THE EFFECT OF PSYCHO-EDUCATION ABOUT MATERNAL ATTITUDES ON CHILDHOOD OBSESSIVE COMPULSIVE DISORDER SYMPTOMS

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THE EFFECT OF PSYCHO-EDUCATION ABOUT MATERNAL ATTITUDES ON CHILDHOOD OBSESSIVE COMPULSIVE DISORDER SYMPTOMS

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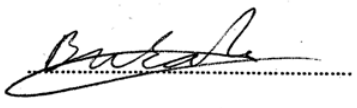
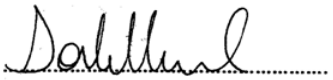
Member Yrd. Doç. Dr. Burak Doğruyol	
Member Yrd. Doç. Dr. Doruk Uysal Irak	

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ABSTRACT

THE EFFECT OF PSYCHO-EDUCATION ABOUT MATERNAL ATTITUDES ON CHILDHOOD OBSESSIVE COMPULSIVE DISORDER SYMPTOMS

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In recent years, studies begin to focus on the role of family in the development, maintenance and treatment of childhood obsessive-compulsive disorder (OCD). Although, the effect of parental attitudes on childhood OCD was revealed, in treatment procedures, it is still unclear which family related factors led to change in child symptomatology. Furthermore, there is also a gap in Turkish literature about effect of parental attitudes on childhood OCD. Therefore, the primary goal of the present study is to investigate relationship between maternal attitudes and subclinical childhood OCD in a Turkish sample. For this aim, sample consisted of ninety-seven, eight to ten-year-old children and their mothers. To examine relationship between maternal attitudes and subclinical childhood OCD, Parental Attitudes Research Instrument, Leyton Obsessional Inventory Child Version, State-Trait Anxiety Inventory for Children and Children's Depression Inventory were used as assessment tools. Moreover present study also investigates the effectiveness of

8-sessions psycho-education program about maternal attitudes. So, after initial assessments and regarding to exclusionary criteria, fifteen mothers randomly assigned either to group psycho-education condition (n=8) or waiting-list control condition (n=7). It was hypothesized that, 8-session psycho-education program would decrease negative attitudes of mothers and children's subclinical OCD symptoms. Finally it was also hypothesized that compared to children-mother pairs in waiting-list control group (n=7), children-mother pairs in psycho-education group (n=8) would experience a significant decrease in both negative attitudes and subclinical OCD symptoms. First findings showed that, marital conflict has a significant relationship with subclinical OCD symptoms. At the same time, marital conflict and authoritarian attitude also have significant relationship with state anxiety symptoms in children. Results also indicated that the psycho-education program was effective in reducing negative maternal attitudes and children's subclinical OCD symptoms.

Keywords: Childhood obsessive-compulsive disorder, parental attitudes, pscyho-education, effectiveness

ÖZ

ANNE TUTUMLARINA YÖNELİK PSİKO-EĞİTİM ÇALIŞMASININ ÇOCUKLUK ÇAĞI OBSESİF KOMPULSİF BOZUKLUĞU SEMPTOMLARINA ETKİSİ

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Son yıllarda yapılan araştırmalar çocukluk çağı obsesif kompulsif bozukluğu' nu (OKB) devam ettirici ve bozukluğun tedavisinde etkili olabilecek ailesel faktörler üzerine odaklanmaya başlamıştır. Ebeveyn tutumlarının çocuklarda görülen OKB üzerine etkisi ortaya çıkarılmasına rağmen, tedavi protokollerinde hangi ailesel faktörlerde yaşanan değişimin çocukların semptomlarını azalttığı direkt olarak gözlenememektedir. Ayrıca Türk literatüründe, ebeveyn tutumları ve çocukluk çağı OKB'si arasındaki ilişkiyi inceleyen araştırmalar yeterli sayıda değildir. Tüm bunlar göz önüne alındığında, bu çalışma öncelikli olarak Türk popülasyonunda anne tutumları ve çocukluk çağı eşik altı OKB belirtileri arasındaki ilişkiyi incelemeyi amaçlamıştır. Bu amaçla örneklem, çocukluk çağı OKB'nin başlangıç yaşı olarak kabul edilen 8-10 yaş grubu çocuklar ve onların anneleri olmak üzere doksan yedi

çocuk-anne çiftinden oluşmuştur. Anne tutumları ve çocuklarda eşik altı OKB belirtileri arasındaki ilişkiyi incelemek amacıyla, Aile Hayatı ve Çocuk Yetiştirme Tutum Ölçeği, Leyton Obsesyon Envanteri – Çocuk Formu, Durumluk-Sürekli Kaygı Envanter –Çocuk Formu ve Çocuklar için Depresyon Ölçeği ölçüm araçları olarak kullanılmıştır. Bunun ötesinde araştırma eş zamanlı olarak, çocuklarda görülen eşik altı OKB belirtileri ile ilişkili olduğu düşünülen ebeveyn tutumlarına müdahale etmek amacıyla oluşturulan sekiz seanslık psiko-eğitim çalışmasının etkililiğini incelemeyi amaçlamıştır. Ölçümler ve dışlama kriterleri göz önüne alınarak on beş anne seçkisiz atama yöntemi ile psiko-eğitim (n=8) ve bekleme listesi-kontrol gruplarına (n=7) atanmıştır. Yapılan psiko-eğitim çalışmasının annelerin olumsuz tutumlarında ve çocukların semptomlarının şiddetinde anlamlı azalmalar sağlayacağı düşünülmüştür. Son olarak, sekiz haftalık psiko-eğitim çalışması sonrasında, psiko-eğitim grubundaki anneler ve çocuklarla, bekleme listesi kontrol grubundaki anne ve çocuklar karşılaştırıldığında, psiko-eğitim grubundaki annelerin olumsuz tutumlarında ve çocuklarının eşik altı OKB semptomlarında anlamlı şekilde azalma olacağı varsayılmıştır. İlk bulgular, ebeveyn tutumu boyutlarından ‘’evlilik çatışması’’nın çocuklarda görülen eşik altı OKB semptomlarıyla ilişkili olduğunu göstermiştir. Aynı zamanda, evlilik çatışması ve otoriter tutumun da çocuklarda görülen sürekli kaygı belirtileriyle anlamlı derecede ilişkili olduğu görülmüştür. Psiko-eğitim sonrası bulgular ise, annelere uygulanan sekiz haftalık psiko-eğitim programının hem annelerin olumsuz tutumlarını hem de çocuklarda görülen eşik altı OKB semptomlarını azaltıcı etki gösterdiğini ortaya koymuştur.

Anahtar kelimeler: Çocukluk çağı obsesif kompulsif bozukluğu, ebeveyn tutumları, psikoeğitim, etkililik

To my lovely dad and mom who have been always supportive, protective and encouraged me.

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Istanbul, May, 2017 Ecem Akıncı

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CHAPTER 1

INTRODUCTION

1.1. Characteristics Of Childhood Obsessive Compulsive Disorder

Childhood Obsessive Compulsive Disorder (OCD) is a type of anxiety disorder and characterized by intrusive, recurrent and inappropriate thoughts, impulses and images that cause anxiety and marked distress which are identified as *Obsessions.* Furthermore, it includes repetitive behaviors (e.g. hand washing, ordering) and mental acts (e.g. counting, repeating words), which are aimed at reducing distress and preventing anxiety that are identified as *Compulsions.* Other symptoms of childhood OCD can show themselves as sleep deprivations, feel of shame, depressive mood due to feel of ‘’being different’’, agitation, irritability, slowness due to ‘’need for get things right’’ and neuropsychological differences such as difficulty in writing, reduction in processing speed or changes in verbal and nonverbal skills. As in adults, these obsessions and compulsions produce distress, time-consuming, and can cause severe impairment in one's social, emotional and educational life (DSM–IV–TR; American Psychiatric Association, 2000).

