through lengthy rituals such as washing, checking, organizing, or neutralization such as repetition of certain words or numbers (Salkovskis, 1985; Abramowitz et al., 2011). In most of the cases, obsessions and compulsions are experienced together although some individuals experience obsessions or compulsions alone (Salkovskis, 1985). OCD has been conceptualized as an ego dystonic mental

disorder since obsessions are not under the voluntary control of the affected person (Salkovskis, 1985). Still, patients' insight into their obsessive beliefs might show variability. According to DSM-V, "good/fair insight" necessitates accepting the unrealistic nature of obsessions and compulsions to some degree while denying the irrationality of obsessive beliefs is counted as an indicator of either "poor" or "absent/delusional" insight" (APA, 2013).

According to several epidemiological studies, the lifetime prevalence of OCD ranged between 1.6% and 3.5% although the rate varies according to rural/urban regions or cultures (Ruscio et al., 2010; Nedeljkovic et al., 2011; Fineberg et al., 2013). In Turkey, women were found to have a greater prevalence of OCD (3.3%) than men (2.5%), but the difference was not statistically significant (Çilli et al., 2004). Moreover, while the prevalence of OCD declines with age in males, it follows an opposite trend among women. As for the onset of the disorder, it is rare to meet the diagnostic criteria before the age of 10 or after the age of 35 (Ruscio et al., 2010). Although not fully established, it has been stated by several researchers that OCD usually begins to emerge in late childhood or early-middle adulthood (Ruscio et al., 2010; Fineberg et al., 2013). OCD is not only observed in clinical samples, but the general population also display obsessive compulsive symptoms that do not require clinical intervention. Scientific research and clinical experience showed that intrusive thoughts, images, or impulses related to obsessions are experienced by many individuals on a daily basis (Clark & Purdon, 1993). Yet, dysfunctionality of the existing beliefs, themes in the value system, and cognitive biases are the factors predisposing individuals to the clinical diagnosis of OCD (Rachman, 2003). OCD also has high comorbidity with other mental disorders. In 76% of OCD cases, anxiety disorders such as social anxiety disorder, specific phobia, general anxiety disorder, and panic disorder are reported to co-occur with clinical-level obsessive-compulsive symptoms. Mood disorders, particularly depression, are also frequently observed among OCD cases (APA, 2013). In an epidemiological study, 75% of people with OCD had anxiety disorders, 55% had impulse control disorders, 38% had substance use disorders, and 63% had mood disorders (Ruscio et al., 2010). According to a study conducted in the psychiatry clinic of a hospital in Turkey, a higher comorbidity was found with major depressive disorder (Karamustafalıoğlu et al., 2009). Existing studies have pointed out that the rate of

comorbidity with early-onset OCD is higher than that of late-onset OCD (de Mathis et al., 2008). Consequently, it is of utmost importance to differentiate OCD from other comorbid mental disorders in terms of etiology, risk factors, and psychosocial outcomes.

1.1.1 Etiological Factors

The existing body of research suggested a complex interplay among genetic, biological, psychosocial, cultural, and cognitive factors in the development and maintenance of OCD. Firstly, twin studies have revealed that genes might play a role in the genesis of OCD (Pauls, 2010). Identical twins were found to be more likely than fraternal twins to display OCD symptoms (Van Grootheest et al., 2007). While relatives of adults with OCD are twice as likely to have the disorder, those of children with OCD are ten times more likely than control groups (Pauls, 2008). Although limited in number, neurochemical studies focus on serotonin and dopamine activations (Pauls, 2010), and changes in different structures of the brain, such as the amygdala, and thalamus. Gray matter abnormalities in anterior cingulate are also examined to identify the factors maintaining the symptoms of OCD (Szeszko et al., 2005; Via et al., 2014).

Extensive research has also been conducted to identify psychosocial correlates of OCD. Particularly, attachment, parenting styles, personality traits, stressful life events, and early childhood experiences were investigated to determine their possible roles in the formation of OCD symptoms. Psychosocial risk factors were initially covered and identified in the family context. A systematic review that included perceived parenting styles as a risk factor concluded that overly protective, rejecting, and uncaring parental attitudes have been linked with OCD symptoms (Brander et al., 2016). Having a demanding or authoritative parent who lacks emotional warmth may also play a role in the development and maintenance of the disorder. Furthermore, attachment has been proposed as another risk factor in the context of the family because attachment styles emerge during interactions with parental figures during childhood years (Bowlby, 1982). A recently published meta-analysis demonstrated that OCD symptoms were more strongly associated with anxious attachment style, while avoidant attachment was found to have a moderate association with OCD

symptoms (Van Leeuwen et al., 2020). In addition, there were no significant differences in terms of effect sizes across studies sampling either general population or OCD groups. Insecure attachment scores, on the other hand, were significantly higher in OCD groups when compared with the community samples. It has been suggested that the effect size differences measured in anxious and avoidant attachment styles could be explained by OCD's heterogeneous structure in terms of symptom manifestation and prognosis.

The researchers additionally examined psychosocial risk factors such as personality traits and stressful life events that were proposed to be related with the formation and maintenance of OCD symptoms. Firstly, it has been determined that personality traits such as self-confidence (Doron & Szepsenwol, 2015), self-worth (Doron & Kyrios, 2005), conscientiousness (Inchausti et al., 2015), and neuroticism (Fullana et al., 2019) may contribute to the development and maintenance of OCD symptoms. Secondly, according to recent reviews and meta-analyses, stressful and traumatic life events such as physical or emotional abuse or neglect, traumatic experiences with attachment figures, and sexual abuse might be potential risk factors for increasing the diathesis and stress for experiencing OCD symptoms (Brander et al., 2016; Fullana et al., 2019). Still, it has been underlined that such life events do not have a causal role in the development of OCD but rather interact with other cognitive and emotional processes in the genesis of the disorder (Brander et al., 2016).

Last but not least, maladaptive beliefs such as intolerance of uncertainty, perfectionism, inflated responsibility, overestimation of threat, and the importance of controlling thoughts have been determined to play an important role in the development and maintenance of OCD (Obsessive Compulsive Cognitions Working Group, 1997). Intolerance to uncertainty has been conceptualized as one’s biased emotional, cognitive, and behavioral responses that occur in situations of uncertainty (Freeston et al., 1994). Overestimation of threat, on the other hand, refers to a biased interpretation of the probability and frequency of any possible danger. Perfectionism is characterized by an excessive desire for every action to be flawless, the pursuit of perfect solutions to problems, and a belief that even seemingly minor mistakes may have serious consequences (OCCWG, 1997; Taylor et al., 2007). Inflated responsibility is related to the individual's belief to have a special power to prevent

negative consequences and to feel responsible for undesirable outcomes. Finally, the importance of controlling thoughts is defined as an excessive evaluation of intrusive thoughts, impulses, and images and it is the value placed on the presence of intrusive thoughts. Based on these conceptualizations, it has been theorized that such maladaptive cognitions can lead to catastrophizing the intrusive thoughts of the individual with OCD, thus increasing their avoidance and compulsive behaviors (Salkovskis, 1985). Several cross-sectional studies showed that these dysfunctional beliefs are involved in the development and maintenance of OCD (Taylor et al., 2007; Taylor et al., 2010). Perfectionism and intolerance of uncertainty, in particular, have been found to predict symmetry symptoms, while overestimation of threat and inflated responsibility beliefs are more closely related to contamination symptoms and intrusive thoughts regarding harming others (Wheaton et al., 2010). At the same time, some meta-analyses indicated that although maladaptive cognitions such as intolerance of uncertainty, inflated responsibility, and perfectionism are more associated with OCD, they might not only be specific to obsessive-compulsive disorder (Gentes & Ruscio et al., 2011; Pozza & Dèttore, 2014; Lunn et al., 2023; Taylor & Jang, 2011). In these meta-analyses, the effect size was found to range from medium to large for intolerance of uncertainty, while the same value was reported as moderate for the inflated sense of responsibility and perfectionism.

1.2 Relationship-related Obsessive Compulsive Disorder (ROCD) Symptoms

Obsessive-compulsive disorder (OCD) has a wide spectrum, involving multiple symptoms varying from person to person. Thus, OCD has a complex structure and includes several different subtypes (Abramowitz et al., 2008; McKay et al., 2004). This complexity results in challenges in diagnosing the correct subtype, measuring symptom severity (Taylor et al., 2007), and even developing effective treatment strategies (Clark & Beck, 2010). For this reason, it is of utmost importance to correctly diagnose the specific subtype of OCD, to determine its prognosis, and to use treatment strategies appropriate to that specific subtype. Identifying effective treatment strategies for OCD is essential for clinical work since the disorder has detrimental impacts in several domains of life including interpersonal relationships (Doron et al., 2014a).

Lately, clinicians and researchers have started to identify a particular symptom cluster while working with patients diagnosed with OCD. Individuals with this symptom cluster express intrusive thoughts and corresponding compulsions, particularly concerning close relationships, and such individuals view their relationship-oriented intrusions as more intense than the usual relationship-related worries (Doron et al., 2012a; Doron et al., 2012b). These thoughts and impulses have been determined to be incompatible with the individual's self and cause significant distress for the affected couples. Based on clinical cases with OC symptoms centering in close relationships, researchers emphasized that this phenomenon should be examined systematically, and the underlying mechanisms should be determined. Regardingly, relationship-related obsessive-compulsive disorder (ROCD) has been conceptualized as a new symptom cluster (Doron et al., 2012a; Doron et al., 2012b) lately. ROCD simply refers to the obsessions and compulsions related to dynamics of interpersonal relations and seems to be correlated with OCD symptom severity in general. In a very recent study, ROCD symptoms were found to have a moderate correlation with general OCD symptoms (Doron et al., 2012a) and was proposed as a possible subtype of OCD (Doron et al., 2016). Additionally, it was found that the clinical ROCD and OCD groups had higher symptom severity when compared with the community-control groups (Doron et al., 2014).

Concerning characteristics of ROCD, researchers in the field earlier indicated that OCD symptoms can be better conceptualized in terms of dimensions rather than distinct categories (Haslam et al., 2005), thus ROCD symptoms can also be seen at multiple degrees ranging from mild to severe (Doron et al., 2014a). Similar to other subtypes, they are usually experienced in the form of thoughts, urges, and images, and symptoms can manifest themselves in various relational contexts including intimate relations with parents, children, romantic partners, mentors, or even with God (Doron et al., 2014a; Doron et al., 2017). Although ROCD symptoms can be noticed in different relationship types, researchers mostly studied its manifestation in romantic relationships (Doron et al., 2014a). Based on clinical observations, an individual might experience ROCD symptoms in two different yet interrelated domains which are conceptualized as (1) relationship-focused OC (RF-OC) symptoms (Doron et al., 2012a) and (2) partner-focused OC (PF-OC) symptoms (Doron et al., 2012b).

1.2.1 Relationship-focused OC (RF-OC) Symptoms

Relationship-focused OC symptoms are manifested as exaggerated preoccupations and doubts about an individual's own feelings toward a romantic partner and a partner's romantic feelings and commitment (Doron et al., 2012a). It also includes symptoms of one's excessive worry regarding the rightness of the relationship. Individuals with RF-OC symptoms feel unsure about whether they really love their partners and/or whether their partners are truly in love with them, or they feel doubtful about the quality of the romantic relationship they have. To escape from uncomfortable feelings stemming from such obsessions and impulses, individuals may exhibit compulsive behaviors such as checking, seeking reassurance, engaging in social comparison, and neutralizing. More specifically, individuals with RF-OC symptoms try to control their partner by constantly questioning if they really love them and they seek reassurance from others by questioning whether their partner or relationship is right for them.

1.2.2 Partner-focused OC (PF-OC) Symptoms

The second domain, titled partner-focused OC symptoms, refers to the exaggerated preoccupations and doubts about the perceived flaws of a romantic partner (Doron et al., 2012b). Obsessions might center around the alleged defects related to the partner's physical appearance (e.g., ''She has big ears.''), sociability, morality (e.g., ''He may not be a good and moral person.''), emotional stability, intelligence, and competence (e.g., ''She is not good at her job.''). Similar to the RF-OC symptoms, corresponding compulsions are usually manifested through checking, engaging in downward comparison, reassurance seeking, and neutralizing (Doron et al., 2012a). Such individuals might constantly compare their partner's characteristics with others, seek confirmation about the partner's desirable characteristics, or try to find supporting evidence for their intrusions. Besides, they might be inclined to avoid situations that can trigger doubts about their partner's desirable characteristics (Doron et al., 2012b). These triggers can be both contextual and emotional (Doron et al., 2014a). Contextual triggers can be romantic cues (e.g., couples interacting), presence or absence of physical attraction, communicating with others having desirable characteristics (e.g., work colleagues), or discussing the commitment in the relationship. For example,

individuals may have compulsions such as comparing their partner to potential partners or movie stars, as well as trying to be sure of their feelings. Because of these compulsions, they may be reluctant to engage in social invitations or watch romantic movies with movie stars that they can compare with their partners. Despite the fact that compulsive behaviors and avoidance provide relief in the short term, they paradoxically contribute to the continuation of these obsessions, even exacerbation of them (Doron et al., 2012a; Doron et al., 2014a).

Until now, studies concentrating on two different subtypes of ROCD symptoms have revealed a variety of outcomes. For instance, relationship- and partner-focused OC symptoms seem to be closely related among individuals with relationship-related OC symptoms (Doron et al., 2012b). Preliminary studies conducted both cross sectionally and longitudinally suggested that questioning the alleged flaws of the partner may cause individuals to start questioning the relationship they are in, too (Doron et al., 2012b; Doron et al., 2016; Szepsenwol et al., 2016). Moreover, as reported by Doron and his colleagues (2014a), RF-OC symptoms may also initiate PF-OC symptoms. While questioning the correctness of the relationship or feelings about a partner, an individual may also exhibit behaviors of evaluating a partner's characteristics. Doron et al. (2014a) also specified that the ROCD symptoms of one of the romantically bonded couples might predict the ROCD symptoms of their partners. It is also found that high-level ROCD symptoms in one partner increased the other partner's ROCD symptoms, regardless of pre-existing ROCD symptoms prior to the romantic relationship (Litman et al., 2023).

1.2.3 Parent-Child Focused OC Symptoms

According to clinical observations, ROCD symptoms observed in romantic relationships can also be generalized to and manifested across different relationship types (Doron et al., 2014a) including the ones in parent-child dyads. Accordingly, researchers have started to investigate the parent-child focused subtype of ROCD (PC-ROCD). PC-ROCD has been used to refer to obsessive preoccupations with the perceived flaws of one’s own children and compulsive behaviors to mitigate the stress resulting from such preoccupations (Doron et al., 2017). Similar to the nature of PF-OC symptoms, parents with PC-OC symptoms are inclined to have doubts and

intrusive thoughts regarding their child's perceived defects in areas such as intelligence, physical appearance, sociality, morality, competence, and emotional stability. Such parents also engage in implicit or explicit compulsions through approval seeking and social comparison to negate the distress aroused by child related obsessions.

Though research on this novel subject is still in its infancy, existing findings underlining the interrelated nature of PC-OC and PF-OC symptoms indicate that PF-OC symptoms in romantic relationships may manifest when people become parents (Doron et al., 2017; Parlapan Baş, 2019). Studies on the psychosocial correlates of PC-OC symptoms also revealed that PC-OC symptoms have been reported to increase depression and anxiety symptoms and stress levels of an individual (Parlapan Baş, 2019). Studies have reported that another psychosocial correlate, the sense of self-worth dependent on the child, has an effect on the increase in these symptoms of parents (Doron et al., 2017; Levy et al., 2020). To explain briefly, when parents perceive their child as a failure, they can base their own values on that perception. As a result, an individual who begins to feel worthless because of the child-value contingent self-worth, may develop feelings of depression, anxiety, and distress (Doron et al., 2017). Although no studies have been carried out, it has been also theorized that PC-OC symptoms may interfere with individuals' parenting experiences, and that this problem may lead to a deterioration in the child's well-being and mental health (Doron et al., 2017; Parlapan Baş, 2019). Accordingly, future research is necessary to gain a better understanding of this symptom group, which has only recently been examined in the ROCD literature.

1.2.4 Prevalence and Characteristics of ROCD Symptoms

Since ROCD is a newly developing research line, studies are scarce as mentioned before. Although existing studies in the field are promising, they have not yet investigated the prevalence rate of this symptom cluster in the general population. Even though there exists no studies on population prevalence rates, it has been reported that ROCD has no significant relationship to gender (Doron et al., 2012b; Doron et al., 2014a), similar to the findings stating that the general type of OCD is more likely to

be seen in women but the difference across genders was not statistically significant (Çilli et al., 2004).

As regards to the characteristics of ROCD symptoms, obsessions observed across different subtypes of ROCD have been claimed to be ego-dystonic (Doron et al., 2014a) because they are opposing one's ideal self-image, beliefs, or personal values. Such relationship and/or partner related obsessions are unacceptable to the affected person and resulting in feelings of anxiety, shame, and guilt (Doron et al., 2014a; Doron et al., 2016; Doron & Derby, 2017). Another significant aspect of symptoms of ROCD is the difference from typical fears and doubts about the close relationships (Doron et al., 2012a). As Brickman (1987) illustrates, conflicts, having ambivalent emotions and attitudes towards partners, and doubts about the relationship are usual, especially at the beginning of a relationship. However, the symptoms of ROCD differ from these usual worries and doubts (Doron et al., 2012a) because these symptoms are described as undesirable, intrusive, and intense. They can also profoundly impact an individual's functionality. On the other hand, researchers stated that ROCD symptoms, although different from the usual worries and doubts, may be more intense at the beginning of the relationship, but these symptoms tend to subside over time as the duration of the relationship has extended (Szepsenwol et al, 2016; Bakçepınar, 2019; Tinella et al., 2023).

Even though the age of onset is still unknown for all subtypes, clinical reports suggested that ROCD symptoms usually begin in early adulthood and continue as the adult relationships are crystallized (Doron et al., 2014a). Symptoms may also begin with the long-term commitments such as getting engaged or having a baby in the later stages of life (Doron et al., 2012a; Doron et al., 2014a). In some rare cases, terminating a relationship can also activate ROCD symptoms as the individuals begin to feel that the previous partner was the only one, thereby avoiding forming a new romantic relationship (Doron et al., 2014a). Such individuals might refrain from committing to a new romantic partner since they feel anxious about the recurrence of ROCD symptoms. Nevertheless, being in an ongoing relationship causes symptoms to be experienced more severely than after the termination of the relationship.

1.2.5 Preliminary Findings about the Etiology and Psychosocial Correlates

Over the past decade, clinical observations have revealed that some individuals have a group of symptoms that conceptually overlap with general OC symptoms but these symptoms are also differentiated as they exclusively focus on close relationships. Consequently, there has been a dramatic increase in the number of studies particularly investigating psychosocial correlates of OC symptoms manifested in relational contexts. Although limited in number, existing studies to date have tended to mostly focus on the etiological factors of ROCD symptoms, associations of ROCD with different subtypes of OCD and with other mental problems, also; possible treatment strategies targeting particularly intrusions and obsessions observed in close relationships.

As for the etiological factors, it was found that the maladaptive beliefs affecting the development and maintenance of OCD are closely similar to those associated with ROCD symptoms (Doron et al., 2012a; Doron et al., 2012b; Doron et al., 2014a; Melli et al., 2018). Particularly, a small to moderate correlation was reported between ROCD symptoms, and cognitive biases and maladaptive beliefs (e.g., inflated responsibility, perfectionism, intolerance of uncertainty) commonly observed in other subtypes of OCD (Melli et al., 2018). For example, catastrophic beliefs about the future might manifest themselves in ROCD as beliefs that continuing or terminating a romantic relationship will have devastating consequences. Also, maladaptive perfectionist tendencies are found in rumination about the accuracy of a relationship or partner's characteristics (Doron et al., 2014a; Yıldırım, 2018). Contrasting with these findings, on the other hand, Melli and colleagues (2018) reported that such maladaptive beliefs did not predict ROCD symptoms when general stress was controlled. They concluded that OCD-related beliefs indirectly increased the general distress, thereby increasing and maintaining ROCD symptoms.

Grounding on the well-established evidence in OCD literature, attachment styles have also been started to be investigated to inspect their role in the development and maintenance of ROCD symptoms (Doron et al., 2013). Preliminary findings have yielded that insecure attachment, particularly anxious attachment, is associated with an increase in the intensity of ROCD symptoms (Doron et al., 2013; Yıldırım, 2018). It has been inferred that it is quite likely for the anxiously attached individuals to feel

insecure in a romantic relationship and this might result in aggravated suspicions against the partner and relationship quality. Supporting this, Özel and Karaköse (2023) have found that insecure attachment styles are associated with decreased marital satisfaction and lower marital satisfaction was associated with increased levels of ROCD symptoms in married couples. Similarly, RF-OC symptoms were found to mediate the relationship between attachment styles and the quality of marriage (Kabiri et al., 2017). In addition to studies about romantic relationship context, it is possible to see the role of insecure attachment styles in the context of relationships with parents. Confirming this, insecure attachment styles were reported to play a mediator in association between low parental care and ROCD symptoms (Trak & İnözü, 2019). Accordingly, a child's perception of neglectful behavior of parents may lead to development of an anxious attachment pattern. Although these behaviors of parents won't necessarily cause ROCD, they may contribute to its development through the potentiating impact of insecure attachment patterns.

Moving on now to explain another predisposing factor that has been limitedly studied in relation to ROCD symptoms is the early maladaptive schemas (EMSs) (Bakçepınar, 2019; Toroslu & Çırakoğlu, 2022). One of these limited studies, Toroslu and Çırakoğlu's (2022) study, discovered that all schema domains included in their study had a positive association with RF-OC and PF-OC symptoms. Regardingly, impaired autonomy, disconnection/rejection, and unrelenting standards were found to have a direct effect on both RF-OC and PF-OC symptoms. Intolerance of uncertainty mediated the association between these schema domains and RF-OC symptoms, while perfectionism mediated the association between these schema domains and PF-OC symptoms. Other directedness and impaired limits schema domains, on the other hand, were revealed to predict RF-OC symptoms only through intolerance of uncertainty while they predictED PF-OC symptoms through both intolerance of uncertainty and perfectionism. In another recent study, it was reported that the previously mentioned schema areas were positively and moderately associated with RF-OC and PF-OC symptoms and that these schemas mediated the relationship between childhood negative experiences such as emotional, physical, and sexual abuse or neglect and ROCD symptoms (Bilge et al., 2022).

Moreover, self-processes are found to be linked to ROCD symptoms. According to the researchers, individuals with ROCD symptoms tend to decide their self-worth based on their partners' or children's perceived flaws and they are more sensitive to their partner's or children's negative characteristics (Doron et al., 2014a; Doron et al., 2017; Trak & İnözü, 2019). It has been noted that such doubts about significant others or relationship quality are associated with lower levels of personal and relational self-esteem (Doron et al., 2012a; Doron et al., 2012b; Doron & Szepsenwol, 2015). Although research is scarce, existing findings have also indicated differential psychosocial correlates for partner-focused and relationship-focused symptoms, as well. For example, Trak and İnözü (2019) found a significant link between partner-value self-esteem and PF-OC symptoms but the same relationship did not emerge significantly with RF-OC symptoms. Similarly, while the interaction effect of anxious attachment and partner-value self-esteem mediated the link between rejecting parenting and PF-OC symptoms, the same mediation did not work on the link between rejecting parenting and RF-OC symptoms. Taken together, a growing body of evidence suggested that although they are conceptually similar and related, PF-OC and RF-OC symptoms might have different risk profiles and psychosocial implications. Supporting this, it has been revealed that RF-OC symptoms were negatively correlated with ego strength (Besharat et al., 2023) while feared self-beliefs were positively associated with both PF-OC and RF-OC symptoms (Fernandez et al., 2021). Another study contributed to this finding displaying that while paranoid traits predicted RF-OC symptoms, narcissistic predispositions predicted only PF-OC symptoms (Tinella et al., 2023).

In addition to the studies conducted to delineate etiological risk factors, researchers have attempted to investigate psychological problems that are associated with ROCD symptoms. Although limited in number, studies to date have yielded that ROCD symptoms are significantly associated with several negative personal and relational outcomes (Doron et al., 2016). More specifically, RF-OC symptoms are significantly linked to OCD-related symptoms, cognitions, mood, and relationship characteristics. Higher levels of RF-OC symptoms had a strong positive association with relationship dissatisfaction and depression even after controlling for OCD symptoms, and symptoms of other mental health problems (Doron et al., 2012a; Doron

et al., 2012b; Doron et al., 2013) and insecure attachment styles (Doron et al., 2012a). Similarly, PF-OC symptoms had a strong positive association with depression, anxiety, stress, low self-esteem, insecure attachment, and poor relationship satisfaction (Doron et al., 2012b). The relationship between PF-OC symptoms and depression remained significant even when RF-OC symptoms, insecure attachment, and low self-esteem were controlled. The same line of research also highlighted that poor relationship satisfaction and RF-OC symptoms might be interdependent factors mutually affecting each other and intensifying negative mental health outcomes (Doron et al., 2014a). Along with these findings, the researchers suggested that ROCD symptoms could have a detrimental effect on the sexual lives of individuals. A link was discovered between ROCD symptoms and sexual satisfaction (Doron et al., 2014b), also; relationship satisfaction mediated the link between poor sexual satisfaction and both dimensions of ROCD. These results are similar to those reported by Derby et al., (2021) stating that individuals with ROCD symptoms may experience sexual dysfunction during intercourse which eventually can cause sexual dissatisfaction. Following the idea that ROCD symptoms are significantly associated with relational outcomes, it has been revealed that individuals with ROCD symptoms have strong beliefs that their partners are untrustworthy (Brandes et al., 2020). It has been even reported that one partner's distrust of the other partner's infidelity builds the other partner's vulnerability to infidelity (Litman et al., 2023). Although extensive research has been carried out on PF-OC and RF-OC symptoms in the aforementioned contexts, a single study conducted by Doron and colleagues (2017) discovered that parental depression, OCD symptoms, and stress were significantly correlated to the PC-ROCD symptoms, as well.

In conclusion, preliminary studies on the etiology of ROCD, albeit limited in number, contribute to a better understanding of the development and maintenance of this symptom cluster. However, although studies in the emerging literature highlighted developmental aspects of the etiology of ROCD, they do not provide insight into the disorder's intergenerational transmission and which etiological factors might have a role in this transmission.

1.3 Intergenerational Transmission of ROCD

A growing body of research has started to investigate whether parental mental disorders impact the development of different or the same mental disorders among offspring. Despite lack of studies, existing findings have suggested that parental psychopathology is a serious risk factor in the development of children's psychological and developmental problems (Stein et al., 2014; Lawrence et al., 2019) which might persist into adolescence and adulthood (Goodman, 2007). Not surprisingly, most of the studies in the literature have focused on the transmission of depression since it is a common disorder among women, especially during and after childbirth (Goodman & Tully, 2006; Goodman, 2007; Goodman et al., 2011; Gotlib & Colich, 2014). These studies yielded that genetic factors play a significant role in the transmission of depression, but the importance of sociocultural and environmental factors cannot be underestimated. In this regard, it has been determined that the duration of exposure to the parent's depression symptoms during pregnancy or after birth, parenting, stressful childhood experiences, support received from co-parents or significant others, family income, parent's marriage status, and being in a minority group are all factors that should be considered in the intergenerational transmission of depression (Goodman, 2020). Aside from depression, there is also empirical evidence for the possible transmission of attention and hyperactivity disorder (Faraone & Larsson, 2019), schizophrenia (Wan et al., 2008; Gottesman et al., 2010), substance use disorder and alcoholism (Handley & Chassin, 2013); Coteţi et al., 2014), externalizing disorders such as antisocial personality disorder, conduct disorder, oppositional defiant disorder (Hicks et al., 2004; Bornovalova et al., 2010) and bipolar disorder (Stapp et al., 2020) from parent to child.

According to the studies conducted to investigate familial transmission of anxiety disorders, a child whose parent has an anxiety disorder is more likely to develop the disorder than a child whose parent does not have it (Ginsburg & Schlossberg, 2002; Beesdo et al., 2009). While earlier research has shown that children with parental OCD are at a greater risk of exhibiting internalizing symptoms, somatization, anxiety, and depression when compared to control groups (Black et al., 2003; Challacombe & Salkovskis, 2009; Frías et al. 2020), more current research indicates that these children are also vulnerable to develop OCD symptoms (Coppola

et al., 2020; Blanco-Vieira et al., 2021; Hasani et al., 2021; Macul Ferreira de Barros et al., 2021). Particularly, maternal OCD has been found to increase the risk for offspring OCD since the mother is still perceived as the main caregiver in most cultures (Frías et al., 2020). Although not completely clarified, researchers are investigating the potential mechanisms accounting for the intergenerational transmission of OCD. First, studies in the literature have already indicated that psychopathology is transmitted through genetic vulnerabilities or specific gene-environment interactions (Pauls, 2010; Jami et al., 2021; Kendler et al., 2023). This line of research underlined that the risk of OCD increases with kinship (Maliken & Katz, 2013) and despite different levels of shared environments, relatives of the same degree still bear similar risks of developing OCD symptoms (Mataix-Cols et al., 2013). Secondly, related literature also provides findings regarding environmental factors, particularly focusing on observation and modeling (Mahaffey, 2009; Rector et al., 2009; Pietrafesa et al., 2010). Accordingly, these studies explained the familial transmission of obsessive beliefs based on Bandura's (1977) social learning theory and suggested that the mother's overt behaviors regarding these beliefs are internalized by the child. Still, no direct effect of a parent's obsessive beliefs on the child's OC symptoms was found (Mahaffey, 2009) meaning that the child did not directly develop these symptoms in response to the maternal OCD through observation and modeling. However, the rearing style of a parent with obsessive beliefs may make the child vulnerable to development of the maladaptive beliefs observed in OCD symptoms. Thus, it has been revealed that critical, rigid, and overprotective parenting styles may have a role in increasing the risk of transmission of obsessive beliefs among children such as inflated responsibility, and overestimation of threat (Mahaffey, 2009; Lennertz et al., 2010; Timpano et al., 2010; Hofer et al., 2018). Although research is scarce, parental stress was also found to influence the association between the parent's OC symptoms and the child's OC symptoms (Coppola et al., 2020). It has been reported that there is a significant relationship between parenting stress and parental OC symptoms (Doron et al., 2017), and parenting stress is also found to be associated with the children’s OC symptoms (Keuthen et al., 2013). Regardingly, even if existing studies do not indicate the direct transmission of OC symptoms from mother to child, the mother's OC symptoms are suggested to be transmitted to the child through adverse impacts of

parenting stress (Coppola et al., 2020). According to these findings, the stress experienced due to parental identity causes the mother to neglect their child. Such mothers may display overly demanding or hostile behaviors, and as a result, the child's sense of responsibility may increase. Then, an inflated sense of responsibility may pose a risk against feelings of failure and inadequacy and such maladaptive belief patterns can make the child more vulnerable to OCD symptoms (Barcaccia et al., 2015).

Although promising research has been carried out on the intergenerational transmission of OCD lately, no single study exists investigating the possible transmission of ROCD symptoms from parents to children. Considering this gap in the literature, the intergenerational transmission of ROCD was discussed in the next section through two psychosocial mechanisms that are attachment styles and perfectionism. In the OCD literature, insecure attachment styles were found to be associated with an increased vulnerability to developing general OCD symptoms (Doron et al., 2012c; Boysan & Çam, 2016) and ROCD symptoms (Doron et al., 2013; Yıldırım, 2018; Özel & Karaköse, 2023). Also, as stated earlier, impact of perfectionism in the development and maintenance of OCD (Gentes & Ruscio et al., 2011; Pozza & Dèttore, 2014; Lunn et al., 2023), as well as its impact on ROCD, is well-known (Doron et al., 2014a; Yıldırım, 2018; Melli et al., 2018). Consequently, these two mechanisms were addressed from a developmental perspective in the following sections.