In childhood, children often produce ritualistic behaviors (mealtime, bedtime rituals etc.), which are a part of normal development. But these are not causing any impairments or distress in children (Geller &March, 2012). In a study, Piacentini et al. (2003) were examined the functional impairments in childhood OCD and findings showed that ninety percent of children with OCD reported at least one significant impairment in academic, social or family functions. Sometimes, obsessions and compulsions can interfere with the learning process of children and that leads academic difficulties or because the time consuming and shameful nature of symptoms, children can withdraw from social world. Furthermore, OCD can cause family conflicts, which makes things worse for children.

OCD is known as one of disorders, in which similar symptomology can be observed both in children and adults. At its core, childhood OCD indicates the cases in which the symptoms presents before the adolescence whereas, the onset of adulthood OCD indicates periods in adolescence or after adolescence (Kalra & Swedo, 2009). Although the symptomology of childhood OCD have similarities with adulthood OCD, researches also emphasize important differences in sex ratios and comorbidities. According to Chansky (2000), in childhood, boys tend to show symptoms of OCD more than girls in contrast, in adulthood OCD gender ratios appears to be more equal. On the other hand, when looking at comorbidities, attention deficit and hyperactivity disorder, separation anxiety disorder and tic disorders most commonly seen in children (Turkbay et al., 2000; Geller, 2006) whereas major depression, generalized anxiety disorder and bipolar disorder are comorbid disorders of adulthood OCD (Turkbay et al., 2000). Studies also mention the significant differences related with the process of child's development. Like in

adults most of children report obsessions with compulsions, but in childhood OCD, it is also not a rare for children to show only compulsions. Swedo et al. (1989) explained that with cognitive development process of children and the level of ability to explain their thoughts. Furthermore, for children, having insight of senseless nature of obsessions is not expected criteria, because of their ongoing cognitive development (DSM-IV; American Psychiatric Association, 2000).

As in adults, childhood OCD also has many subtypes. Common subtypes of obsessions are can be categorized as fear of contamination, fear of harm to oneself and another people, need for symmetry or doubting. On the other hand, common subtype of compulsions in children show themselves as, excessive washing and cleaning, checking, repeating, counting and praying (March & Mulle, 1998; Chansky, 2000; Fitzgibbons & Pedrick, 2003).

Contamination themes represent themselves as fear of touching doorknobs, money, shoes, dirty things, fear of germs, fear of illness or death. The obsessions about harm can be seen as fear of causing harm of someone; stabbing something like knife or poisoning and fear of being harmed by an illness, burglars etc. Obsessions about symmetry themes may be include need for lining up objects. Obsessions related with doubting themes indicate, being unsure about completed common actions. One of the prevalent compulsions in children is washing and cleaning compulsion (repeated hand washing and repeated showering) and it is mostly following contamination obsessions; avoiding touching doorknobs, money, shoes, dirty things. Whereas, rechecking doors, windows, locks etc. are examples of checking compulsions. Repeatedly seeking reassurance also can be seen as a verbal

form of checking compulsion (Fitzgibbons & Pedrick, 2003). Symmetry compulsions mostly involves actions like pulling up socks until they come the same high, retying something or lining up objects. The compulsion about counting directly indicates counting to certain number while doing something. Repeating/redoing show up with repeated actions like opening and closing doors, turning lights on and off, rewriting, erasing, rereading and so on. Finally, continuous praying and hoarding useless objects are also types of compulsions in children.

1.2. Subclinical OCD

Subclinical OCD defines a widely seen condition in both nonclinical children and adult population in which obsessive and compulsive symptoms still exist like in clinical OCD but apart from that there is no severe functional impairments in ones life (Black and Gaffney, 2008). Likewise, in subclinical OCD, obsessive-compulsive symptoms are not severe enough to diagnosing full-blown OCD (Brown et. al., 2014). Flament et al. (1988) mentioned that, children and adolescents with subclinical OCD can also have awareness about differences in their behaviors compared to their peers but they also organize their life around these different behaviors. On the other hand, children and adolescents with subclinical OCD can experience signs of mild impairments as well. Malakar and Basu (2016) reported that, fourteen-year-old students with subclinical obsessive-compulsive symptoms show lower school achievements when compared with their healthy peers.

Additionally, previous researches (Leonard et al., 1993; Valline-Bassile et al., 1996) demonstrated the prevalence of subclinical OCD in young population. The

results of previous researches showed that, nineteen percent and twenty-seven percent of the samples showed subclinical OCD symptoms, respectively.

These findings reveal the importance of investigating links between subclinical OCD and clinical OCD. But the relationship between subclinical OCD and clinical OCD is still controversial. According to Valline-Bassile et al. (1996), subclinical OCD can be precursor of OCD or it can be also a part of OCD spectrum, which is not indicated a progression to OCD. In their study, from among OCD diagnosed subjects, twenty one percent remained their diagnosis, seventeen percent moved to subclinical OCD diagnosis in one-year follow up. At the same time, from among subclinical OCD diagnosed subjects, twenty four percent remained their diagnosis, one point five percent moved to OCD diagnosis in one-year follow up. Black et al. (2003) also reported changeable transition relationship between subclinical OCD and clinical OCD. With 2-year follow up their findings showed that, from among fifteen children with subclinical OCD, four developed full-blown OCD, seven continued to have subclinical OCD whereas four of them progressed to neither condition. In 2008, Black et al. reviewed their previous findings and suggested more comprehensive and long term follow up studies for examining the relationship.

1.3. Epidemiology Of OCD

1.3.1. Prevalence

Before 1980's, OCD was considered to be an adulthood disorder and findings about childhood onset only were obtained from retrospective examinations. Even though OCD is thought as an adulthood disorder, later researches proved that OCD

also common in children and adolescents. In 1988 Flament et al. conducted first epidemiological study with three hundred and fifty six students, and found the one year prevalence of OCD in students as zero point seven percent. According to literature review of Heyman et al. (2001), between the years of 1988 and 1998 researches found the prevalence rate of OCD in children and adolescents between zero point six percent and three point six percent. In more recent years studies reported the prevalence rates as one percent and two percent (Piacentini et al., 2003; Karaman et al., 2011; Walther et al., 2014).

In Turkey, Diler and Avcı (2002) conducted a study with 1,739 outpatient children aged ranged between nine to fifteen and found one-year prevalence as two point seven percent. Abay et al. (2010) also found prevalence of OCD as one point four percent and Selvi et al. (2010) reported one-year prevalence of OCD as five point nine percent. It is obviously seen that, in worldwide studies, obtained prevalence rates in communities vary but in general, they were reported one percent to four percent. This prevalence shows that OCD in children is not rare, but it is rarely diagnosed. According to Chansky (2000), the first reason is that, children with OCD mostly try to hide their symptoms from their families to not being perceived as problematic. They also tend to hide because of their intense worry to be ashamed and be ridiculed. Another reason results from inadequacy of mental health professionals about childhood OCD. Because children cannot talk about their obsessive and compulsive symptoms openly, most of mental health professionals misdiagnose OCD as other anxiety disorders or depression (Swedo et al., 1992). These points are clearly indicating the reasons of underestimation in the prevalence rates of childhood OCD.

1.3.2. Age Of Onset, Gender Differences, Course and Prognosis

In developmental perspective, it is known that, younger children have more dependence on their families. Especially, in primary and elementary school years, children still remain dependence on their families (March & Mulle, 1998). Literature mentioned that, the onset of OCD symptomatology in children begin to show itself in related years. According to studies, for children, the age onset range between eight and eleven years (Oy, 1994; Pigott, 1998; Palulu et al., 1999; Oner & Aysev, 2001; Karaman et al., 2011). Addition to that, it can be rarely seen in very early onset as in first five years. A previous research (Nakatani et al., 2011) showed that, families with children in early onset OCD, representing more impairment in social functioning.

Most of research especially focuses on the onset of OCD to investigate link between childhood OCD and adulthood OCD. Retrospective studies have a consensus on that, at least 1/3 of the adults who has OCD diagnosis, had their first symptoms in childhood and adolescence (Karno et al., 1988; do Rosario-Campos et al., 2001) Furthermore, Geller (2006) also emphasized that, severity and persistence of OCD highly associated with early onset. Additionally, it is known that approximately eighty percent of the adults who get OCD diagnosis in their adulthood also had OCD symptoms before age eighteen. Because the childhood OCD has a tendency to persist into adulthood, it can cause more severe impairments in functioning of one's life (Karaman et al., 2011).