1.3.1 Attachment Theory

According to Bowlby (1982), attachment is an emotional bond providing a sense of protection and reassurance for the child in the context of danger or uncertainty. Sensitive and supportive parenting results in feelings of security for the child as a result of which a secure attachment style is established. On the other hand, when the parents are not present in times of personal crisis, an anxious or avoidant attachment is constructed. Interactions of the child with the parent and the consistency of the parental responses lay the foundation of internal working models (IWM) which refer to the child's mental schemas regarding self and others. While other-directed IWMs include perceptions and expectations about significant others, IWM of self is formed based on one’s self-worth. These schemas have profound and long-lasting impacts on

relationship quality, self-esteem, emotion regulation skills, and mental health outcomes throughout life (Mikulincer & Shaver, 2007). As mentioned earlier, it has been well-established in the literature that secure attachment protects against psychopathology, while insecure attachment styles are significantly associated with the development and maintenance of mental disorders (Doron, 2020). Specifically for OCD, emerging evidence has shown that insecure attachment may lead to the development of maladaptive beliefs about the world (e.g., not having a safe place) and the self (e.g., I am vulnerable to dangers), which in turn increase the risk for developing obsessive thoughts (Doron et al., 2007; Van Leeuwen et al., 2020). Aside from studies on general OCD, research in the ROCD literature also emphasized the possible role of attachment patterns, particularly the anxious attachment style in symptom manifestation (Doron et al., 2013; Yıldırım, 2018).

There is a growing body of research to delineate roles of insecure attachment styles in the intergenerational transmission of different mental disorders within families. Accordingly, researchers have been mostly focused on the mediation role of attachment styles in understanding familial transmission of post-traumatic stress disorder, trauma experiences and internalizing symptoms (Schwerdtfeger & Goff, 2007; Enlow et al., 2014). Although attachment styles did mediate the link between parent-to-child transmission of traumatic life experiences, the relationship between parental psychopathology and child internalizing behaviors was not mediated by insecure attachment styles (Reck et al., 2016). Although the number of intergenerational transmission studies involving attachment is still limited in number and obtained findings are mixed, several studies implicated that insecure attachment styles might play a pivotal role in developing OCD symptoms among children (Bogels & Brechman-Toussaint, 2006; Goli et al., 2019; Rezvan et al., 2013; Yarbro et al., 2013). Particularly, it has been postulated that anxious attachment style mediated the link between neglectful/strict parenting and obsessive beliefs among children (Yarbro et al., 2013). Given these findings and the relevance of insecure attachment styles in ROCD literature addressed before, attachment styles were considered as a theoretically sensible mechanism while understanding the intergenerational transmission of ROCD symptoms across generations.

1.3.2 Perfectionism

Perfectionism is a multidimensional concept that has been researched extensively to delineate its role in the maintenance of OCD symptoms. Perfectionism is characterized by an individual's striving for flawlessness and overly critical evaluations, as well as behaviors that develop in response to having high standards (Flett & Hewitt, 2002). It is also described as a persistent pursuit of reaching subjectively established goals despite the presence of adverse circumstances (Shafran et al., 1996). Hamachek (1978) investigated perfectionism essentially involving over-criticism, effort, and setting high standards in two separate dimensions. These dimensions are conceptualized as normal and neurotic perfectionism. Accordingly, neurotic perfectionists are unduly critical of themselves even in the face of small mistakes, while normal perfectionists can tolerate their own mistakes and still perceive themselves as successful. Hewitt and Flett (1991) further examined perfectionism under three dimensions referring to its nature as self-oriented, socially prescribed, and other-oriented perfectionism. The conceptualization here is mainly established based on to whom the perfectionist's thoughts and behaviors will be directed. On the other side, Frost et al. (1990) claimed that perfectionism can be more comprehensively conceptualized in six subfactors which are personal standards, organization, doubting of actions, concern over mistakes, parental expectations, and parental criticism. Personal standards are characterized by setting high standards and placing too much emphasis on those subjective standards. Doubts about whether a performance is good or not are characterized as doubting actions, whereas organization refers to giving excessive importance to order and organization. Concern over mistakes includes a fear of failure due to mistakes and the perception that even the smallest error represents failure. Finally, parental expectations and criticism refer to the subjective perception that the family members have high expectations for the individual and are overly critical. These dimensions are classified as adaptive or maladaptive in two upper dimensions.

There are several research in the literature that examine how adaptive and maladaptive thoughts of perfectionism impact mental health outcomes. Accordingly, adaptive perfectionism regarding personal standards and organization was found to be related to a positive attitude toward life and increased quality of life (Frost &

DiBartolo, 2002). In contrast, the maladaptive dimensions of perfectionism were closely linked to mental disorders (Frost & DiBartolo, 2002) including eating disorders (Czepiel & Koopman, 2021), depression (Smith et al., 2016) anxiety disorders, and OCD (Frost & DiBartolo, 2002; Lunn et al., 2023). Concerningly, the association between psychopathologies and perfectionism was found to have a medium to large effect size in recent meta-analysis studies underlining that perfectionism is an important cognitive factor in understanding the development and maintenance of different mental disorders (Limburg et al., 2017; Lunn et al., 2023). Specifically for OCD, existing findings have confirmed that perfectionism is a risk factor for OCD development, while meta-analysis studies measured the corresponding effect size as moderate (Gentes & Ruscio et al., 2011; Pozza & Dèttore, 2014; Lunn et al., 2023). Closely related to the aims of the current study, several studies have focused on the role of perfectionism as a mediator variable in explaining the relationship between insecure attachment styles and OCD symptoms. These studies have yielded that individuals with insecure attachment styles set unrealistic standards for themselves, have perfectionist tendencies, and make negative attributions to other people in an attempt to hide their perceived flaws and weakness (Mikulincer & Horesh, 1999; Mikulincer & Shaver, 2007; Rice at al., 2005; Rice & Mirzadeh, 2000; Yıldırım, 2018; Wei et al., 2004). Eventually, such perfectionistic tendencies set the ground for developing OCD.

In conclusion, existing studies conducted so far described perfectionism as an important cognitive risk factor for OCD symptoms and reported that perfectionism may operate as a mediator variable in explaining the relationship between different level diathesis and mental disorders. Yet, to the authors knowledge, there is currently very limited research that explicitly assesses the contribution of perfectionism in the intergenerational transmission of different mental disorders including OCD. Even if findings on the transmission of OCD are scarce, it has been proposed that that obsessive beliefs might have an effect on the association between parental OC symptoms and the child OC symptoms , yet the results are still inconclusive (Jacobi et al., 2006; Pietrafesa et al., 2010; Berman et al., 2018). Expanding on these findings, the current study aimed to understand the possible role of perfectionism in the

intergenerational transmission of ROCD symptoms to enhance the knowledge about the shared cognitive mechanisms of general OCD and ROCD symptoms.

1.4 The Aim of The Study

About a decade ago, a group of symptoms mainly centering on relationship related intrusions and over-compensatory behaviors have taken the attention of clinicians, which later gave payment to research efforts to delineate the nature and psychosocial correlates of this symptom cluster. Although this symptom cluster has not officially been accepted as a new mental diagnosis, its relationship with mental health and relational outcomes necessitates understanding the psychosocial mechanisms operating in the genesis and maintenance of ROCD symptoms (Doron et al., 2012a; Doron et al., 2012b; Doron et al., 2014a; (Doron et al., 2014b; Kabiri et al., 2017; Cebeci, 2019 Derby et al., 2021). Research carried out to this end mainly demonstrated that ROCD symptoms might share some common cognitive and psychosocial mechanisms with general OCD symptoms (Doron et al., 2012a; Doron et al., 2012b; Doron et al., 2014a; Melli et al., 2018). Yet, such research has been mostly restricted to possible etiological factors and psychosocial correlates of ROCD symptoms and no study has so far focused on the intergenerational transmission of ROCD symptoms from parents to children.

Consequently, the current study aimed to understand psychosocial factors that might be involved in the intergenerational transmission of ROCD symptoms. Based on the preliminary findings in the general OCD literature, attachment styles and perfectionism were conceptualized as two essential components that might account for the familial transmission ROCD symptoms. Because ROCD symptoms were initially described in relation to OCD symptoms (Doron et al., 2016), examining these two mechanisms in the familial transmission of ROCD may yield comparable results with the OCD literature. Also, due to the importance of romantic relationships during late adolescence (Furman & Wehner, 1994), it can be important to investigate RF-OC and PF-OC symptoms at this stage in life. Therefore, in the current study the role of insecure attachment styles and perfectionism in the intergenerational transmission of ROCD from mother to late adolescents were examined to clarify underlying

mechanisms of its transmission. Considering the existing literature, the following hypotheses were developed for this study.

1. Parent-child-focused ROCD symptoms of mothers will be indirectly related to relationship-focused ROCD symptoms of their children, and this relationship is sequentially mediated through first anxious attachment style and then perfectionism.

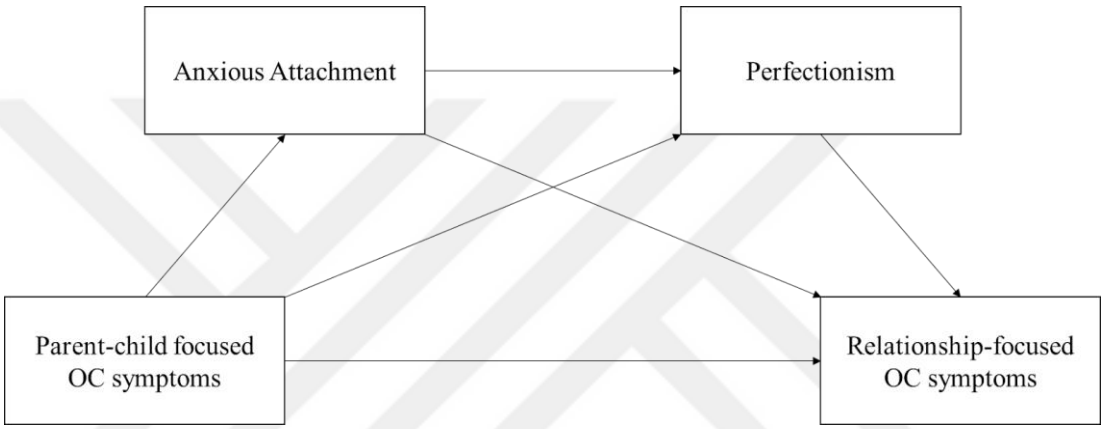

***Figure 1*:** Model of the Hypothesis 1

2. Parent-child-focused ROCD symptoms of mothers will be indirectly related to relationship-focused ROCD symptoms of their children, and this relationship is sequentially mediated through first avoidant attachment style and then perfectionism.

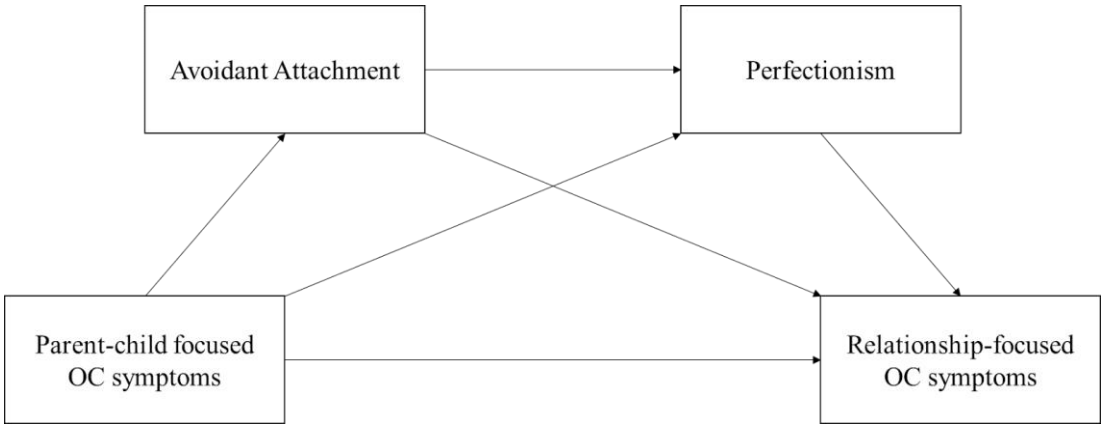

***Figure 2*:** Model of the Hypothesis 2

3. Parent-child-focused ROCD symptoms of mothers will be indirectly related to partner-focused ROCD symptoms of their children, and this association is sequentially mediated through first anxious attachment style and then perfectionism.

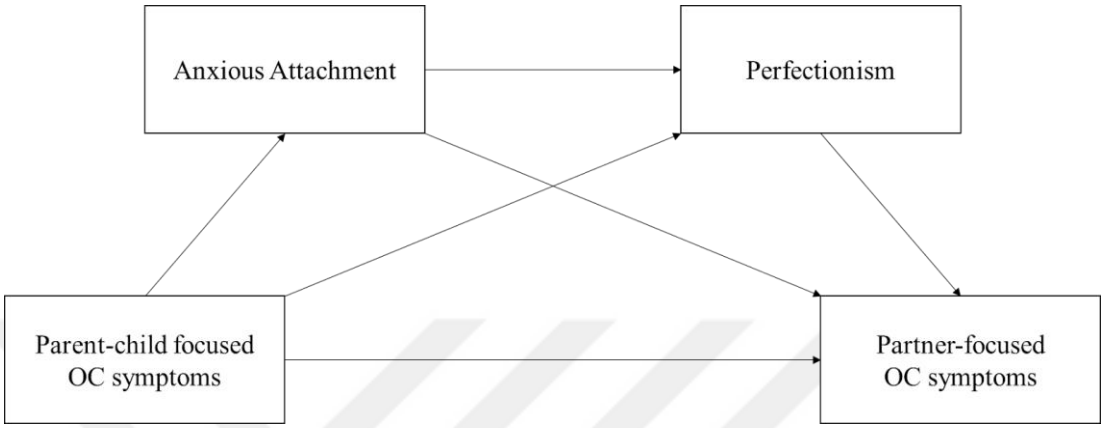

***Figure 3*:** Model of the Hypothesis 3

4. Parent-child-focused ROCD symptoms of mothers will be indirectly related to partner-focused ROCD symptoms of their children, and this relationship is sequentially mediated through first avoidant attachment styles and then perfectionism.

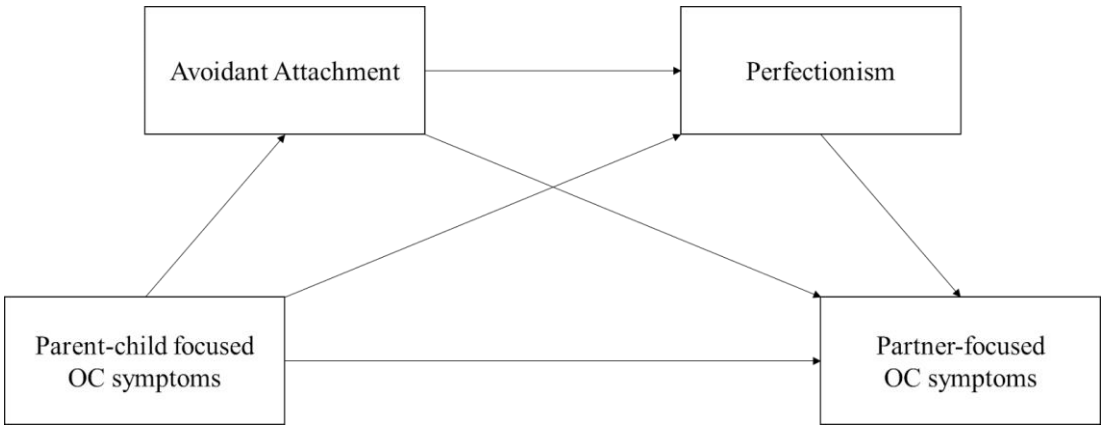

***Figure 4*:** Model of the Hypothesis 4

CHAPTER 2

METHOD

2.1 Participants

In the current study, inclusion criteria for late adolescents were (1) being between the ages of 18 and 23, and (2) having a romantic relationship at least for 3 months. No specific inclusion criteria were set for mothers except for volunteering to participate in the study. The initial sample included 213 mothers and 499 late adolescents overall, consisting of 151 matched mother-child dyads. Twelve of these dyads were excluded from the study either because they quit completing the inventories or because late adolescents failed to meet the inclusion criteria regarding age. In total, 139 mother-child dyads were used for subsequent statistical analysis. The mean age of late adolescents was 21.37 (*SD* = 1.57) while the mean age of mothers was 48.86 (*SD* = 4.97). Also, 87.8% (*n* = 122) of late adolescent participants were women while 12.2% (*n* = 17) were men. The mean relationship duration was 26.22 months (*SD* = 22.21) for late adolescents while it was 21.42 (*SD* = 11.13) years for the mothers. Moreover, whereas late adolescents have a minimum relationship duration of 4 months, the maximum relationship duration is calculated to be 99 months. Detailed demographic information for late adolescent-mother pairs was presented in Table 1.