Gender differences also examined with the studies that focused on onset of disorder. In an epidemiological study (Ruscio et al., 2010), within 2073 participants,

males reported very early onsets, with nearly twenty percent of males having onsets before age ten. In general gender findings showed that, in childhood period, the ratio of boys to girls seen as 3:2. With the adolescence, the ratio of gender equalizes to each other.

The prognosis of childhood OCD has gradual, wax and wane pattern (Pişgin& Özen, 2010). OCD is determined as a chronic disease and positive long-term outcomes can obtain with just treatments. Berg et al., (1989) conducted a two year follow up study with untreated sample, and found that, among from OCD diagnosed subjects, fifty percent of them remain the same diagnosis in two-year follow-up. On the other hand, in a longitudinal study (Bloch et al., 2009), forty-six children with OCD reassessed after nine years. In follow-up evaluation, forty-four percent of treated children experience remission from clinical OCD to subclinical OCD.

Earlier onset, severe childhood OCD symptoms, and comorbid disorders associated with persistence of OCD symptoms into adulthood. Other longitudinal study emphasized the differences in OCD courses both in children and adults. Mancebo et al. (2014) conducted first prospective study that examine course of OCD both in children and adults at the same time. Results indicated that, within three-year follow up, seventy-nine percent of children experienced remission. Moreover, the rate of achieving remission for children significantly higher than adults which suggest that children can remit from OCD at a faster rate than adults. These results show that, remission can be maintained in children more likely than adults and having treatment in the early course of disorder predicts better prognosis.

1.3.3. Comorbidity

OCD is a heterogeneous disorder with its comorbidities. Sixty percent to eighty percent of children and adolescents have one or more comorbid psychiatric disorders like in adulthood OCD (de Alvarenga et al., 2012). High rate of comorbidity can have a contribution to higher levels of impairment in children with OCD. National Institute of Mental Health (NIMH) reported that, only twenty-six percent of the children had OCD alone. Langley et al. (2010) examined the influence of comorbidities on the demographic, psychiatric, and functional status of two hundred and nine children and adolescents with OCD. Results showed that, thirty three percent of the sample has secondary anxiety disorders and thirteen percent of them have secondary externalizing disorder such as attention deficit hyperactivity disorder (ADHD) and Oppositional defiant disorder (ODD). Adult OCD populations are not report disruptive disorders much as children with OCD. As expected, children with secondary externalizing disorder had greater functional impairments and children with secondary anxiety disorders reported higher levels of family conflict. In 2001, Heyman et al. reported that within four hundred thirty-eight subjects, twenty-five children aged between five and fifteen received OCD diagnosis, fifty-two percent of them met also criteria for another anxiety disorder, twenty percent for a major depressive disorder, forty-four percent for a conduct disorder and one percent for an eating disorder. Geller (2006) reported that during the course of OCD thirty-nine percent of children and sixty-two percent of adolescents have also symptoms of depression.

Nowadays, researches put emphasis on the comorbidity of ADHD with OCD. Because OCD and ADHD were categorized as neurodevelopmental disorders it is

thought that they have high comorbidities. Based on their common traits Sheppard et al. (2010) examined one hundred and fifty five children with OCD and found that eleven percent of them met criteria for ADHD as well. Additionally, Sudhodolsky et al. (2005) mentioned functional impairment in a large group of children with OCD with and without comorbid ADHD. Findings showed that, children with OCD plus ADHD have more functional impairments in school and social functioning when compared to OCD only group.

It is also thought that association between OCD and Tourette's syndrome (TS) is significant. Because OCD symptoms and TS symptoms resembles, it is difficult to differentiate them. But in some cases, TS and OCD become comorbid. According to Chansky (2000), thirty percent of children with OCD also have TS whereas fifty percent of children with TS also have obsessive compulsive symptoms.

1.4. Etiology

Even though the intense efforts of researches, the exact causes of OCD has not found yet. But most of researches have a consensus on the idea that, the combinations of biological and environmental factors have an influence on development of OCD. Family related researches about OCD reveal the genetic component of disorder, so the contribution of genetic factors is considered as well. Psychological theories also explain the contribution of psychological factors to development of OCD likewise.

1.4.1. Biological Factors

Biological theories focus on the link between OCD and brain structure. They try to explain OCD in terms of the deficits that in the specific areas of the brain structure. Researches about biological factors revealed that, people with OCD have abnormal activities in basal ganglia, the prefrontal orbital cortex and the cingulate gyrus. In one study (Pujol et al., 2004), brain structures of seventy-two OCD patients and seventy-two control group subjects compared with magnetic resonance images (MRI), and findings indicated the alterations in basal ganglia, in the medial frontal gyrus and the medial orbitofrontal cortex. Brain scanning techniques are also use for to determine differences in brain structures of children with OCD. Yalçın et al. (2011) explored the metabolic variations between untreated OCD cases and healthy cases in thirty children age ranged eight to sixteen. Results showed that, children with OCD have metabolic alterations in anterior cingulate cortex and in the left inferior frontal gyrus when compared to healthy cases. Szesko et al. (2004) also compared twenty-three children with OCD with twenty-seven healthy subjects and found brain abnormalities in related areas of children with OCD.

All of these brain structures use serotonin as a messenger. Serotonin is a neurotransmitter that carries massages between the related areas of brain. Studies also mentioned about dysregulation in the activity level of serotonin, which is a neurotransmitter that responsible from modulation of emotions, moods and other psychological and physiological functions (Waite& Williams, 2009). Because imbalance in serotonin levels has a role in OCD, serotonin reuptake inhibitors (SSRIs) are used as medications in treatment of both adults and children. But, in literature there is a confusing point about biological factors. March and Mulle

(1998), reported about brain scanning works that showed the effect of psychotherapies without any medication in which brain abnormalities return to normal. Without any medications, psychotherapies work in many OCD cases in both adults and children. Therefore, there is still uncertainty about whether the biological factors cause OCD alone, or not.

1.4.2. Genetic Factors

Studies mention about the genetic factors that may be associated with development of OCD. According to March and Muller (1998), a child has chance to develop OCD with the range of two percent to eight percent, if child has a parent with OCD. Addition to that, this ratio increases if parent developed OCD in his childhood. In 2002, Vural et al. examined the familial characteristics of forty OCD diagnosed children and their first-degree relatives. Findings stated that, eleven percent of first-degree relatives also had OCD symptoms. Chabane et al. (2005) conducted a study with one hundred and eight children and adolescents in early onset OCD and with their first-degree one hundred and ninety-nine relatives. Results indicated that, for the risk of OCD among first-degree relatives is seventeen percent, and thirty-two percent of children with OCD have also family history of OCD.

Twin studies also showed the role of genetic factors in OCD. In one of these studies it is found that, OC symptoms had a significant genetic influence with the range of twenty-seven percent to forty-seven percent in adults whereas forty-five percent to sixty-five percent in children (van Grootheest et al., 2005). In another research, Bolton et al. (2007), included 854 six years-old twins to study and found that, genetic factors also play important role in OCD not just obsessive-compulsive behaviors.

In all that researches, the genes that related with OCD have not been able to find yet. This suggests the idea of learning through modeling. But in most of OCD cases in which both children and parent have OCD, symptoms are quite different in each of family member (March and Muller, 1998). In conclusion, although researches show the hereditary component of OCD, there are still OCD cases without any family history.

1.4.3. Psychological Factors

Many of the psychological theories account for the development and maintenance of OCD. Nowadays, just two of these theories proved their effectiveness on the treatment of OCD. Behavioral and cognitive theories are resource of evidence-based cognitive behavioral therapies.

1.4.3.1. Behavioral Theories

The fear and avoidance behaviors in anxiety related disorders are explained on the basis of Mowrer's Two- Process Theory. The theory explains how an anxiety develops and maintain. According to Mowrer (1960) two processes have role in development and maintenance of anxiety. First process involves classical conditioning, and the second process involves operant conditioning. According to Foa (1985), in the first stage a certain object or situation associate with fear. The emotion of fear experienced by individual as aversive and leads to seeking behavioral solutions to decrease effects of fear. In the second process, these behavioral solutions reduces the effect of fear, also decreases the anxiety and by this way they negatively reinforced.

In OCD, people also associate a certain stimuli with fear, and to reduce this fear they produce behaviors. These behaviors lead temporary reduction in fear and

they turn into compulsive behaviors. Once the situation and fear connect each other, avoidance behavior reinforced instead of tolerating the emotion of fear so obsessional fears and compulsive behaviors maintain in this way (Rector et al., 2001). However, because obsessions are the products of cognitive processes, it is thought that behavioral theory is insufficient for explaining OCD alone.

1.4.3.2. Cognitive Theories

In general, cognitive theories focus on mistaken assumptions and the misinterpretations of thoughts. In OCD, people report intrusive, recurrent and inappropriate thoughts, which causes anxiety. Essentially, all the people without OCD also have intrusive thoughts. But distinction is originated from the interpretation of these intrusive thoughts rather than presence of them (Rector et. al., 2001). Cognitive theory suggests that, people with OCD tend to overstate the importance of intrusive thoughts and perceive them as potential danger. In the process, they also exaggerate the severity and probability of the harm. Perceived personal responsibility about intrusive thoughts, thought- action fusion (TAF) and thought suppression have also role in this misinterpretation and leads to increase in anxiety. Increased anxiety force people to practice both avoidance and compulsions. Farrell and Barret (2006) investigated the developmental differences in cognitive processing in the sample of children, adolescents and adults with OCD. Findings showed that, perceived responsibility, probability biases and thought suppression strategies were higher in adolescents and adults with OCD when compared to children with OCD. Findings also mentioned that, children with OCD experienced fewer uncontrollable, intrusive and distressing thoughts when compared to adolescents and adults. In another research, cognitive appraisals of threat in a sample of children with OCD aged ranged between seven to thirteen years were examined

and compared with anxious and healthy children. Results showed that, children with OCD had higher ratings of responsibility and TAF and lower cognitive control rates when compared to healthy children but differences were not significant (Barrett &Healy, 2003). Considering these findings, there is confusion about whether cognitive model of OCD fully overlap the sample of children with OCD. So related researches suggested that, OCD related- cognitions of children may not fully developed until adolescence or measurements are inadequate for assessing children's cognitive processes in OCD.

1.4.4. Psycho-social Factors

Familial factors do not cause OCD alone, but family members can affect maintenance of OCD, and they also can affect by child's OCD. It is known that there is a bidirectional relationship between child's OCD and parental factors. Because children have more dependence on their families, OCD is not just having an effect on child's life but also have negative affect on all family members or vice versa (March& Mulle, 1998). Researches showed that, the way family reacts to child, has an effect on the course of OCD.

Most of study (Farrell& Barrett, 2007; Waters& Barrett, 2000; March, 1995) in the literature put emphasis on the relation between childhood OCD and familial factors. According to these studies, family interaction, accommodation and family involvement in OCD symptoms are significant factors for maintenance of OCD in children. The majority of researches have a consensus on that, parenting behaviors such as accommodation and parent child interactions have direct influence on child's OCD and treatment outcomes (Storch& McKay, 2013).

1.4.4.1. Family Interaction

Family interaction considered as a one of the risk factors in development and maintenance of childhood OCD. Therefore, researches try to investigate the link between childhood OCD, expressed emotion and parental rearing styles.

Barrett et al. (2002), tried to examine the differences in family interactions and for that they compared families who have child with OCD, families with other clinically diagnosed child, and families with nonclinical child. Results indicated that parent and child behaviors during family interactions showed differentiation in families who have child with OCD and in other families. Children with OCD were less warmth, less use positive problem solving skills and less confident. On the other hand, parents of child with OCD showed less permitting for autonomy and less confidence in their child's ability. Hibbs et al. (1991) also found that families of children with OCD have an increase in the level of criticism, hostility and/or emotional over involvement, which defined as, expressed emotion. In parallel with other studies Amir et al. (2000) found a link between increased rejection/ criticism and child's compulsions. They predicted that, this relation can be a reaction of child to punishing negative attitudes of family members or these negative attitudes (rejection and criticism) can cause increase in child's anxiety and this leads more compulsions. On the other hand in a more recent study (Schlup et al., 2011), criticism, over involvement, doubt, avoidance, warmth, confidence, positive problem solving and rewarding independence determined as a behavioral dimensions of child-mother interaction in OCD diagnosed group. Researchers tried to examine the changes in these dimensions after a manualized cognitive behavioral therapy (CBT) treatment. Results indicated that, negative behaviors (criticism, over involvement and

doubt) showed reduction, positive behaviors (warmth, confidence and positive problem solving) showed increase with treatment process.

Researches also put emphasis on relationship between parents as well. Marital conflict defined incoherency, inconsistency and instability between spouses. Emery (1982) explained the contribution of marital conflict on childhood anxiety disorders. According to explanation, parents' inconsistent and instable attitudes lead to experience uncontrollability and insecurity in children and in the end it leads to anxiety. Jekielek (1998) conducted a longitudinal study between six and fourteen years old children and found that marital conflict was a predictor of anxiety in children. Spence et al. (2002) tried to examine the relationship between marital conflict and anxiety symptoms and found that marital conflicts during childhood significantly related with anxiety in adolescents. March & Mulle (1998) also stated marital conflict as a one of the factors that exacerbate the course of OCD and threaten the treatment process as well. Disagreement over the disorder can cause distress in children and that affects the course of OCD.

Literature also demonstrated the association between parental rearing styles and anxiety in children. In a study, Wolfradt et al. (2003) examined the relation between perceived parental styles and anxiety. Study found a significant relationship between authoritarian attitude and anxiety. According to results, higher perceived control and pressure of parents and lower perceived warmth were predictor of anxiety. Brown and Whiteside (2008) also examined the relation between perceived parental rearing styles and child anxiety. Findings stated that, children who perceived higher parental rejection also had higher levels of anxiety. Like previous findings Alonso et al. (2004) reported that, OCD patients perceived higher parental rejection

and lower parental emotional warmth when compared to control group. Timpano et al. (2010) investigated relationship between parenting styles and obsessive-compulsive symptoms in nonclinical sample. Retrospective reports stated that, there was a positive relationship with obsessive-compulsive symptoms and authoritarian parenting style at the same time these symptoms negatively correlated with authoritative parenting style. In a Turkish study, Haciomeroglu & Karanci (2013) examined the perceived parental rearing behaviors and obsessive-compulsive symptoms. Related findings also indicated that, mother overprotection has a predictive role in obsessive-compulsive symptoms. Based on empirical studies about the association between compulsive-like behavior and pathological OCD in children, Yamauchi et al. (2016) tried to investigate affect of maternal rearing attitudes on compulsive-like behavior in children and mediating factor role of children's emotions in a recent study. Findings did not establish any direct relation between maternal rearing attitudes and compulsive-like behaviors but it is supported that, maternal rearing attitudes had an effect on children's compulsive-like behaviors through shaping of emotion in children.

1.4.4.2. Family Accommodation

Family accommodation refers to involvement of family members to child's OCD rituals. Families participate or assist to child's rituals or reorganize their family life around these rituals (Waters & Barrett, 2000). The accommodation behaviors can described as participation to rituals, providing reassurance and assisting child to avoid unwanted situations (Lebowitz et al., 2012). Allsopp and Verduyn (1990) investigated the prevalence of accommodation in families and reported that, seventy percent of families were accommodate the child's obsessive-compulsive symptoms.