Table 1. *Socio-demographic characteristics of participants*

	Late adolescents				**Mothers**			
Variable	**F**	**%**	**M**	**SD**	**F**	**%**	**M**	**SD**
Age	139		21.37	1.57	139		48.86	4.97
Gender								
Female	122	87.8			200	100		
Male	17	12.2						
Education Level								
Primary school graduate					26	18.7		

Secondary school graduate			17	12.2
High school graduate	101	72.7	37	26.6
Undergraduate	36	25.9	50	36
Graduate	1	.7	3	2.2
Postgraduate			4	2.9
Literate	1	.7	2	1.4
Socioeconomic Status				
Low	10	7.2	11	7.9
Medium	121	87.1	122	87.8
High	8	5.8	6	4.3
Relationship Status				
Married			109	78.4
Single			1	0.7
Divorced			26	18.7
Widow			3	2.2
Current Psychological Support				
Yes	31	22.3	12	8.6
No	108	77.7	127	91.4
Psychological Support History				
Yes	69	43.2	42	30.2
No	79	56.8	97	69.8

2.2 Materials

2.2.1 Demographic Information Form – Late Adolescent Version

The adolescent version of the demographic information form was developed by the researcher to obtain information regarding age, gender, education level, socioeconomic status, presence of an ongoing relationship, duration of the romantic relationship, history of mental disorder, and psychiatric treatment (see Appendix C).

2.2.2 Demographic Information Form – Parent Version

The parent version of the demographic information form was developed by the researcher to obtain information regarding the mother's age, gender, education level, socioeconomic status, relationship status, whether her partner is the biological father of the child participating in the study, duration of the relationship, number of children, history of mental disorder and psychiatric treatment (see Appendix D).

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

The scale was originally developed by Doron et al. (2017) to assess parent-child focused relationship related obsessions and compulsions. The scale includes 28 items that are rated on a 5-point Likert response format (1 = *Not at all*, 5 = *All the time*). There are also four additional items to check the reliability of given responses. The scale has five subscales which are named as (1) appearance, (2) intelligence, (3) competence, (4) morality, and (5) sociability-emotional stability. For the total scale, Cronbach's alpha coefficient was .94. Cronbach's alpha coefficients were reported as .89, .75, .84, .83, and .84, respectively for the subscales. PROCSI-PC was translated and adapted to Turkish by Parlapan Baş (2019). The Cronbach's alpha value of the total scale was .91 while it ranged from .74 to .85 for the subscales. Higher scores obtained from the scale indicate an increase in parent-child focused ROCD symptoms (see Appendix E). The internal reliability of the total scale was .91 in the current study.

2.2.4 Relationship Obsessive–Compulsive Inventory (ROCI)

The scale was originally developed by Doron et al. (2012a) to evaluate the severity of romantic relationship-related obsessions and compulsions. It is a self-report scale composed of 14 items and two of them were control items that control the reliability of the given responses. Questions are answered in a 5-point Likert-type format (0 = *Not at all*, 4 = *Very much*). The scale has three subscales which are named as (1) love towards the partner, (2) the partner's perceived love, and (3) whether the relationship is the right one. The internal consistency of the total scale was .93 for the original version. The Cronbach's alpha coefficients were .84, .87, and .79 for subscales, respectively. Turkish adaptation of the scale was conducted by Trak and İnözü (2017). The Cronbach's alpha coefficients were calculated as .73, .83, and .78 for the subscales and .89 for the total scale. Higher scores indicate higher levels of relationship-related obsessive–compulsive symptoms (see Appendix F). The internal reliability of the total scale was .92 in the current study.

2.2.5 Partner-Related Obsessive–Compulsive Symptoms Inventory (PROCSI)

The scale was originally developed by Doron and his colleagues (2012b) to measure the severity of partner-related obsessions and compulsions. The scale consists of 24 items and includes four items that control the reliability of the given responses. Items are answered on a 5-point Likert type format (0 = *Not at all*, 4 = *Very much*). The scale has six subscales which are named as (1) physical appearance, (2) sociability, (3) morality, (4) emotional stability, (5) intelligence, and (6) competence. Cronbach's alpha coefficient was .95 for the total scale. The Cronbach's alpha coefficients were reported as .83 for physical appearance and intelligence, .84 for sociability and emotional stability, .87 for competence, and .89 for morality. Turkish adaptation of the scale was conducted by Trak and İnözü (2017). The Cronbach's alpha coefficients ranged from .71 to .88. Cronbach's alpha coefficient was calculated as .94 for the total scale. Higher scores obtained from items indicate higher levels of partner-related obsessive–compulsive symptoms. (see Appendix G). The internal reliability of the total scale was .93 in the current study.

2.2.6 Frost-Multidimensional Perfectionism Scale (F-MPS)

The scale was originally developed by Frost et al. (1990) to evaluate the perfectionist tendencies across several domains. The original scale consists of 36 items responded on a 5-point Likert type format (1 = *Strongly disagree*, 5 = *Strongly agree*). There are six subscales of the scale which are (1) personal standards, (2) concern over mistakes, (3) parental expectations, (4) parental criticism, (5) doubting of actions, and (6) organization. Internal consistency coefficients of the subscales ranged between .77 and .93. The Cronbach's alpha coefficient for the total scale was .90. Firstly, F-MPS was adapted to Turkish by Mısırlı-Taşdemir and Özbay (2003). The Turkish version of the scale loaded into 6 dimensions with 35 items. Cronbach's alpha coefficients for the subscales were found between .63 and .87 and were found as .83 for the total scale. In this study, the adaptation study of Sayıl et al. (2012) with an adolescent sample was used. Researchers calculated the Cronbach Alpha values as .69 for doubting of actions, .74 for parental criticism, .78 parental expectations, .83 for concern over mistakes and .91 for organization. An increase in the scores obtained from the subscales indicates which personality trait of the participant is more dominant. It is also possible to use the scale as compatible and incompatible perfectionism sub-dimensions. Personal standards and organization subscales are evaluated under adaptive perfectionism; while concern over mistakes, parental expectations, parental criticism and doubting of actions subscales were evaluated under maladaptive perfectionism. (see Appendix H). The internal reliability of the total scale was .92 in the current study.

2.2.7 Experiences in Close Relationships-Revised (ECR-R)

The scale was originally developed by Fraley et al. (2000) to measure adult insecure attachment organizations. It has two separate subscales which are avoidant and anxious attachment styles. The scale consists of 36 items that are rated on a 7-point Likert-type format (1 = *Disagree strongly*, 7 = *Agree strongly*). Eighteen items measure avoidant attachment style while the remaining 18 items used to assess anxious attachment style. The scale was adapted to Turkish by Selçuk et al. (2005), and the factor structure of the original scale was found to be consistent with the Turkish version. The Cronbach's alpha coefficients for the Turkish sample are .90 and .86 for avoidant and anxious attachment style subscales, respectively. Items of 4, 8, 16, 17,

18, 20, 21, 22, 24, 26, 30, 32, 34, and 36 are scored reversely. High scores collected from subscales are associated with higher levels of insecure attachment. (see Appendix I). The internal reliability of the anxious attachment styles subscale was .91, while the internal reliability of the avoidant attachment styles subscale was .90 in the current study.

2.2.8 Procedure

Before data collection, ethical approval was obtained from the Human Subjects Ethics Committee of TED University. To reach out to potential participants, announcements were posted on social media platforms and course instructors made announcements in classes at TED University. In general, mother participants were reached through their late adolescent children. Participants who met the eligibility criteria participated in the study voluntarily. Both mother and late adolescent participants were able to access the questions via the same link prepared on the Qualtrics platform. To protect their personal information and to match the mother-child dyads, both children and mothers were asked to create a nickname containing the last letter of the child's name, the birth date of the child, and the last two letters of the mother's name. After giving their demographic information, late adolescents filled out PROCSI-PC (child version), ROCI, PROCSI, ECR-R, and F-MPS. Mothers filled out only PROCSI-PC (parent version). At the end of the study, the purpose of the study was explained to both late adolescents and their mothers in a debriefing form (see Appendix J).

CHAPTER 3

RESULTS

3.1 Statistical Analysis

Before the main analysis, obtained data were cleaned by eliminating participants with missing data or who failed to meet the inclusion criteria regarding age criteria. The linearity assumption was checked and met as there was no curve shape in the scatter plot (Field, 2018). Then, the data were inspected for multicollinearity using Variance Inflation Factor (VIF) values for the relationship-focused OC symptoms, partner-focused OC symptoms, attachment, and perfectionism. The corresponding VIF values were 3.44, 2.76, 2.45 and 1.42, respectively. The findings suggested that the independent variables of the current study were not multicollinear.

Following the descriptive analysis of the study variables shown in Table 2., the serial mediation model was tested via PROCESS Macro v4.2 (Hayes, 2022). Model 6 was used to assess the effect of perfectionism and insecure attachment styles on the intergenerational transmission of relationship-related obsessive-compulsive symptoms. That is, it was investigated whether insecure attachment styles (M1) and perfectionism (M2) mediate the association between parent-child-focused OC symptoms (X) and partner-focused and relationship-focused OC symptoms (Y). To assess the significance values of serial mediation, a bias-corrected bootstrap confidence interval with 5.000 bootstrap resamples was calculated. The effects of mediators on the model can be assessed by examining whether the lower and upper-level confidence intervals contain zero, and the absence of zero shows that the mediators have a statistically significant effect.

3.2 Descriptive Statistics of Study Variables

Standard deviations, means, and maximum-minimum scores of the variables were calculated by descriptive statistics analysis and presented in Table 2.

Table 2. *Descriptive Statistics of Study Variables*

	N	M	SD	Minimum	Maximum
Variables of Mothers					
PROCSI-PC	139	56.03	13.31	41	115
Variables of Late Adolescent					
ROCI	139	25.20	11.67	12	58
PROCSI	139	57.42	16.05	40	128
F-MPS	139	117.30	25.10	63	175
ECR-R	139	117.04	37.49	50	231
ECR-R - Anxious	139	69.09	23.13	25	122
ECR-R - Avoidant	139	47.94	21.46	18	123

Note. PROCSI-PC: Parent-Child Related Obsessive Compulsive Symptom Inventory; ROCI: Relationship Obsessive–Compulsive Inventory; PROCSI: Partner-Related Obsessive–Compulsive Symptoms Inventory; F-MPS: Frost-Multidimensional Perfectionism Scale; ECR-R: Experiences in Close Relationships-Revised

3.3 Bivariate Correlations among Study Variables

Pearson correlation analysis was conducted to calculate correlations among study variables. Relationship-focused OC symptoms, partner-focused OC symptoms, attachment, perfectionism, and parent-child-focused OC symptoms were all significantly associated with each other, as illustrated in Table 3.

Table 3. *Bivariate Correlations among Study Variables*

	1	2	3	4	5	6
Scales of Mothers						
1. PROCSI-PC	1	.30*	.31*	.35*	.23*	.45*
Scales of Late Adolescent						
2. ROCI		1	.78*	.49*	.65*	.57*
3. PROCSI			1	.39*	.58*	.53*
4. F-MPS				1	.44*	.42*
5. ECR-R (Anxious)					1	.41*
6. ECR-R (Avoidant)						1

Note. * p < .05, PROCSI-PC: Parent-Child Related Obsessive Compulsive Symptom Inventory; ROCI: Relationship Obsessive–Compulsive Inventory; PROCSI: Partner-Related Obsessive–Compulsive Symptoms Inventory; F-MPS: Frost-Multidimensional Perfectionism Scale; ECR-R: Experiences in Close Relationships-Revised

3.4 Tests of the Serial Mediation Models

3.4.1 The Mediating Roles of Anxious Attachment and Perfectionism between Parent-child focused OC symptoms and Relationship-focused OC symptoms

In the first proposed model, it was hypothesized that anxious attachment and perfectionism would mediate the relationship between parent-child focused OC symptoms and relationship-focused OC symptoms. The results of the analysis indicated that the serial mediation model (Fig. 5) explained 49% variance in scores for relationship-focused OC symptoms (F (3, 135) = 43,66, $p < .05$). As demonstrated in Figure 5, all the paths were significant in the proposed model, except for the direct effect of parent-child focused OC symptoms on relationship-focused OC symptoms.

The association between parent-child focused OC symptoms and anxious attachment was significant ($\beta = .38$, $SE = .13$, $t = 2.79$, $p < .05$, 95% CI [.11, .66]). The association between parent-child focused OC symptoms and perfectionism was also significant ($\beta = .48$, $SE = .13$, $t = 3.57$, $p < .05$, 95% CI [.21, .76]). Besides, there was

a significant association between anxious attachment and perfectionism (β = .41, *SE* = .08, *t* = 5.07, *p* < .05, 95% *CI* [.25, .57]). The association between anxious attachment and relationship-focused OC symptoms (β = .27, *SE* = .03, *t* = 7.8, *p* < .05, 95% *CI* [.20, .33]); and the relationship between perfectionism and relationship-focused OC symptoms was significant (β = .10, *SE* = .03, *t* = 3.09, *p* < .05, 95% *CI* [.03, .16]). Regarding direct effect, there was no significant association between parent-child focused OC symptoms and relationship-focused OC symptoms (β = .08, *SE* = .05, *t* = 1.47, *p* > .05, 95% *CI* [-.02, .19]). For the indirect effects of mediators, confidence intervals were calculated and intervals not containing the value of zero were counted as indicating statistically significant indirect effects. The results revealed that the indirect effects of anxious attachment (*a1b1* = .10, *SE* = .05, 95% *CI* [.01, .23]), perfectionism (*a2b2* = .05, *SE* = .02, 95% *CI* [.01, .10]), and both anxious attachment and perfectionism at the same time (*a1db2* = .01, *SE* = .01, 95% *CI* [.01, .04]) were found to be all significant.

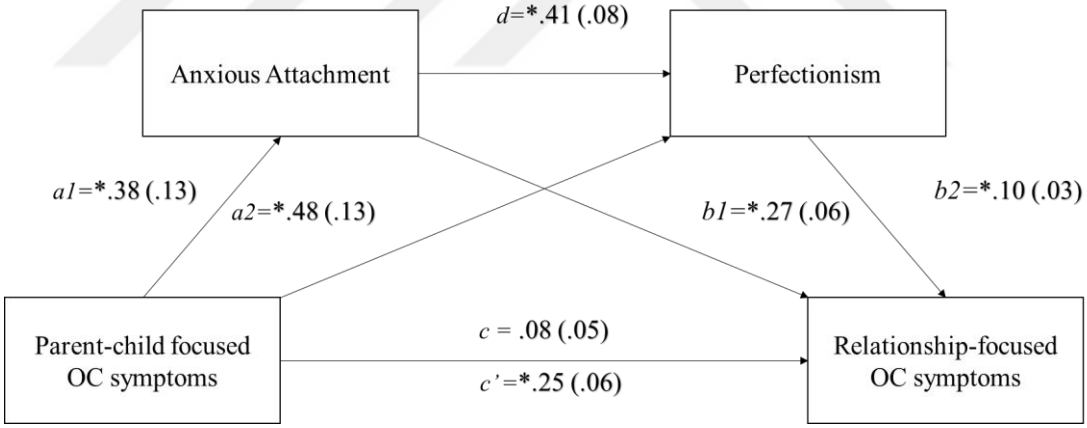

***Figure 5*:** Serial Mediation Model of Relationship between Relationship-focused OC symptoms and Parent-child focused OC symptoms: Anxious Attachment and Perfectionism

Note. Standardized regression coefficients were used. Standard errors are indicated in parentheses.