Peris et al. (2008) conducted a study with sixty-five children with OCD and their families. They tried to explore family accommodation, and found that with the fifty-six percentages family accommodation was common among these families. Findings also showed that, parental involvement in rituals highly correlate with OCD symptom severity. Bipeta et al. (2013) included thirty-five treatment-naive children and adolescents with OCD to study and findings suggested that, family accommodation was positively related with severity of symptoms and functional impairment. The family accommodation also associates with family stress. The relationship between family distress and family accommodation was investigated in a study, and findings revealed that, high familial distress and accommodation associate with anxiety and depression in the family members (Amir et. al., 2000). The effect of family accommodation to treatment outcome also investigated. Merlo et al. (2009) examined the effect of family accommodation on treatment outcome within fifty children and adolescent aged ranged six to eighteen. All of these subjects and their parents participated in cognitive behavioral therapy for OCD. Results indicated that, family accommodation decreases with cognitive behavioral therapy and this result leads more positive therapy outcomes in children and adolescents.

These findings suggest that, family interaction and family accommodation to child's OCD behavior is an important factor that effects childhood OCD and also reveals importance of family participation to treatment.

1.5. Treatment Of Childhood OCD

Before planning treatment, a detailed assessment with child, parents and school is essential. Childhood OCD can show differentiation depending on the cases.

The course of childhood OCD can be affected by several factors (comorbid disorders, developmental level of child, familial context or other psychosocial factors), so that, all of these information must obtain with assessments. Because the course of OCD differentiates person-to-person, treatment plans of OCD are organized as more individualistic way. In general, the treatment of OCD includes pharmacotherapy, cognitive behavioral psychotherapy (CBT) and combined therapies.

1.5.1. Pharmacological Treatments

Medication use is the one of the most common interventions in childhood OCD. Because an imbalance in serotonin levels may have an effect on development of OCD, pharmacotherapies mostly comprise of both serotonin re-uptake inhibitors (SRIs) and selective serotonin reuptake inhibitors (SSRIs) (March & Mulle, 1998). It is determined that, Clomipramine is the most effective SRIs whereas; fluoxetine, fluvoxamine, paroxetine and sertraline are effective SSRIs. According to Geller et al. (2012), the most common side effects of both Clomipramine and other SSRIs are cardiovascular changes, headache, nausea, tremor, gastrointestinal complaints, drowsiness, restlessness, insomnia, disinhibition, agitation or hypomania. They also mentioned that, most of patients do not respond pharmacological treatments for six to ten weeks, and ten-twelve weeks necessary to decide whether a child respond to treatment or not. In a meta-analysis research, the effect of pharmacological treatments was assessed in twelve studies with 1044 children and adolescent participants. Results showed the significant effect of medications and furthermore, clomipramine was found superior to each of the SSRIs (Geller et. al., 2003). On the other hand, a previous research (De- Veaugh- Geiss et al., 1992) also indicated that,

SRIs leads decrease in Children's Yale Brown Obsessive Compulsive Scale results, which means a reduction in severity of child's Obsessive-compulsive symptoms. On the other hand, meta-analysis researches (Abramowitz et. al., 2005; Watson &Rees, 2008) that examined the effect of medication and CBT showed that, both of medication and CBT are the only effective treatments of childhood OCD, moreover the effect of CBT on symptomatology is greater than medication.

Studies reported that, in some cases patients could be unresponsive to medications. Geller et al. (2012) reported that, the long-term maintenance of pharmacotherapy is unclear but the long-term maintenance of CBT supported by researches. For that reasons, in treatment of OCD medication plus CBT procedures should be considered (March& Mulle, 1998).

1.5.2. Cognitive Behavioral Therapy

Cognitive behavioral therapies (CBT) also used in treatment of childhood OCD. CBT is mainly focuses on both one's way of thinking, behaving and the interaction between them. For treatment of OCD, CBT generally uses two behavioral techniques that are exposure (E) and response prevention (RP). Exposure includes systematic confrontations to anxiety-producing situations, and response prevention includes not doing compulsive behaviors voluntarily when they are triggered by anxiety or obsessions (Fitzgibbons & Pedrick, 2003). The two techniques bonded each other with a principle, which states that, exposure can be successful only the absence of compulsions and rituals (March & Mulle, 1998).

As shown in Table 1.1, the well-accepted CBT protocol of childhood OCD consists of twelve sessions and developed by March & Mulle (1998). The program

contains (1) psycho-education, (2) cognitive training, (3) mapping OCD, (4) graded exposure and response prevention and (5) relapse prevention sessions. Families just attend the sessions 1,7 and 11. In first session, disorder is placed in neurobehavioral framework and treatment process also explained to parents. In 7th and 11th sessions information and instructions are given to parents about how they can assist their child during the process. In general parents are also included to other parts of sessions for to follow child's homework and improvement. Considering the child's developmental stage and level of family accommodation, parents can be participating sessions more frequently (Reinecke et al., 2006).

Table 1.1. CBT Treatment Protocol

Visit Number	Goals
Session 1	Psycho-education
Session 2	Cognitive training
Session 3	Cognitive training and mapping OCD
Session 4-10	Exposure and response prevention
Session 11-12	Relapse prevention
Session 1,7,11	Parent sessions

Source: Reinecke, M. A., Dattilio, F. M., & Freeman, A. (Eds.). (2006). *Cognitive therapy with children and adolescents: A casebook for clinical practice*. Guilford Press.

CBT is a prominent therapy, which shows effective results in the treatment of children with OCD. Most of research, generally reported the superiority of the CBT in the treatment of childhood OCD. In a randomized controlled study (Williams et al., 2010), twenty-one children and adolescents with OCD were assigned to CBT condition and waiting-list condition. In CBT condition, subjects received 10 sessions CBT. In result, the symptoms of the group who received CBT produced significant reduction while, symptoms of waiting list group showed small changes. However,

when the waiting list groups were treated with same protocol, they also showed same treatment outcomes. Weidle et al. (2015) examined the change in the quality of life in children with OCD. The sample consisted of one hundred and thirty five children and adolescents with age ranged seven to seventeen, and all subjects assessed before and after fourteen CBT sessions. They were also compared with normal population. Findings indicated that, the level of quality of life in children and adolescents with OCD showed significant improvement, and became the same range as quality life in the general population.

Literature also emphasized the superiority of the CBT against the medication. In a meta-analysis research (Abramowitz et al., 2006), studies were examined between 1970 and 2004; findings indicated that, CBT produced significant improvements in the treatment of childhood OCD when compared to medication. More recently, first meta-analysis research which examined treatment efficacy, treatment response, and symptom/diagnostic remission all together, both in CBT and SRIs treatment for children and adolescents with OCD, conducted by McGuire et al. (2015). The results of comprehensive Meta analysis indicated that, CBT has a large to excellent treatment effect for treatment efficacy, treatment response, and symptom/diagnostic remission whereas, SRIs has moderate to large treatment effect in all factors.

Despite the all these findings, studies also supported the effectiveness of the collaboration of combined therapies consist of both CBT and medications. In a previous research (O'Connor, et al., 2006), CBT, medication, CBT plus medication and placebo conditions were compared. Results showed that, both CBT and medication produced effective treatment results when compared to placebo

condition. On the other hand, CBT found more effective than medication in the treatment of OCD. Furthermore, CBT plus medication treatments produced greater clinical improvements when compared to other conditions.

1.5.3. Family Focused Treatments

In the view of family-child interaction related studies, the significance of family participation in treatment of childhood OCD is revealed. Storch et al. (2010) examined the factors that related with poor results of CBT in childhood OCD. Results indicated the family-related issues as one of the most important factor that associated with poor results of CBT in childhood OCD. With this finding the importance of collaboration with family members in treatment of childhood OCD is revealed. The links between familial expressed emotion and severity of childhood OCD symptoms also demonstrated in previous researches. Parent's behaviors like criticism, over control, rejection and avoidance serves a role of reinforcement and maintenance in development of anxiety in children. Therefore a treatment process with both family and child can be more effective (Hudson and Rapee, 2001). Smorti (2012) explained the importance of family involvement in treatment with three reasons. Firstly, in most cases, expressed emotion in family highly associated with the idea that, compulsions are manageable. So explaining the nature of behaviors and externalizing the disorder can be helpful for parents to regulate their own attitudes. Secondly, it is apparent that, there is a link between family accommodation and course of OCD. The tendency of family members to accommodate child's rituals can be seen more clearly with their participation in sessions. Lastly, parents can learn to become a coach of children in external world, so that, more significant treatment outcomes can be obtained.