*p < .05

3.4.2 The Mediating Roles of Avoidant Attachment and Perfectionism between Relationship-focused OC symptoms and Parent-child focused OC symptoms

In the second proposed model, it was hypothesized that avoidant attachment and perfectionism would mediate the relationship between parent-child focused OC symptoms and relationship-focused OC symptoms. The results of the analysis indicated that the serial mediation model (Fig. 6) explained 41% variance in scores for relationship-focused OC symptoms (F (3, 135) = 30,88, $p < .05$). As demonstrated in Figure 6, all the paths were significant in the model, except for the direct effect of parent-child focused OC symptoms on relationship-focused OC symptoms.

The association between parent-child focused OC symptoms and avoidant attachment was significant ($\beta = .70$, $SE = .11$, $t = 5.99$, $p < .05$, 95% CI [.47, .94]). The association between parent-child focused OC symptoms and perfectionism was also significant ($\beta = .37$, $SE = .15$, $t = 2.42$, $p < .05$, 95% CI [.06, .68]). Besides, there was a significant association between avoidant attachment and perfectionism scores ($\beta = .38$, $SE = .09$, $t = 3.90$, $p < .05$, 95% CI [.19, .58]). The association between avoidant attachment and relationship-focused OC symptoms ($\beta = .24$, $SE = .04$, $t = 4.13$, $p < .05$, 95% CI [.15, .32]); and the association between perfectionism and relationship-focused OC symptoms was significant ($\beta = .14$, $SE = .03$, $t = 4.13$, $p < .05$, 95% CI [.07, .21]). Regarding direct effect, there was no significant association between relationship-focused OC symptoms and parent-child focused OC symptoms ($\beta = -.01$, $SE = .06$, $t = -.18$, $p > .05$, 95% CI [-.13, .11]). For the indirect effects of mediators, confidence intervals were calculated and intervals not containing the value of zero were counted as indicating statistically significant indirect effects. Results revealed that the indirect effects of avoidant attachment ($a1b1 = 17$, $SE = .04$, 95% CI [.08, .26]), perfectionism ($a2b2 = 05$, $SE = .02$, 95% CI [.01, .10]), and both avoidant attachment and perfectionism at the same time ($a1db2 = .03$, SE = .01, 95% CI [.01, .07]) were found to be all significant.

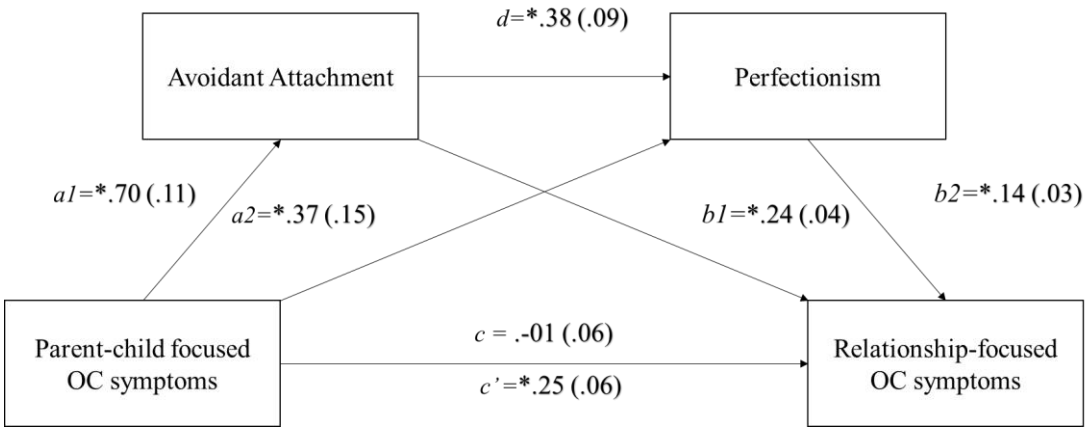

Figure 6: Serial Mediation Model of Relationship between Relationship-focused OC symptoms and Parent-child focused OC symptoms: Avoidant Attachment and Perfectionism

Note. Standardized regression coefficients were used. Standard errors are indicated in parentheses.

*p < .05

3.4.3 The Mediating Roles of Anxious Attachment and Perfectionism between Parent-child focused OC Symptoms and Partner-focused OC Symptoms

In the third proposed model, it was hypothesized that anxious attachment and perfectionism would mediate the relationship between parent-child focused OC and partner-focused OC symptoms. The results of the analysis indicated that the serial mediation model (Fig. 7) explained 38% variance in scores for partner-focused OC symptoms (F (3, 135) = 27,79, $p < .05$). As demonstrated in Figure 7, all paths were significant in the model, except for the direct effect of parent-child focused OC symptoms on partner-focused OC symptoms and the association between perfectionism and partner-focused OC symptoms.

The association between parent-child focused OC symptoms and anxious attachment was significant (β = .38, SE = .13, t = 2.79, $p < .05$, 95% CI [.11, .66]). The association between parent-child focused OC symptoms and perfectionism was also significant (β = .48, SE = .13, t = 3.57, $p < .05$, 95% CI [.21, .76]). Besides, there was a significant association between anxious attachment and perfectionism (β = .41, SE = .08, t = 5.07, $p < .05$, 95% CI [.25, .57]). The association between anxious attachment and partner-focused OC symptoms was also significant (β = .35, SE = .05, t = 6.5, $p < .05$, 95% CI [.24, .46]). On the other hand, the association between perfectionism and

partner-focused OC symptoms was not significant (β = .07, SE = .05, t = 1.47, p > .05, 95% *CI* [-.02, .18]). Regarding direct effect, there was a significant relationship between partner-focused OC symptoms and parent-child focused OC symptoms (β = .18, *SE* = .08, t = 2.12, p < .05, 95% *CI* [.01, .36]). For the indirect effects of mediators, confidence intervals were calculated and intervals not containing the value of zero were counted as indicating statistically significant indirect effects. Results revealed that the indirect effects of anxious attachment (*a1b1* = .13, *SE* = .07, 95% *CI* [.02, .29]) were found to be significant. However, the indirect effects of perfectionism (*a2b2* = .03, *SE* = .03, 95% *CI* [-.01, .10]), and the indirect effects of both anxious attachment and perfectionism at the same time (*a1db2* = .01, SE = .01, 95% *CI* [-.01, .04]) were not significant.

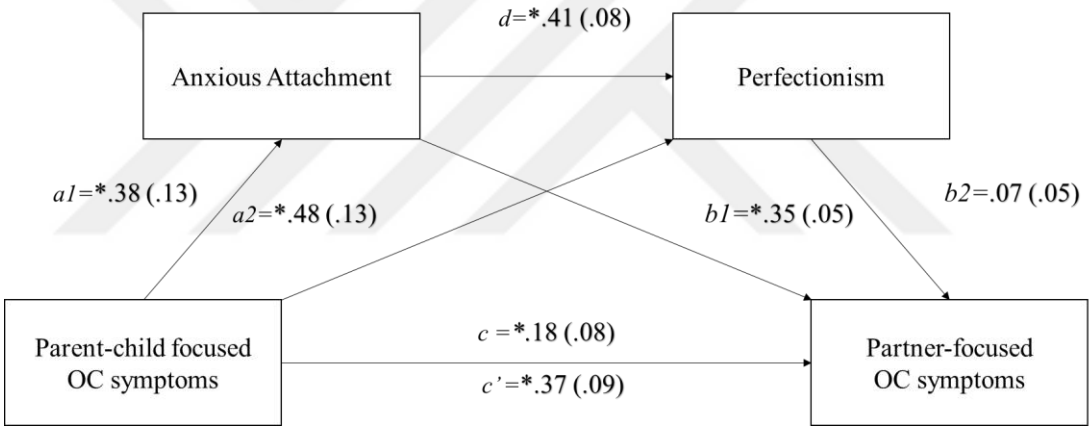

Figure 7: Serial Mediation Model of Relationship between Partner-focused OC symptoms and Parent-child focused OC symptoms: Anxious attachment and Perfectionism

Note. Standardized regression coefficients were used. Standard errors are indicated in parentheses.

*p < .05

3.4.4 The Mediating Roles of Avoidant Attachment and Perfectionism between Parent-child focused OC Symptoms and Partner-focused OC Symptoms

In the final proposed model, it was hypothesized that anxious attachment and perfectionism would mediate the relationship between parent-child focused OC symptoms and partner-focused OC symptoms. The results of the analysis indicated that the serial mediation model (Fig. 8) explained 32% variance in the scores for

partner-focused OC symptoms (F (3, 135) = 21,62, $p < .05$). As demonstrated in Figure 8, all paths were significant in the model, except for the direct effect of parent-child focused OC symptoms on partner-focused OC symptoms.

The association between parent-child focused OC symptoms and avoidant attachment was significant ($\beta = .70$, $SE = .11$, $t = 5.99$, $p < .05$, 95% CI [.47, .94]). The association between parent-child focused OC symptoms and perfectionism was also significant ($\beta = .37$, $SE = .15$, $t = 2.42$, $p < .05$, 95% CI [.06, .68]). Besides, there was a significant association between avoidant attachment and perfectionism scores ($\beta = .38$, $SE = .09$, $t = 3.90$, $p < .05$, 95% CI [.19, .58]). The association between avoidant attachment and partner-focused OC symptoms emerged as significant, as well ($\beta = .34$, $SE = .06$, $t = 5.22$, $p < .05$, 95% CI [.21, .47]). On the other hand, the relationship between perfectionism and partner-focused OC symptoms was not significant ($\beta = .12$, $SE = .05$, $t = 2.37$, $p > .05$, 95% CI [.02, .23]). Regarding direct effect, no significant association was found between partner-focused OC symptoms and parent-child focused OC symptoms ($\beta = .05$, $SE = .09$, $t = .55$, $p > .05$, 95% CI [-.14, .24]). For the indirect effects of mediators, confidence intervals were calculated and intervals not containing the value of zero were counted as indicating statistically significant indirect effects. Results revealed that the indirect effects of avoidant attachment ($a1b1 = .24$, $SE = .07$, 95% CI [.10, .39]), perfectionism ($a2b2 = .04$, $SE = .02$, 95% CI [.01, .11]), and both avoidant attachment and perfectionism at the same time ($a1db2 = .03$, $SE = .01$, 95% CI [.01, .07]) were found to be significant.

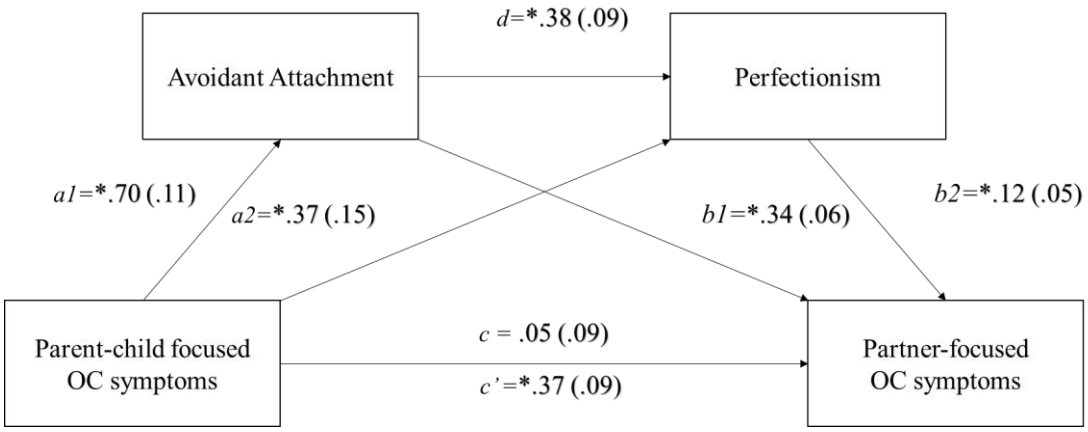

***Figure 8**:* Serial Mediation Model of Relationship between Partner-focused OC Symptoms and Parent-child focused OC Symptoms: Anxious Attachment and Perfectionism

Note. Standardized regression coefficients were used. Standard errors are indicated in parentheses.

*p < .05

CHAPTER 4
DISCUSSION

A growing body of research has indicated that parental psychopathology is a potent risk factor for the psychosocial development and mental health of the affected offspring (Stein et al., 2014; Lawrence et al., 2019; Weijers et al., 2018; Elsayed et al., 2019). Existing studies on parental obsessive-compulsive disorder continue to yield new insights into the psychosocial mechanisms (e.g., parenting styles, parental stress, attachment) through which obsessive-compulsive symptoms are transmitted from parents to children (Mahaffey, 2009; Lennertz et al., 2010; Timpano et al., 2010; Hofer et al., 2018; Coppola et al., 2020; Kendler et al., 2023). These studies have mostly focused on the transmission of maternal symptoms since mothers are still counted as the major caregivers in most cultures (Black et al., 2003; Wilcox et al., 2008). Although research into the intergenerational transmission of general type OCD continues, studies investigating the etiology and familial transmission of relationship-related OCD symptoms are still in infancy. Even though preliminary studies have suggested that relational obsessions and compulsions may affect parent's relationship with their children and their parenting styles (Doron et al., 2017; Parlapan Baş, 2019), these studies are still insufficient for understanding how the parent-child focused OCD subtype is associated with relational and mental health outcomes among children. Based on this information, the current study was conducted to better understand the etiology of ROCD and to understand whether and in what ways ROCD can be transmitted from mother to children. In an attempt to fill this gap, the mediating roles of insecure attachment styles (M1) and perfectionism (M2) in the association between parent-child-focused OC symptoms and relationship focused and partner focused OC symptoms were investigated. In this way, the study aimed to contribute to our current understanding of psychosocial risk factors that may play a role in the intergenerational transmission of relationship-related OC symptoms from parents to children. Our hypotheses were exploratory since there exists no study in the literature examining how parents' child-focused OC symptoms might be associated with ROCD symptoms among children.

Accordingly, in the following sections, the current study's findings were reviewed alongside the previous studies from the literature. Following that, the clinical implications, and limitations of the study, as well as recommendations for future investigations, were presented.

4.1 The Roles of Insecure Attachment Styles and Perfectionism in the Relationship between Parent-child Focused OC Symptoms and Relationship-focused OC Symptoms

To evaluate the mediating factors in the association between parent-child focused OC symptoms and relationship-focused OC symptoms among children, two different serial mediation models were proposed in the current study. The first model tested the serial mediation roles of anxious attachment and perfectionism, while the second model tested the serial mediation roles of avoidant attachment and perfectionism on the relationship between parent-child focused OC symptoms and relationship-focused OC symptoms. Both models revealed that mediator variables had significantly mediated relationship between parent-child focused OC symptoms and relationship-focused OC symptoms. By contrast, the direct effect emerged as non-significant, indicating that relationship-related OC symptoms were not directly transmitted from mother to child, but they were transmitted through the roles of both anxious and avoidant attachment styles, as well as perfectionist tendencies.

First of all, parent-child focused OC symptoms were significantly associated with both children's anxious and avoidant styles in the present study. Although no previous study has directly examined the association between parent-child focused OC symptoms and offspring attachment styles, our results contributed to the limited findings highlighting the relationship between parental OCD symptoms, dysfunctional parenting styles, and child mental health outcomes. Adults with OCD symptoms have been known to have significant impairment in their work life, partner relationships, and parenting (Coluccia et al., 2016; Schwartzman et al., 2017; Doron et al., 2017). In the related literature, it has been shown that parents with obsessions and compulsions tend to show more controlling, boundary-violating, and rejecting attitudes toward their children (Challacombe & Salkovskis, 2009; Griffiths et al., 2012). Affected children even reported that they sometimes become part of the compulsive rituals to reduce

their parents' distress (Griffiths et al., 2012). Relatedly, parental OCD has been suggested to increase children's vulnerability to developing depression and anxiety disorders (Black et al., 2003; Frías et al. 2020). Although they are not identical, the conceptual convergence between general OCD symptoms and parent-child focused OC symptoms might explain the significant association we found between child-related intrusions/compulsions and insecure attachment styles developed among children. Parent-child focused OC symptoms are related to parents' doubts and preoccupations with their children's perceived flaws. Unwanted intrusions might be centered around a child's intellectual capacity ("Even though she is not stupid, I still worry about her capacity.''), physical appearance ("I am not happy with the physical appearance of my child.'') and social capability ("I try to compensate for the social incompetence of my child.''). Even though parents are to some extent aware of their extreme concerns, they engage in social comparison and approval seeking to cope with their anxiety (Doron et al., 2017). Thus, it is theoretically sensible that parents' excessive concerns about their children's alleged defects and over-compensatory behaviors influence the bond they develop with their children, which in turn, might shape the children's perception of themselves and others. Supporting this, Doron et al. (2017) revealed that parent-child focused OC symptoms are connected with parental anxiety, depression, and stress, and parent-child-focused OC symptoms are significantly associated with parenting stress even after controlling for the effects of parental OCD and depression. The stress generated by these symptoms may cause the parent to display dysfunctional parenting styles which might endanger the attachment organization of the affected children (Trak & İnözü, 2019).