Based on literature, the importance of bidirectional relationship between familial factors and childhood OCD and the significance of family-involve therapies can be seen obviously. All of these studies underscored the role of family-related issues as maintenance factor on childhood OCD and the effect of child's OCD on family functioning revealed as well. Black et al. (1998) examined the effect of OCD on family functioning and results indicated that, caregivers of OCD patients had higher pathological scores and had more severe impairments in functioning when compared to control group. They also determined that, the anger/frustration, depression, fatigue, family crisis and disrupted family/ personal life was the most disruptive results of OCD that faced by caregivers.

For anxiety disorders Creswel and Cartwright-Hatton (2007) put emphasis on the effect of family-based cognitive behavioral therapy. Results of the review showed that, family-based CBT shows more efficacy than other therapies. In a recent study, Peris et al. (2012) examined the children with OCD receiving Family Focused CBT and their family functioning and its relationship with treatment outcome. They reported that, families with lower levels of parental blame and family conflict and higher levels of family cohesion were likely to have child who positively responded family-based CBT when compared to families with high level parental blame, conflict and lower family cohesion. Depending on these earlier studies, a comprehensive meta-analysis was conducted by Thompsan-Hollands et al. (2014). In the study, twenty-nine earlier studies that were examining family based treatment response in 1,366 OCD patients were reviewed.

As a result similar with early studies, literature showed that family based treatments were associated with a significant effect on OCD symptomatology and family treatments were also associated with a larger effect on patient functioning than other treatments**.**

With relevant findings in the literature, parental participation to OCD treatments strengthens its importance. However, when the literature examined, it can obviously seen that, family involvement in childhood OCD therapies generalized with particular frames. For example in most of studies, family component of therapies are consist of informing or educating parents about implementation of exposure or response prevention strategies or psycho-education about OCD. In one comprehensive study Waters et al. (2001) developed a family treatment model for children and adolescents with OCD, and they added a specific psycho-education for parental accommodation to classical cognitive behavioral intervention. Parental dimension of treatment consisted of learning about child relaxation techniques, importance of family accommodation, parental anxiety management techniques and response prevention techniques. In results, family accommodation showed a decrease but because of lack of comparison group, it cannot be determined that which specific component of the treatment led to reduction in family accommodation. In other study (Ginsburg et al., 2011), researchers applied a specific interventional model to seven different OCD cases, which included parenting practices (strategies for anxiety-enhanced behaviors such as criticism, over-involvement, lack of support) in addition to other familiar techniques. Although, this study also stated reduction in OCD symptoms, it cannot evaluate which aspects of treatment were effective for behavioral change.

1.6. Psycho-education Programs For OCD

In general psycho-education defines as a process that is crucial for all treatment processes in which knowledge about relevant disorder is provided to clients (Dobson& Dobson, 2009). When the literature examined, it is determined that 'psycho-education' is the common component in family-based OCD interventions too. But in general, psycho-education was just used as an educating program for the child and family about the disorder. It provides knowledge to the child and family about OCD symptoms, how the disorder is developed and maintained and contains information about treatments. In more comprehensive studies, psycho-education can also use as a guide for families to cope with their child's symptoms and behaviors and for to teach how to cope with child's rituals. In one study Piacentini et al. (2011) used a psychosocial comparison condition addition to family based CBT and applied a psycho-education/ relaxation-training program to some of the participants and their families. Even though the particular content of psycho-education shows similarity with classical studies, results indicated that, psycho-education/relaxation training program caused reduction in family-reported, psychosocial impairments.

Even though the maintenance effect of parental attitudes on childhood OCD is obvious, there is still a significant gap in the literature about specific intervention studies that focuses parental attitudes. Steketee and Noppen (2003) emphasized the rarity of studies that examine the effect of psycho-educations in the literature. They also suggested psycho-educational programs in which knowledge about OCD, accommodation behaviors and negative attitudes that effect OCD provided to parents. Kircanski et al. (2011) also mentioned the relationship between family

factors and treatment outcomes and underscored the necessity of family interventions beyond the traditional psycho-educations. It is obviously seen that large part of the studies did not contain any family specific psycho-education programs that is just focusing on families' own attitudes. Considering the importance of parental attitudes on childhood OCD, it is thought that, examining the utility of a specific psycho-education program that contains information about negative effect of parental attitudes can be significant.

1.7. Aim Of The Current Study

Although previous studies focused on the development of OCD and found that it is a neurobiological disorder, recent studies begin to focus on the maintenance factors of OCD. Especially in childhood OCD, familial factors stand out as maintenance factor. As it mentioned in previous studies (Farrell& Barrett, 2007; Waters& Barrett, 2000; March, 1995) family interaction, accommodation and family involvement in OCD symptoms are significant factors for maintenance of OCD in children. Negative attitudes (criticism, over-involvement, doubt, hostility etc.) of parents and parental rearing styles have a role in childhood OCD as well. Correspondingly, family involvement in treatment of childhood OCD becomes more popular. As it mentioned before, previous studies (Water et al., 2001; Ginsburg et al., 2011; Peris et al., 2012; Thompson-Hollonds et al., 2014) showed the effectiveness of family involvement in the treatments.

Further to that, rather than family involvement, parent-only interventions becomes more of an issue in recent years. Lebowitz (2013) conducted a study with families of children with OCD who also refused individual CBT. A manualized

parent-only intervention was applied to parents within ten sessions. In result, parents reported reduction in the OCD symptoms of children. More recently, Rosa-Alcazar et al. (2017) also assessed the effectiveness of parent only intervention of OCD over against to cognitive behavioral family-based treatment (CBFT). Results showed that both parent training condition and CBFT condition produced positive treatment outcomes. Moreover, in both condition, family accommodation, internalizing and externalizing problems also significantly reduced. However, both family-involved treatment processes and parent only interventions are not containing any strategies for to change negative parental attitudes directly. All of these findings reveal the effectiveness of family on childhood OCD. But, it is still unclear which family related factors led to change in child symptomatology. Furthermore, there is also a gap in Turkish literature about effect of parental attitudes on childhood OCD.

Therefore, the primary goal of the present study is to investigate relationship between parental attitudes and subclinical childhood OCD in a Turkish sample. In current study, a structured and manualized psycho-education program was developed based on previous parent only interventions. So, second goal of the study is examining the effect of specific psycho-education about parental attitudes on subclinical childhood OCD symptomatology.

Consequently, hypothesis of present study are proposed as follows:

H1: There will be significant relationship between parental attitudes and child's subclinical obsessive-compulsive symptoms.

H2: Psycho-education will produce significant reductions in negative parental attitudes.

H3: Psycho-education will produce significant reductions in negative parental attitudes when compared to waiting-list-control group.

H4: Psycho-education will produce significant reductions in child's subclinical obsessive-compulsive symptoms.

H5: Psycho-education will produce significant reductions in child's subclinical obsessive-compulsive symptoms when compared to waiting-list-control group.

1.8. Importance Of The Current Study

Although foreign literature has some studies that examined relationship between parental attitudes and childhood OCD, there is a lack of research in Turkish literature about related issue. Current study will provide crucial information about association between parental attitudes and childhood OCD and therefore the gap in the Turkish literature will be filled.

Most of researches about treatment of childhood OCD have included families to process but it is not still known that which part of the intervention effects the treatment outcomes. With this study, direct effect of the specific psycho-education on both maternal attitudes and child symptomatology will be observed.

It seems apparent that family involvement in treatment of OCD contributes to efficacy of treatment results, addition to that importance of the parental attitudes in treatment of childhood OCD will reveal with present study. With manualized psycho-education program, current study will also contribute to treatment of childhood OCD.

Moreover, because subclinical sample assessed with present study, in the long run it is expected to be a preventive study regarding clinical OCD. For all aspects, it is expected that present research will fill important gaps in the Turkish literature and it is also expected to provide significant information for therapeutic applications.

CHAPTER 2

METHOD

2.1. Participants

The participants in this study comprised third and fourth grade students and their mothers, who selected from two government schools in Kocaeli. Consent forms sent to families via the third and fourth grade students in these schools. Based on mothers' approval, ninety-seven child mother pairs included to study. Children's age ranged between 8 and 10 *(M= 8,88, SD= .68)* and 57 (58,8%) of the children were girls, 40 (41,2%) of them were boys. Forty-nine (50.5%) of children were attending 3rd grade and forty-eight (49.5%) of them were attending 4th grade of schools. For all children, exclusionary criteria included having diagnosis of major depressive disorder, early onset psychosis or bipolar disorder, mental retardation, attention deficit hyperactivity disorder, learning disabilities and neurological disorders or other medical diagnosis. All detailed information relevant to demographic characteristics of children was presented in Table 2.1.

Table 2.1. Socio-demographic Characteristics of Children

Variables	N	%
Age		
8	29	29,9
9	51	52,6
10	17	17,5
Gender		
Girl	57	58,8
Boy	40	41,2
Grade		
3rd grade	48	49,5
4th grade	49	50,5

Mothers' age ranged between 27 and 48 *(M= 35,41, SD = 4,92)*. Mothers' education levels varied from primary school to university. 28 of mothers (28.9%) graduated from primary school, 19 of them (19.6%) graduated from secondary school, 33 of them (34 %) graduated from high school, 6 of them (6.2%) graduated from college and 11 (11.2%) of them graduated from university. While looking at mothers' current working status, 26 (26.8%) of them are working in a job and 71 (73.2%) of them are housewives. On the other hand 93 (95,9%) of the mothers are married whereas 4 (4,1%) of them are divorced. All detailed information relevant to socio-demographic characteristics of mothers was presented in Table 2.2.

Table 2.2. Socio-demographic Characteristics of Mothers

Variables	N	%
Age		
≤ 30	20	20,6
30-40	58	59,8
≥ 40	19	19,6
Education		
Primary School	28	28,9
Secondary School	19	19,6
High School	33	34
College	6	6,2
University	11	11,3
Working Status		
Working	26	26,8
Housewife	71	73,2
Marital Status		
Married	93	95,9
Divorced	4	4,1

Within all sample, twenty-nine children scored above the mean scores in Leyton Obsessional Inventory Child Version (LOI-CV) and State-Trait Anxiety Inventory for Children (STAI-CH) and, at the same time, their mothers also got high scores from at least one of the subscales of Parental Attitudes Research Instrument (PARI) which indicated negative parental attitudes. These twenty-nine mothers selected for the effectiveness study of psycho-education. Fifteen of them, approved to participate in group sessions. At the end, these mothers randomly assigned either to group psycho-education condition or waiting-list control condition (see procedures below more details). In psycho-education group one mother dropped out at the beginning of sessions.

In both conditions, none of the mothers received any psychological interventions and none of them used psychiatric drugs during the process. All detailed information relevant to socio-demographic characteristics of mothers in both psycho-education and waiting-list control condition was presented in Table 2.3.

Table 2.3. Socio-demographic Characteristics of Mothers in Psycho-education and Waiting-list Control Condition

	Psycho-education group		Waiting-list-control group	
Variables	N	%	N	%
Age				
≤ 30	2	28,6	1	14,3
30-40	3	42,9	6	85,7
≥ 40	2	28,6	0	0
Education				
Primary School	2	28,6	4	28,9
Secondary School	1	14,3	1	19,6
High School	4	57,1	2	34
Working Status				
Working	1	14,3	3	42,9
Housewife	6	85,7	4	57,1
Marital Status				
Married	7	100	7	100

In both groups, none of the children had any primary psychiatric disorder diagnosis. None of them received psychological intervention and did not use any psychiatric drugs during the process.

All detailed information relevant to demographic characteristics of children in both conditions was also presented in Table 2.4.

Table 2.4. Socio-demographic Characteristics of Children in Psycho-education and Waiting-list Control Condition

	Psycho-education group		Waiting-list-control group	
Variables	N	%	N	%
Age				
8	2	28,6	2	28,6
9	3	42,9	2	28,6
10	2	28,6	3	42,9
Gender				
Girl	4	57,1	4	57,1
Boy	3	42,9	3	42,9
Grade				
3th grade	2	28,6	4	57,1
4th grade	5	71,4	3	42,9

2.2. Measures

In this study, mothers' instruments consisted of a demographic questionnaire (see Appendix A) and The Parental Attitude Research Instrument (see Appendix B). At the same time, Leyton Obsessional Inventory Child Version (see Appendix C), State-Trait Anxiety Inventory for Children (see Appendix D) and Children's Depression Inventory (see Appendix E) were used as assessment tools for children.

2.2.1. Demographic Questionnaire

A demographic questionnaire was created for getting more detailed information about families by the researcher. Mothers were asked to complete the questionnaire which includes the school name, grade, age, gender, psychological treatment status, psychiatric medication use of children; at the same time, marital status, ages, working status, education levels, psychological treatment status, psychiatric medication use and socioeconomic status of parents.

2.2.2. Parental Attitudes Research Instrument (PARI)

The PARI originally developed by Shaffer and Bell in 1958 is to assess mother's child rearing attitudes and feelings towards to family life. In the present time, PARI is widely used in researches about parent-child relationships.

The first form of PARI consists of 115 items. Then PARI was shortened to 60 items and became more practical. The items rated on a 4-point Likert scale, ranging from 1- ''completely disagree'' to 4 - "'completely agree''. The items, 2, 29 and 44 reversely coded. The instrument has 5 sub-scales, which are: (1) dependency, (2) egalitarianism and democratic attitude, (3) rejection of the homemaking role, (4) marital conflict and (5) authoritarianism. ''Dependency'' indicates mother's over controlling and over protective attitudes towards child and consists of 16 items. ''Egalitarianism and democratic attitudes'' subscale consist of 9 items and indicates cooperation and friendship between mother and child. ''Rejection of the homemaking role'' subscale consists of 13 items and it contains feelings of incompetency, dissatisfaction about being parent and other negative attitudes. 6 itemed ''marital conflict'' subscale aimed to measure tension between spouses.

Lastly, ‘’ strictness and authoritarianism’’ subscale indicate expectation of obedience from children and it consist of 16 items. Except the ’Egalitarianism and democratic attitudes’’, other four subscales, refers to negative parental attitudes and higher scores indicates greater level of negative attitudes.

The shortened version of PARI was firstly adapted Turkish by Le Compte and Özer in 1978 and the short version was used in current study. Test-retest reliability of the factors was found between .58 and .88 for Turkish version. Küçük has performed the second adaptation of PARI in 1987. In that study, construct validity of PARI subscales were also supported.

In current study, the alpha coefficient of the egalitarianism and democratic attitude subscale was found .28 that indicated unacceptable value whereas alpha coefficients of other subscales were between .74 and .81 that indicated acceptable values.

2.2.3. Leyton Obsessional Inventory Child Version (LOI-CV)

Leyton Obsessional Inventory Child Version (Berg et al., 1986) is a 44-item tool for determining current OCD symptomatology in children. In later years, LOI-CV was shortened to reduce the time needed for children to complete scale. It is demonstrated that, LOI-CV is an effective tool for distinguishing the group of children with diagnosis of OCD from normal population in 8-18 age range. Grados &Riddle (1999) mentioned that inventory is beneficial for determining basic OCD symptomatology and monitoring treatment change over time. Furthermore, it is a practical tool because not requiring clinician administration and not time consuming.

Short form of LOI-CV consisted of 20 items. Each 20 item includes two responses: the presence/absence of the symptom described in the item (*yes/ no*) and the interference of the symptom if it is present-from 0 (*no interference*) to 3 (*high interference*). At the end, three scores can be calculated as total score, total interference score and yes score. If a child chooses the "yes" option he/she is then required to rate the interference of the item on a 4-point Likert scale. Cut-off points for evaluating LOI-CV are 15 for yes scores, 25 for interference score, whereas 35 for total score. Higher scores indicate greater level of interference. The inventory consists of four factors: (1) general obsessive; (2) dirt-contamination; (3) numbers-luck and (4) school.