The results of the current study also revealed that both anxious and avoidant attachment styles were significantly related to perfectionism, and there was a positive association between perfectionism scores and relationship-focused OC symptoms. It has been theorized that individuals with insecure attachment styles set unattainable standards for themselves and others and display perfectionist tendencies (Mikulincer & Shaver, 2007). In this regard, both anxious attachment and avoidant attachment organizations were found to be linked to self and interpersonal-related maladaptive perfectionism (Wei, et al., 2004; Mikulincer & Shaver, 2007; Yıldırım, 2018) that are found to be related with depression, OCD and social anxiety (Egan et al., 2011).

Anxious or preoccupied individuals have a disproportionate need to form close relationships with others and are prone to shame since they perceive themselves as responsible for the perceived mistakes or signs of rejection (Boone, 2013; Chen et al., 2015). Therefore, such individuals might be hypervigilant about their self-presentations in interpersonal relationships and set perfectionist standards for themselves to ensure acceptance and approval. Avoidant individuals, on the other hand, tend to undervalue the significance of close relationships since they are not comfortable with intimacy (Wei et al., 2006). Consequently, they might be doubtful about the quality of relationships explaining their perfectionist tendencies in close relations. As for the positive association between perfectionism and relationship-focused OC symptoms, our results supported several studies indicating an association between perfectionism and different mental symptoms (Kawamura et al., 2001; Argus & Thompson, 2008; Moretz & McKay, 2009). To the authors' knowledge, only a few studies have so far examined the impact of perfectionist evaluations on relationship-focused OC symptoms. Accordingly, a small-to-moderate relationship was found between the two constructs (Melli et al., 2015; Yıldırım, 2018). Particularly, excessive concern over mistakes and doubts about the catastrophic consequences of the relationship seems to be two cognitive mechanisms related to perfectionism that significantly predicted relationship-focused OC symptoms (Melli et. al., 2018).

Finally, both anxious and avoidant attachment styles and then perfectionist tendencies mediated the relationship between parent-child-focused OC symptoms and relationship-focused OC symptoms among children. Children having mothers with parent-child-focused OC symptoms are at a greater risk of receiving inconsistent messages from their parents. Their parents are doubtful about their inherent characteristics, question them because of persistent distress, and compare them with others to relieve their anxiety (Doron et al., 2014a). The mothers who struggle with these ego-dystonic symptoms might become more stressed due to parental identity (Parlapan Baş, 2019) and provide inconsistent care and affection toward their children. Consequently, affected children might be more prone to develop dysfunctional mental schemas about themselves, others, or the world (Mikulincer & Shaver, 2007). An anxiously attached child may implicitly believe that being perfect and good is the only way that will guarantee love and acceptance. They may particularly set unrealistic

standards for not making any mistakes to guarantee the continuous presence of the romantic partner (Chen et al., 2015; Wei et al., 2004). Besides, these children might be preoccupied with doubts about their partner's love as they might be hypervigilant about minor setbacks that might signal a possible breakup (Doron et al., 2012c). In other words, they might display perfectionist tendencies in their romantic relationships resulting in demanding behavior and persistent questioning to ensure that their partner will be there whenever needed because possible flaws in the relationship or partner might be perceived as threatening to the intimate bond between them. The avoidantly attached ones, on the other hand, might be unsure how much they should trust their partner; thus becoming more prone to emotional distancing. Since they are fearful of being rejected in times of need, they may set unreasonably strict and high standards in the relationship. In reality, despite their belief that they have a weak and imperfect self as a result of the insecure attachment, they can conceal themselves and attribute negative evaluations to others (Mikulincer & Shaver, 2007; Doron et al., 2012c). Individuals with these high and strict standards may become overly sensitive to possible imperfections in their relationship and may constantly question their commitment and their partner's love as a distancing strategy (Toroslu & Çırakoğlu, 2022).

4.2 The Roles of Insecure Attachment Styles and Perfectionism in the Relationship between Parent-child Focused OC Symptoms and Partner-focused OC Symptoms

Two serial mediation models were inspected in the current study to examine the mediating mechanisms of the link between parent-child-focused OC symptoms and partner-focused OC symptoms. According to the analysis results, one of the study's hypotheses was confirmed, indicating a serial mediation role of avoidant attachment and then perfectionism in the relationship between parent-child focused OC symptoms and partner-focused OC symptoms. On the other hand, anxious attachment and then perfectionism did not mediate this relationship. Likewise, the direct effect of parent child-focused OC symptoms on partner-focused OC symptoms was not statistically significant, yielding that relationship-related OC symptoms were not directly transmitted from mothers to children. Still, rather avoidant attachment styles and then

perfectionist tendencies played a role in this transmission. As mentioned in the previous section, these findings were exploratory as the proposed mediation model has never been tested fully before in the literature. On the other hand, our results provide indirect support for the other research analyzing the associations among study variables separately.

Consistent with the first two model, parent child-focused OC symptoms were positively associated with both anxious and avoidant attachment styles among children. Parent child-focused OC symptoms mainly refer to a parent's excessive concern over a child's presumed defects and failures in physical, psychological, and social realms that might result in downward comparison and reassurance seeking (Doron et al., 2017). As stated by Doron et al. (2017) parent child-focused OC symptoms are accompanied by parental depression, anxiety, and stress that might endanger the quality of the bond between the parents and children. Although there is scarce research on the parenting practices of parents with child-focused OC symptoms, it has been revealed in the literature that mothers with general OCD symptoms are more critical and rigid toward their children (Challacombe & Salkovskis, 2009) and the distress generated by their symptoms make it difficult for such mothers to build a secure relational base with their children (Trak & İnözü, 2019). These findings were confirmed in both models since we found a significant positive relationship between parent-child focused OC symptoms and insecure attachment styles. Based on our findings, it can be inferred that some children responded to parent child-focused OC symptoms by developing an anxious attachment style in which fear of abandonment and doubts about the availability of support characterize their relationship patterns with others (Mikulincer & Shaver, 2007). By contrast, other children responded to their parents' excessive concerns through developing an avoidant attachment style in which self-sufficiency and emotional distancing are used to prevent further rejection in close relationships (Mikulincer & Shaver, 2007; Wei et al., 2006). Still, more empirical research is necessary to delineate the differential mechanisms of the development of anxious and avoidant attachment patterns among children in the context of parent child-focused OC symptoms.

Furthermore, both anxious and avoidant attachment styles were found to be associated with perfectionism, similar to the models investigating the relationship

between parent-child- focused OC symptoms and relationship-focused OC symptoms among children. These findings are consistent with the existing findings in the literature indicating that insecure attachment styles and perfectionism are significantly correlated (Wei, et al., 2004; Mikulincer & Shaver, 2007; Yıldırım, 2018). In contrast to the significant association between perfectionism and relationship-focused OC symptoms, no significant relationship was found between perfectionist tendencies and partner-focused OC symptoms among children. These results contradict the limited findings in the related literature indicating that perfectionism has a significant association with both relationship-focused and partner-focused OC symptoms (Melli et al., 2015; Yıldırım, 2018). Clinical observations regarding relationship-related obsessive-compulsive symptoms led researchers to investigate whether maladaptive beliefs operating in the genesis and maintenance of general OCD symptoms (i.e. inflated sense of responsibility, catastrophizing, and intolerance to uncertainty/perfectionism) also play a role in the development of ROCD symptoms (Doron et al., 2014a; Melli et al., 2018). Accordingly, Doron et al. (2016) revealed that both patients diagnosed with OCD and ROCD showed greater levels of intolerance for uncertainty, estimation of threats, and perfectionism when compared with a community control group. Similarly, Melli and Carraresi (2015) indicated that both relationship-focused and partner-focused OC symptoms were significantly associated with general OCD-related maladaptive beliefs including perfectionism. Yet, they also emphasized that "concern over the mistakes" is more strongly related to relationship-focused OC symptoms than partner-focused OC symptoms. All of these findings implicated that although OCD and ROCD may operate based on common maladaptive belief patterns, some dysfunctional beliefs might be more pertinent to ROCD symptoms, rather than OCD symptoms, and these maladaptive beliefs might further operate differently on the basis of relationship-focused and partner-focused OC symptoms. Supporting this, Melli and colleagues recently (2018) reported that even though both perfectionist expectations regarding possible mistakes and doubts about being in the wrong relationship were associated with general ROCD symptoms, catastrophizing cognitions about having a mistaken relationship were more strongly linked to partner-focused OC symptoms. In the current study, perfectionism was measured as a unidimensional cognitive construct, and we did not measure

relationship-specific perfectionist tendencies separately about ROCD symptoms. Thus, this lack of specificity regarding the measurement of perfectionism might explain the non-significant relationship we found between perfectionism and partner-focused OC symptoms.

Contrary to our expectations, the serial mediation effects of anxious attachment style and then perfectionism were not significant while explaining the relationship between parent-child-focused OC symptoms and partner-focused OC symptoms. This finding may be related to previous research indicating that anxious attachment is associated more with relationship-focused OC symptoms, whereas avoidant attachment is associated more with partner-focused OC symptoms (Doron et al., 2012c; Tunçel, 2021). While relationship-focused OC symptoms are more pertinent to the doubts about a partner's feelings and commitment in a romantic relationship, partner-focused OC symptoms refer to one's concerns over a partner's alleged defects across physical, social, and psychological domains (Doron et al., 2012a; Doron et al., 2012b). Accordingly, anxiously attached individuals might be more concerned about their partner's commitment and their own mistakes rather than questioning the personal attributes of their partners. Individuals with anxious attachment styles are riddled with the fear that others will not be available in times of need and crisis (Doron et al. 2012c). They tend to be over-critical of their own faults since they inherently believe that being good and flawless enough is the only way to guarantee being loved and accepted by important others (Wei, et al., 2004). Therefore, they might constantly question their approach to receiving and giving love to keep the relationship going instead of questioning the characteristics of their intimate partner. In a way, the anxiously attached individuals may already be admiring or accepting the characteristics of their partner since they relentlessly search for adequate attention and love (Doron et al., 2012c). Yet, they may have excessive doubts about their partner's love as they did not receive consistent love and attention as a child. Even minor problems in their relationship can be interpreted as a threat to their intimate bond, this is why they may frequently doubt the genuineness of their relationship. Thus, anxiously attached individuals' unrealistic expectations may be tied more to their self-presentation and partner's commitment to the romantic relationship, rather than the perfection of their partners. In other words, these individuals' obsessive thoughts and

compulsions may become more associated with their relationship and love for one another, but not the characteristics of their partner.

Finally, the serial mediation effects of both avoidant attachment style and then perfectionism were found as significant while explaining the relationship between parent child-focused OC symptoms and partner-focused OC symptoms. Individuals with avoidant attachment styles are described with a tendency to refrain from close relationships and to minimize the significance of relational bonds (Wei et al., 2006). It is challenging for such individuals to develop emotional bonds because they implicitly believe that other people are unreliable and do not meet their psychosocial needs (Mikulincer & Shaver, 2007). Thus, they are more prone to rejecting relationships rather than investing in them. They usually establish rigid and high personal standards to avoid others, and by doing so, they can conceal their weaknesses and flaws while projecting negative attributes onto others. Individuals with unattainable standards may be more sensitive to possible imperfections or negativities in their relationships or partners as they already tend to move away from close relations when compared with individuals having anxious attachment styles (Yıldırım, 2018). This might explain why avoidant individuals focus more on the alleged flaws of their partners and relationships rather than their own imperfections.

4.3 The Importance of the Study and Clinical Implications

Clinical observations regarding specific obsessions and compulsions that appeared in close relationships have directed researchers' attention to examine psychosocial risk factors associated with ROCD symptoms (i.e., relationship-focused OC symptoms, partner-focused OC symptoms, and child-focused OC symptoms). Accordingly, emerging evidence has indicated that ROCD symptoms are positively associated with anxiety, depression, low relationship satisfaction, and compromised sexual intimacy (Doron et al., 2012a; Doron et al., 2012b; Doron et al., 2013; Doron et al., 2014b; Doron et al., 2017). The current thesis expanded on these earlier findings to examine the possible transmission of ROCD symptoms from mothers to offspring from a developmental and clinical perspective. In that respect, our study is the first to provide important insight into the intergenerational transmission of relationship-related OC symptoms based on attachment styles and perfectionism. Current findings

indicated that both anxious and avoidant attachment styles and perfectionist cognitions had mediating roles in the transmission of OC symptoms associated with relationships. As a result, it is believed that the study provides preliminary suggestions for clinicians working with ROCD symptoms among late adolescents who have also been exposed to parental child-focused OC symptoms. Accordingly, clinicians might benefit from not only attachment-based strategies in their practice but also from cognitive-behavioral strategies aiming to combat perfectionism while working with clients having ROCD symptoms. First, psychoeducation can be provided with the help of a case formulation. In this psychoeducation, an individual can be informed about factors such as attachment and maladaptive beliefs that may play a role in the development and maintenance of ROCD symptoms. Clinical experience has shown that by using CBT therapies, it is possible to study factors, including self-vulnerabilities and maladaptive beliefs, that contribute to the development of ROCD (Derby et al., 2021). Regardingly, in therapy process, the reality of the individual's beliefs about abandonment fear might be questioned, whether there is evidence confirming this thought (Doron & Moulding, 2009). Behavioral experiments, in which an individual is exposed to the word "abandonment" and engages in imaginary exposures where significant others have abandoned an individual, can be used as well. Additionally, by ensuring the parent's participation in the therapy process, emotions can be shared in parent-child conversations about child not having a safe environment when he or she needs it (Herres et al., 2023). Moreover, the relationship between maladaptive perfectionist tendencies and attachment, as well as ROCD symptoms, can be explored with an individual, thus challenging the thought that being perfect provides a guarantee of not being abandoned (Doron & Moulding, 2009).

4.4 Limitations of the Study and Future Directions

Despite being one of the first exploratory studies about the possible mechanisms of intergenerational transmission of ROCD symptoms, the current study is not without limitations. Firstly, we collected data from a non-clinical sample which could hinder the generalizability of our results. Likewise, the majority of the late adolescent participants consisted of women with a middle-class economic background, again compromising the generalizability of the results to the other populations from

different socio-economic and educational backgrounds. Furthermore, the cross-sectional nature of the study prevents inferring cause-effect relationships necessitating future longitudinal research to examine the familial transmission of ROCD symptoms. Moreover, we were able to reach fewer participants than we had planned at the conception of the study. The reasons for reaching fewer participants than expected might be related to the inclusion criteria about age and romantic relationship status. Although age limitations have been introduced due to the previous findings in the literature reporting that ROCD symptoms are usually manifested in young adulthood (Doron et al., 2014a), future research might be conducted with an expanded age range to identify whether this symptom cluster is more specific to younger age groups or not. Also, mothers' parent-child-focused OC symptoms were measured retrospectively which might have created misleading and heterogeneous responses. Additionally, the current study measured perfectionism as a single construct. Hence, further research is necessary to understand the impacts of different dimensions of perfectionism (e.g., self-prescribed and social-prescribed perfectionism) on the transmission of ROCD symptoms together with attachment styles. Furthermore, mother-to-child transmission was investigated in this study since the mothers are still perceived as the major caregiver in Turkish culture and several studies showed that only mothers' parenting practices play a role in the transmission of OCD (Black et al., 2003; Wilcox et al., 2008). Hence, further studies can investigate the transmission of parent-child-focused OC symptoms by reaching out to fathers, as well. Lastly, while these symptoms centering in close relationships have attracted the attention of researchers, it is considered premature to define this cluster of symptoms as a disorder due to the limited number of studies available. The potential associations of this new symptom cluster with disorders other than general OCD should also be carefully examined. Therefore, in this study, rather than categorizing these symptoms as a disorder the literature, it is defined as a new cluster of symptoms. It is thought that further consideration is necessary in future studies regarding this matter.

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APPENDICES

Appendix A: Late Adolescents Consent Form

Sayın Katılımcı,

Mevcut araştırma, TED Üniversitesi Psikoloji Bölümü Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans programında öğrenci olan Sevilay Arı tarafından, Dr. Öğr. Üyesi Yağmur Ar-Karcı danışmanlığında yürütülmektedir. Araştırmanın amacı ilişki temalı obsesif kompulsif belirtilerin birtakım psikososyal mekanizmalar aracılığıyla kuşaklar arası aktarımını incelemektir.

Bu araştırmanın katılımcılarını 18-23 yaş arası genç yetişkinler ve anneleri oluşturmaktadır. Söz konusu araştırma kapsamında hem sizlerden hem de annelerinizden bazı anket sorularını cevaplamanız istenmektedir. İlgili anket sorularını online (çevrimiçi) yanıtlamanız yaklaşık 30 dk., annenizin yanıtlaması ise yaklaşık 10 dk. sürecektir. Araştırmaya gönüllü katılmayı anneniz ile birlikte onayladığınız takdirde, araştırmanın katılımcısı olacaksınız. Hem sizin hem de annenizin doldurması gereken anketlerin online linki aynıdır. Dolayısıyla, ilgili linki anneniz ile paylaşmanız yeterli olacaktır. Qualtrics programı kendi algoritması çerçevesinde sizin ve annenizin doldurması gereken soruları otomatik olarak atayacaktır. Birbirinizin anketlere verdiği yanıtları görmeniz mümkün değildir.

Anketlerde size yöneltilen soruların DOĞRU veya YANLIŞ cevabı yoktur, bu nedenle tüm sorulara içtenlikle ve eksiksiz yanıt vermeniz araştırmanın sonuçları açısından önemlidir. Anne ve çocukların anketleri yalnız, sakin bir ortamda ve birbirinizden bağımsız doldurması da sonuçların etkilenmemesi için önemlidir. Çalışma süresince ve sonrasında kişisel bilgileriniz araştırma dışındaki hiç kimseyle izniniz dışında paylaşılmayacaktır. Çalışmanın sonuçları tüm katılımcılardan gelen veriler ile değerlendirilecek olup, bireysel değerlendirme yapılmayacaktır. Bu araştırma kapsamında elde edilecek olan bilimsel bilgiler sadece araştırmacılar tarafından yapılan bilimsel yayınlarda, sunumlarda ve eğitim amaçlı çevrimiçi bir ortamda paylaşılacaktır. Toplanan veriler isimsiz bir şekilde bilgisayarda şifreli bir dosyada tutulacaktır.

Bu araştırmaya katılım gönüllülük esasına dayalıdır. Araştırmada yer alan sorular kişisel rahatsızlık verecek nitelikte değildir. Ancak herhangi bir nedenden dolayı çalışmanın herhangi bir bölümünde kendinizi rahatsız hissederseniz, nedenini açıklamaksızın araştırmadan ayrılabilirsiniz. Araştırmadan ayrılmanın herhangi bir olumsuz sonucu olmayacaktır. Araştırmadan ayrılan katılımcıların verisi kullanılmayacaktır. Çalışmaya katıldığınız için şimdiden teşekkür ederiz.

Çalışma hakkında daha fazla bilgi almak ve yanıtlanmasını istediğiniz sorularınız için araştırmayı yürüten Psk. Sevilay Arı (E-posta: s) ve Dr. Öğr. Üyesi Yağmur Ar-Karcı (E- posta: y ile iletişim kurabilirsiniz.

Araştırmacı tarafından çalışma hakkında yeterince bilgilendirildim. Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip

çıkabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayınlarda kullanılmasını kabul ediyorum.

Araştırmaya katılmayı onaylıyorum. Evet / Hayır

Teşekkürler,
Psk. Sevilay ARI

Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağına inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na (
telefon numarasından veya r *e-posta adresinden ulaş*

Appendix B: Mother Consent Form

Sayın Katılımcı,

Mevcut araştırma, TED Üniversitesi Psikoloji Bölümü'nde Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans programında öğrenci olan Sevilay Arı tarafından, Dr. Öğr. Üyesi Yağmur Ar-Karcı danışmanlığında yürütülmektedir. Araştırmanın amacı ilişki temalı obsesif kompulsif belirtilerin birtakım psikososyal mekanizmalar aracılığıyla kuşaklar aktarımını incelemektir.

Bu araştırmanın katılımcılarını 18-23 yaş arası genç yetişkinler ve anneleri oluşturmaktadır. Söz konusu araştırma kapsamında hem sizlerden hem de genç yetişkin çocuklarınızdan bazı anket sorularını cevaplamanız istenmektedir. İlgili anket sorularını online (çevrimiçi) olarak yanıtlamanız yaklaşık 10 dk. sürecektir. Araştırmaya gönüllü katılmayı çocuğunuz ile onayladığınız takdirde, araştırmanın katılımcısı olacaksınız. Hem sizin hem de çocuğunuzun doldurması gereken anketlerin online linki aynıdır. Qualtrics programı kendi algoritması çerçevesinde sizin ve çocuğunuzun doldurması gereken soruları otomatik olarak atayacaktır. Birbirinizin anketlere verdiği yanıtları görmeniz mümkün değildir.

Anketlerde size yöneltilen soruların DOĞRU veya YANLIŞ cevabı yoktur, bu nedenle tüm sorulara içtenlikle ve eksiksiz yanıt vermeniz araştırmanın sonuçları açısından önemlidir. Anne ve çocukların anketleri yalnız, sakin bir ortamda ve birbirinizden bağımsız doldurması da sonuçların etkilenmemesi için önemlidir. Çalışma süresince ve sonrasında kişisel bilgileriniz araştırma dışındaki hiç kimseyle izniniz dışında paylaşılmayacaktır. Çalışmanın sonuçları tüm katılımcılardan gelen veriler ile değerlendirilecek olup, bireysel değerlendirme yapılmayacaktır. Bu araştırma kapsamında elde edilecek olan bilimsel bilgiler sadece araştırmacılar tarafından yapılan bilimsel yayınlarda, sunumlarda ve eğitim amaçlı çevrimiçi bir ortamda paylaşılacaktır. Toplanan veriler isimsiz bir şekilde bilgisayarda şifreli bir dosyada tutulacaktır.

Bu araştırmaya katılım gönüllülük esasına dayalıdır. Araştırmada yer alan sorular kişisel rahatsızlık verecek nitelikte değildir. Ancak herhangi bir nedenden dolayı çalışmanın herhangi bir bölümünde kendinizi rahatsız hissederseniz, nedenini açıklamaksızın araştırmadan ayrılabilirsiniz. Araştırmadan ayrılmanın herhangi bir olumsuz sonucu olmayacaktır. Araştırmadan ayrılan katılımcıların verisi kullanılmayacaktır. Bu çalışmaya katıldığınız için şimdiden teşekkür ederiz.

Çalışma hakkında daha fazla bilgi almak ve yanıtlanmasını istediğiniz sorularınız için araştırmayı yürüten Psk. Sevilay Arı (E-posta:
ve Dr. Öğr. Üyesi Yağmur Ar-Karcı (E- posta: y) ile iletişim kurabilirsiniz.

Araştırmacı tarafından çalışma hakkında yeterince bilgilendirildim. Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.

Araştırmaya katılmayı onaylıyorum. Evet / Hayır

Teşekkürler,
Psk. Sevilay ARI

Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağına inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na (
telefon numarasından veya r *e-posta adresinden ulaş*

Appendix C: Late Adolescent Demographic Information Form

Yaşınız:
Cinsiyetiniz (belirtiniz): …
Eğitim Seviyeniz (son aldığınız diplomaya göre):

- ð İlkokul mezunu
- ð Ortaokul mezunu
- ð Lise mezunu
- ð Üniversite mezunu
- ð Yüksek lisans mezunu
- ð Doktora mezunu
- ð Okuryazar değil

Ekonomik Durumunuz:

- ð Düşük
- ð Orta düzey
- ð Yüksek

Süregiden romantik bir ilişkiniz var mı?

- ð Evet
- ð Hayır
- ð Diğer: …

İlişkinizin Süresi (Ay ve/veya Yıl Olarak):

- Geçmişte herhangi bir psikiyatrik/psikolojik yardım aldınız mı?
  - ð Evet
  - ð Hayır

Evet ise lütfen ne tür bir yardım (psikoterapi, ilaç gibi) aldığınızı yazınız:

- Şu anda herhangi bir psikiyatrik/psikolojik yardım alıyor musunuz?
  - ð Evet
  - ð Hayır

Evet ise lütfen hangi sebepten olduğunu kısaca yazınız:

Appendix D: Mother Demographic Information Form

Yaşınız:
Cinsiyetiniz (belirtiniz): …
Eğitim Seviyeniz (son aldığınız diplomaya göre):

- ð İlkokul mezunu
- ð Ortaokul mezunu
- ð Lise mezunu
- ð Üniversite mezunu
- ð Yüksek lisans mezunu
- ð Doktora mezunu
- ð Okuryazar değil

Ekonomik Durumunuz:

- ð Düşük
- ð Orta düzey
- ð Yüksek

İlişki Durumu:

- ð Evli
- ð Bekar
- ð Boşanmış
- ð Eşini Kaybetmiş
- ð Diğer (Lütfen belirtiniz): ….

Şu an birlikte olduğunuz kişi (partneriniz) araştırmaya katılan çocuğunuzun babası mı?

- ð Evet
- ð Hayır

Anketi dolduran çocuğunuzun babası ile evli veya romantik ilişki içinde olduğunuz ilişkinizin süresi (Yıl Olarak Belirtiniz):
Çocuk Sayısı (Belirtiniz):

- Geçmişte herhangi bir psikiyatrik/psikolojik yardım aldınız mı?
  - ð Evet
  - ð Hayır

Evet ise lütfen ne tür bir yardım (psikoterapi, ilaç gibi) aldığınızı yazınız:

- Şu anda herhangi bir psikiyatrik/psikolojik yardım alıyor musunuz?
  - ð Evet
  - ð Hayır

Evet ise lütfen hangi sebepten olduğunu kısaca yazınız:

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

Aşağıda insanların çocuğu ile ilişkisinde yaşayabilecekleri deneyimlere ilişkin ifadeler yer almaktadır. **Sizin** çocuğunuzla ilişkilerinizde neler yaşadığınızı değerlendirmek istiyoruz. Lütfen aşağıdaki ifadelerin **çocuğunuz çocukluk dönemindeyken** onunla ilgili düşünce ve davranışlarınızı ne ölçüde yansıttığını belirtiniz. Rakamlar aşağıda görülen sözlü ifadelere denk gelmektedir:

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 memnundum.	0	1	2	3	4
2.	Çocuğumun sosyal becerilerini tekrar tekrar gözden geçirirdim.	0	1	2	3	4
3.	Çocuğumun yeterince akıllı ve zeki biri olup olmadığını sürekli sorgulardım.	0	1	2	3	4
4.	Çocuğumun dış görünüşünden memnundum.	0	1	2	3	4
5.	Çocuğumun sosyal becerileri ile ilgili düşünceler beni rahatsız ederdi.	0	1	2	3	4
6.	Çocuğumun ahlaklı olup olmadığına ilişkin şüpheler beni rahatsız ederdi.	0	1	2	3	4
7.	Çocuğumun duygusal olarak dengesiz olduğu fikrini zihnimden uzaklaştırmakta zorlanırdım.	0	1	2	3	4

8.	Çocuğumun yeterince zeki olup olmadığı konusunda çevremdeki insanlardan (arkadaşlarımdan, ailemden vs.) sık sık onay arardım.	0	1	2	3	4
9.	Çocuğumla birlikteyken onun fiziksel kusurlarını görmezden gelmekte zorlanırdım.	0	1	2	3	4
10.	Çocuğumun hayatta "bir şey başarma" becerisini sürekli olarak diğer çocuklarınkiyle karşılaştırırdım.	0	1	2	3	4
11.	Çocuğumun zekâ seviyesini sürekli olarak diğer çocuklarınkiyle karşılaştırırdım.	0	1	2	3	4
12.	Çocuğumun duygusal tepkilerini diğer çocuklarınki ile karşılaştırma eğilimimi kontrol etmekte zorlanırdım.	0	1	2	3	4
13.	Çocuğumun yeterince zeki olmadığı düşüncesi beni çok rahatsız ederdi.	0	1	2	3	4
14.	Çocuğumun fiziksel görünüşündeki kusurlarla ilgili düşünceler beni rahatsız ederdi.	0	1	2	3	4
15.	Çocuğumun "iyi ve ahlaklı" biri olmadığı düşüncesi beni rahatsız ederdi.	0	1	2	3	4
16.	Çocuğumun zekâ seviyesinden memnundum.	0	1	2	3	4
17.	Çocuğumun yeterince ahlaklı olduğuna dair sürekli olarak kanıt arardım.	0	1	2	3	4
18.	Çocuğumun sosyal konulardaki beceriksizliğine ilişkin düşünceler beni rahatsız ederdi.	0	1	2	3	4
19.	Çocuğum aklıma her geldiğinde görünüşündeki kusurları düşünürdüm.	0	1	2	3	4

20.	Çocuğumun ahlak düzeyini sürekli incelerdim.	0	1	2	3	4
21.	Sürekli, çocuğumun sosyal yetersizliklerini telafi etmeye çalışırdım.	0	1	2	3	4
22.	Çocuğumun duygusal olarak dengesiz olduğuna ilişkin şüpheler beni rahatsız ederdim.	0	1	2	3	4
23.	Çocuğumun sosyal becerilerinden memnundum.	0	1	2	3	4
24.	Sürekli, çocuğumun tuhaf davranıp davranmadığını incelerdim.	0	1	2	3	4
25.	Zihnim çocuğumun hayatta başarılı olup olmayacağını değerlendirmekle çok meşguldü.	0	1	2	3	4
26.	Çocuğumun fiziksel kusurlarını diğer çocuklarınki ile karşılaştırma konusunda kontrol edemediğim bir dürtü hissederdim.	0	1	2	3	4
27.	Çocuğumun başarılı biri olup olmayacağıyla ilgili düşünceler zihnimi meşgul ederdi.	0	1	2	3	4
28.	Sürekli, çocuğumun iş okul hayatındaki potansiyel başarısına dair kanıt arardım.	0	1	2	3	4

Appendix F: Relationship Obsessive–Compulsive Inventory (ROCI)

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 şu an romantik ilişki içinde olduğunuz kişi (eş, sevgili, nişanlı, sözlü vb.) kastedilmektedir.

Rakamlar aşağıda görülen sözlü ifadelere denk gelmektedir:

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

1.	Partnerimi gerçekten sevmediğim fikrini aklımdan çıkaramam.	0	1	2	3	4
2.	Partnerimle ilgili şüphelerimi aklımdan kolaylıkla çıkarabilirim.	0	1	2	3	4
3.	İlişkimden sürekli şüphe duyarım.	0	1	2	3	4
4.	Partnerimin bana olan sevgisiyle ilgili şüphelerimi aklımdan çıkarmakta zorlanırım.	0	1	2	3	4
5.	İlişkimin doğru olup olmadığını tekrar tekrar kontrol ederim.	0	1	2	3	4
6.	Sürekli, partnerimin beni gerçekten sevdiğine dair kanıt ararım.	0	1	2	3	4

7.	Partnerimi neden sevdiğimi kendime tekrar tekrar hatırlatmam gerektiğini hissederim.	0	1	2	3	4
8.	Partnerimin beni sevdiğinden eminim.	0	1	2	3	4
9.	İlişkimde bir şeylerin “doğru olmadığına” dair düşüncelerden aşırı derecede rahatsız olurum.	0	1	2	3	4
10.	Partnerime olan sevgimden sürekli şüphe duyarım.	0	1	2	3	4
11.	Partnerime sürekli beni sevip sevmediğini sorarım.	0	1	2	3	4
12.	Sık sık ilişkimin “doğru” olduğuna dair onay ararım.	0	1	2	3	4
13.	Partnerimin aslında benimle birlikte olmak istemediği düşüncesi beni sürekli rahatsız eder.	0	1	2	3	4
14.	Partnerimi ne kadar sevdiğimi tekrar tekrar kontrol etmem gerektiğini hissederim.	0	1	2	3	4

Appendix G: Partner-Related Obsessive–Compulsive Symptoms 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. 0	Bana biraz uygun. 1	Bana orta düzeyde uygun. 2	Bana oldukça uygun. 3	Bana çok uygun. 4

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
4.	Partnerimin dış görünüşünden memnunum.	0	1	2	3	4
5.	Partnerimin sosyal becerileri ile ilgili düşünceler beni rahatsız eder.	0	1	2	3	4
6.	Partnerimin ahlaki düzeyine ilişkin şüpheler beni sürekli rahatsız eder.	0	1	2	3	4
7.	Partnerimin zihinsel olarak dengesiz olduğu fikrini aklımdan çıkarmakta zorlanırım.	0	1	2	3	4

8.	Partnerimin yeterince zeki olup olmadığı konusunda çevremdeki insanlardan (arkadaşlarımdan, ailemden vs.) sık sık onay ararım.	0	1	2	3	4
9.	Partnerimle birlikteyken onun fiziksel kusurlarını görmezden gelmekte zorlanırım.	0	1	2	3	4
10.	Partnerimin hayatta "bir şey başarma" becerisini sürekli diğer insanlarınkiyle karşılaştırırım.	0	1	2	3	4
11.	Partnerimin zeka seviyesini diğer insanlarınkiyle sürekli karşılaştırırım.	0	1	2	3	4
12.	Partnerimin duygusal tepkilerini diğer insanlarınkiyle sürekli karşılaştırma eğilimimi kontrol etmekte zorlanırım.	0	1	2	3	4
13.	Partnerimin yeterince zeki olmadığı düşüncesi beni çok rahatsız eder.	0	1	2	3	4
14.	Partnerimin fiziksel görünüşündeki kusurlarla ilgili düşünceler beni sürekli rahatsız eder.	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 zekâ seviyesinden memnunum.	0	1	2	3	4
17.	Sürekli, partnerimin yeterince ahlaklı olduğuna dair kanıt ararım.	0	1	2	3	4
18.	Partnerimin sosyal konulardaki beceriksizliğine ilişkin düşünceler beni her gün rahatsız eder.	0	1	2	3	4
19.	Partnerim aklıma her geldiğinde görünüşündeki kusurları düşünürüm.	0	1	2	3	4

20.	Partnerimin ahlak düzeyini sürekli incelerim.	0	1	2	3	4
21.	Sürekli, partnerimin sosyal yetersizliklerini telafi etmeye çalışırım.	0	1	2	3	4
22.	Partnerimin duygusal olarak dengesiz olduğuna ilişkin şüpheler beni rahatsız eder.	0	1	2	3	4
23.	Partnerimin sosyal becerilerinden memnunum.	0	1	2	3	4
24.	Partnerimin tuhaf bir şekilde davranıp davranmadığını sürekli incelerim.	0	1	2	3	4
25.	Zihnim partnerimin hayatta başarılı olup olmayacağını değerlendirmekle çok meşguldür.	0	1	2	3	4
26.	Partnerimin fiziksel kusurlarını diğer insanlarınkiyle karşılaştırma konusunda kontrol edemediğim bir dürtü hissederim.	0	1	2	3	4
27.	Partnerimin başarılı biri olup olmadığıyla ilgili düşünceler zihnimi meşgul eder.	0	1	2	3	4
28.	Sürekli, partnerimin iş/okul hayatındaki başarısına dair kanıt ararım.	0	1	2	3	4

Appendix H: Frost-Multidimensional Perfectionism Scale (F-MPS)

Aşağıda SİZİNLE ilgili bazı ifadeler yer almaktadır. Lütfen bu ifadeleri dikkatlice okuyun ve sizin için ne kadar geçerli olduğunu size uyan rakamı işaretleyerek belirtiniz.

Hiç katılmıyorum 1	Pek katılmıyorum 2	Ne katılıyorum ne katılmıyorum 3	Biraz katılıyorum 4	Tamamen katılıyorum 5

1.	Anne-babamın benim için koyduğu hedef ve beklentiler çok yüksekti.	1	2	3	4	5
2.	Plan yapmak benim için çok önemlidir.	1	2	3	4	5
3.	Çocukken, işleri en iyi şekilde (mükemmel) yapamadığım için cezalandırılırdım.	1	2	3	4	5
4.	Kendim için yüksek standartlar belirlemezsem, ikinci sınıf bir insan olurum.	1	2	3	4	5
5.	Anne-babam hiçbir zaman hatalarımı anlamaya çalışmadılar.	1	2	3	4	5
6.	Yaptığım her şeye tam anlamıyla hakim olmak benim için önemlidir.	1	2	3	4	5
7.	Düzenli/tertipli biriyim.	1	2	3	4	5
8.	Planlı, programlı biri olmak için çaba gösteririm.	1	2	3	4	5
9.	Eğer yaptığım işte başarısız olursam, kişi olarak başarısızımdır.	1	2	3	4	5

10.	Eğer bir hata yaparsam üzgün olmam gerekir.	1	2	3	4	5
11.	Anne-babam benim her şeyde en iyi olmamı istediler.	1	2	3	4	5
12.	Birçok insana göre, daha yüksek hedeflerim vardır.	1	2	3	4	5
13.	Eğer birisi, bir işi benden daha iyi yaparsa, kendimi o işte tamamen başarısız hissederim.	1	2	3	4	5
14.	Kısmen başarısız olmam tamamen başarısız olmam kadar kötü bir şeydir.	1	2	3	4	5
15.	Anne babam için sadece üstün başarı iyi bir sonuçtu.	1	2	3	4	5
16.	Çabalarımı bir amaca (hedefe) doğru yöneltmede çok iyiyimdir.	1	2	3	4	5
17.	Bir işi çok dikkatli yapsam bile, sık sık, o işi çok doğru yapmadığımı hissederim.	1	2	3	4	5
18.	Yaptığım şeylerde, en iyi olamamaktan nefret ederim.	1	2	3	4	5
19.	Çok yüksek hedeflerim vardır.	1	2	3	4	5
20.	Anne babam benden mükemmel olmamı beklerlerdi.	1	2	3	4	5
21.	Eğer bir şeyde hata yaparsam insanlar, beni olduğumdan daha beceriksiz düşüneceklerdir.	1	2	3	4	5
22.	Anne babamın beklentilerini karşılayabildiğim duygusunu hiçbir zaman hissetmedim.	1	2	3	4	5

23.	Eğer bir şeyi diğer insanlar kadar iyi yapmazsam, bu benim işe yaramaz bir insan olduğum anlamına gelir.	1	2	3	4	5
24.	Kendimle karşılaştırdığımda, diğer insanlar daha düşük yaşam koşullarından memnun gibiler.	1	2	3	4	5
25.	Yaptığım işte her zaman iyi olmazsam insanlar bana saygı duymazlar.	1	2	3	4	5
26.	Anne babamın, geleceğim hakkındaki beklentileri daima benimkilerden yüksekti.	1	2	3	4	5
27.	Düzenli/tertipli biri olmak için çaba gösteririm.	1	2	3	4	5
28.	Basit gündelik işleri bile iyi yaptığım konusunda sık sık kuşku duyarım.	1	2	3	4	5
29.	Düzen ve tertiplilik benim için çok önemlidir.	1	2	3	4	5
30.	Günlük işlerimi yaparken, çoğu insana göre, kendimden daha yüksek performans beklerim.	1	2	3	4	5
31.	Planlı biriyim.	1	2	3	4	5
32.	Yaptığım işte genellikle geri kalırım çünkü tekrar tekrar yaptığıma geri dönerim.	1	2	3	4	5
33.	Bir şeyi “tam” yapmak çok zamanımı alır.	1	2	3	4	5
34.	Ne kadar az hata yaparsam insanlar benden o kadar çok hoşlanacaklardır.	1	2	3	4	5
35.	Anne babamın standartlarını karşılayabildiğim duygusunu hiçbir zaman hissetmedim.	1	2	3	4	5

Appendix I: Experiences in Close Relationships-Revised (ECR-R)

Aşağıdaki maddeler romantik ilişkilerinizde hissettiğiniz duygularla ilgilidir. Bu araştırmada sizin ilişkinizde yalnızca şu anda değil, genel olarak neler olduğuyla ya da neler yaşadığınızla ilgilenmekteyiz. Maddelerde sözü geçen "birlikte olduğum kişi" ifadesi ile romantik ilişkide bulunduğunuz kişi kastedilmektedir. Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşılarındaki 7 aralıklı ölçek üzerinde, ilgili rakamı işaretleyerek belirtiniz.

1----------2----------3----------4----------5----------6----------7

Hiç katılmıyorum — Kararsızım/ fikrim yok — Tamamen katılıyorum

1.	Birlikte olduğum kişinin sevgisini kaybetmekten korkarım.	1	2	3	4	5	6	7
2.	Gerçekte ne hissettiğimi birlikte olduğum kişiye göstermemeyi tercih ederim.	1	2	3	4	5	6	7
3.	Sıklıkla, birlikte olduğum kişinin artık benimle olmak istemeyeceği korkusuna kapılırım.	1	2	3	4	5	6	7
4.	Özel duygu ve düşüncelerimi birlikte olduğum kişiyle paylaşmak konusunda kendimi rahat hissederim.	1	2	3	4	5	6	7
5.	Sıklıkla, birlikte olduğum kişinin beni gerçekten sevmediği kaygısına kapılırım.	1	2	3	4	5	6	7
6.	Romantik ilişkide olduğum kişilere güvenip inanmak konusunda kendimi rahat bırakmakta zorlanırım.	1	2	3	4	5	6	7

7.	Romantik ilişkide olduğum kişilerin beni, benim onları önemsediğim kadar önemsemeyeceklerinden endişe duyarım.	1	2	3	4	5	6	7
8.	Romantik ilişkide olduğum kişilere yakın olma konusunda çok rahatımdır.	1	2	3	4	5	6	7
9.	Sıklıkla, birlikte olduğum kişinin bana duyduğu hislerin benim ona duyduğum hisler kadar güçlü olmasını isterim.	1	2	3	4	5	6	7
10.	Romantik ilişkide olduğum kişilere açılma konusunda kendimi rahat hissetmem.	1	2	3	4	5	6	7
11.	İlişkilerimi kafama çok takarım.	1	2	3	4	5	6	7
12.	Romantik ilişkide olduğum kişilere fazla yakın olmamayı tercih ederim.	1	2	3	4	5	6	7
13.	Benden uzakta olduğunda, birlikte olduğum kişinin başka birine ilgi duyabileceği korkusuna kapılırım.	1	2	3	4	5	6	7
14.	Romantik ilişkide olduğum kişi benimle çok yakın olmak istediğinde rahatsızlık duyarım.	1	2	3	4	5	6	7
15.	Romantik ilişkide olduğum kişilere duygularımı gösterdiğimde, onların benim için aynı şeyleri hissetmeyeceğinden korkarım.	1	2	3	4	5	6	7
16.	Birlikte olduğum kişiyle kolayca yakınlaşabilirim.	1	2	3	4	5	6	7
17.	Birlikte olduğum kişinin beni terk edeceğinden pek endişe duymam.	1	2	3	4	5	6	7

18.	Birlikte olduğum kişiyle yakınlaşmak bana zor gelmez.	1	2	3	4	5	6	7
19.	Romantik ilişkide olduğum kişi kendimden şüphe etmeme neden olur.	1	2	3	4	5	6	7
20.	Genellikle, birlikte olduğum kişiyle sorunlarımı ve kaygılarımı tartışırım.	1	2	3	4	5	6	7
21.	Terk edilmekten pek korkmam.	1	2	3	4	5	6	7
22.	Zor zamanlarımda, romantik ilişkide olduğum kişiden yardım istemek bana iyi gelir.	1	2	3	4	5	6	7
23.	Birlikte olduğum kişinin, bana benim istediğim kadar yakınlaşmak istemediğini düşünürüm.	1	2	3	4	5	6	7
24.	Birlikte olduğum kişiye hemen hemen her şeyi anlatırım.	1	2	3	4	5	6	7
25.	Romantik ilişkide olduğum kişiler bazen bana olan duygularını sebepsiz yere değiştirirler.	1	2	3	4	5	6	7
26.	Başımdan geçenleri birlikte olduğum kişiyle konuşurum.	1	2	3	4	5	6	7
27.	Çok yakın olma arzum bazen insanları korkutup uzaklaştırır.	1	2	3	4	5	6	7
28.	Birlikte olduğum kişiler benimle çok yakınlaştığında gergin hissederim.	1	2	3	4	5	6	7
29.	Romantik ilişkide olduğum bir kişi beni yakından tanıdıkça, “gerçek ben”den hoşlanmayacağından korkarım.	1	2	3	4	5	6	7

30.	Romantik ilişkide olduğum kişilere güvenip inanma konusunda rahatımdır.	1	2	3	4	5	6	7
31.	Birlikte olduğum kişiden ihtiyaç duyduğum şefkat ve desteği görememek beni öfkelendirir.	1	2	3	4	5	6	7
32.	Romantik ilişkide olduğum kişiye güvenip inanmak benim için kolaydır.	1	2	3	4	5	6	7
33.	Başka insanlara denk olamamaktan endişe duyarım.	1	2	3	4	5	6	7
34.	Birlikte olduğum kişiye şefkat göstermek benim için kolaydır.	1	2	3	4	5	6	7
35.	Birlikte olduğum kişi beni sadece kızgın olduğumda önemser.	1	2	3	4	5	6	7
36.	Birlikte olduğum kişi beni ve ihtiyaçlarımı gerçekten anlar.	1	2	3	4	5	6	7

Appendix J: Debriefing Form

Sayın Katılımcımız,

Öncelikle araştırmamıza katıldığınız ve çalışmamıza destek olduğunuz için sizlere teşekkür ederiz.

Katıldığınız araştırmanın amacı, ilişkilerde görülen obsesif kompulsif belirtilerin, yetişkin bağlanma stilleri ve mükemmeliyetçilik aracılığıyla kuşaklararası aktarımını incelemektir. Araştırmamızda değişken olarak kullanılan ilişki temalı obsesif kompulsif belirtiler arasında, ebeveyn-çocuk, romantik ilişki ve partner odaklı belirtiler bulunmaktadır. Bu kapsamda, ebeveynlerin çocuklarına karşı gösterdiği ilişki temalı obsesif kompulsif belirtilerin, çocuklarının romantik ilişkilerine aktarılıp aktarılmadığını incelemeyi amaçlıyoruz. Bu amaçla da anne katılımcılarımızın ebeveyn-çocuk temalı obsesif kompulsif belirtilerini ölçebileceğimiz anket soruları kullanırken, genç yetişkin katılımcılarımızın romantik ilişki ve partner odaklı obsesif kompulsif belirtilerini ölçebileceğimiz anket sorularını kullanıyoruz. Ebeveyn-çocuk temalı obsesif kompulsif belirtilerin anneden çocuğa aktarımında rol oynayabilecek, yetişkin bağlanma stilleri ve mükemmeliyetçilik belirtilerini ölçmek amacıyla da genç yetişkin katılımcılarımıza bu değişkenleri ölçmeye ilişkin kullanılan bazı anket soruları yöneltiyoruz. Yukarıdaki değişkenlerin gönüllü katılım formunda açıkça belirtilmiyor olmasının nedeni anket sorularını cevaplandırdığınız süre boyunca istemli veya istemsizce oluşabilecek yanlılığı engellemektir.

Çalışmanın sağlıklı ilerleyebilmesi ve sonuçların güvenilirliği adına, çalışmaya katıldığını bildiğiniz diğer kişiler ile detaylı bilgi paylaşımında bulunmamanızı rica ederiz. Çalışmamıza katkı sağladığınız için sizlere tekrar çok teşekkür ederiz.

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