The original version of the inventory was found to have a Cronbach's alpha of .81 for total score.

The Turkish version of the LOI-CV developed by Palulu and Erol (1999), with a sample including 1762 children and adolescent age between 8-16. The inventory showed adequate internal consistency with Cronbach's alpha coefficient .80 and test-retest reliability coefficient was also significant (r= .73). The study demonstrated that, Turkish version of the inventory is a reliable tool to determine childhood OCD symptomatology. Turkish version of inventory also consists of four factors: (1) cleanliness and tidiness; (2) repetition and indecision; (3) special words and numbers and (4) checking. In current study LOI was used to identify subclinical obsessive-compulsive symptoms.

In current study, the alpha coefficient of the total score was found to be .89.

2.2.4. State-Trait Anxiety Inventory for Children (STAI-CH)

The State- Trait Anxiety Inventory for Children (Spielberger, 1973) is a widely used measurement that for designed to measure two types of anxiety in children: (1) state-anxiety, (2) trait anxiety. State anxiety can be conceptualized as a child's subjective, temporary reaction to specific anxiety situations. Thus, the intensity of state anxiety can vary over the time. On the other hand, trait anxiety is the relatively stable reaction of child to anxiety states.

The STAI-CH can be administered children between the ages of 6 and 14. Inventory, consist of two separate, self-report scales and each section consist of 20 statements. In State Anxiety scale (A- State), children asked to rate how they feel at a particular moment in time. And in Trait Anxiety scale (A-Trait), children asked to rate how they generally feel. In both sections, it is required that to rate on 3 point scale ranging from *hardly ever* to *often*. In A- State, 10 items reversely coded. For both sections, total score range from 20 to 80, with higher scores indicating greater level of anxiety.

Ozusta (1995) was made Turkish adaptation of the inventory with a sample including 615-nonmedicated children age between 9 and 12. Turkish version of STAI-CH (Ozusta, 1995) shows adequate internal consistency with Cronbach's alpha coefficient .82, and .81 respectively for A-State and A-Trait scales.

In current study, the alpha coefficients of the A-State and A-Trait were found .87 and .84, respectively.

2.2.5. Children's Depression Inventory (CDI)

The CDI (Kovacs, 1981) is widely used measurement, which was developed based on Beck Depression Inventory for evaluating depression in children. The presence and severity of three dimensions (cognitive, affective and behavioral) of depression symptoms can be assessed through CDI. CDI is an effective self-report tool for determining depression symptoms during previous two weeks in children and adolescents age between 7 to 17 years.

The CDI consists of 27 items and each item gets scores between 0 and 2. Items are scored depending on the severity of the response. The score '0' means that the symptom is not present, score '1' means the symptom is present and mild whereas score '2' means the symptom is definitely present. 13 items reversely coded in CDI. Total scores ranged from 0 to 54 and cut off point is proposed as 19. Higher scores indicate greater depression level.

The original version of CDI has demonstrated relatively high levels of internal consistency, with a coefficient alpha of .86 (Kovacs, 1992).

Oy (1992) made the validity and reliability assessment of Turkish version of the CDI with a sample age between 8-13. CDI have good concurrent validity and reliability with Cronbach's alpha .77.

In current study, the alpha coefficient of the scale was found to be .80.

2.3. Procedure

Firstly, an approval for this study was obtained from Bahçeşehir University Committee for Research and Publishing (see Appendix F). Then, permission of Kocaeli City National Education Directorate was received for the data collection and

application in schools (see Appendix G). In conclusion, study was formed in three phases: pre-assessment phase, psycho-education phase and post-assessment phase.

2.3.1. Pre-assessment Phase

First of all, school administrations and related teachers were informed about study by researcher. Prepared information form (see Appendix H), consent form (see Appendix I), demographic questionnaire and PARI packs were distributed to children with the help of teachers. Children were told that they are taking part in a study that tried to examine emotions and behaviors of children and mothers. They were also reminded that it was not a test and there were no correct answers. Then, children were asked to take information form, consent forms, demographic forms and PARI home and have mothers complete them. In information forms mothers informed about study that tried to examine specific anxiety symptoms in children and maternal attitudes. It was requested that mothers give their contact numbers in consent forms, to communicate with them about psycho-educations. Because personal information was requested, mothers also informed with information forms about confidentiality. It was clarified that, only the researcher held all the personal information and not shared them with anyone including school administrations and teachers. The researcher's contact details were provided and participants were encouraged to make contact if they had any questions. In consent forms, mothers were informed about expectations from them, number of assessment tools that were used for both mother and child, and aim of study in general. Mothers willing to participate were asked to return the signed consent forms with completed demographic questionnaires and PARI to the schools with children. As a result, ninety-seven mothers approved to participate in study and completed PARI. Thus, pre-assessment phase for mothers were completed.

Based on mothers' consents, their children were also assessed. By permission of school administrations, researcher attended to one lesson of 3rd and 4th grade children in both school, separately. During these classes, the symptomatology of these ninety-seven children was assessed through LOI, STAI and CDI. LOI was applied to assess the sub-clinic population; STAI and CDI were used to assess the severity of depression and anxiety symptoms. Finally, pre-assessment phase for children were also completed.

Within these ninety-seven participants, twenty-nine of children scored above the mean scores in LOI and STAI and, at the same time, their mothers also got high scores from at least one of the subscales of PARI which indicated negative parental attitudes.

In conclusion, with the determination of targeted sample for psycho-educations, the all pre-assessment phase completed.

2.3.2. Psycho-education Phase

According to findings that obtained in pre-assessment phase, twenty-nine mothers were invited to participate psycho-education program with telephone calls by researcher. The first information about findings and psycho-education sessions were given to mothers with telephone calls. The reason that they chose to this program also was explained them, briefly. The day and time options that they prefer were noted by researcher. Finally, within these twenty-nine mothers, fifteen of them, approved to participate psycho-education groups. For comparison, these mothers randomly assigned either to group psycho-education condition or waiting-list control condition. At the end, researcher got in contact with these eight mothers in psycho-

education condition, and an agreement was made about the days and times of psycho-education sessions. Waiting-list control condition group also were informed about the process and date the their psycho-education sessions would begin.

The psycho-education program was developed based on a literature review about problems that experienced by the parents of children with OCD and other anxiety disorders. Within this framework, psycho-education program was constituted of eight sessions which includes information about nature of OCD, its development and maintenance in children, prevalent negative parental attitudes, proper parental attitudes, emotional self-awareness, thought-emotion-behavior relationship, managing with stressful situations, coping techniques and effective communication skills. For each topic a presentation was prepared. Presentations supported by videos, exercises and role-plays. For each topic a booklet was also given to mothers. Weekly homework was assigned to mothers with booklets.

For psycho-education program, all mothers in both schools invited to meet in one of these schools. Program was arranged 90 minutes group session for each week. Each topic and the sessions were held once a week in the conference hall of a selected school. All detailed information relevant to psycho-education program was presented in table 2.5.

Table 2.5. Psycho-education Program

Week	**Topics**	**Homework**
1	• Acquaintance • Revision of Group Rules • Introduction to Childhood Fears and Anxieties	• Family Culture Monitoring Form (Fitzgibbons & Pedrick, 2003)
2	• Developmentally Normal and Unusual Behavior Routines • Obsessive-Compulsive (O-C) Symptoms	• O-C Symptoms Monitoring Form (Fitzgibbons & Pedrick, 2003)
3	• Relationship between Childhood O-C Symptoms and Negative Parental Attitudes • Prevalent Negative Attitudes	• O-C Symptoms Monitoring Form • Coping Strategies about Child's Problematic Behavior Monitoring Form
4	• What to Do Instead of Exhibiting Negative Attitudes	• Negative Attitude Monitoring Form (Fitzgibbons & Pedrick, 2003) • O-C Symptoms Monitoring Form
5	• Realization of Own Feelings • Thought-Emotion-Behavior Circle	• Thought-Emotion-Behavior Monitoring Form • O-C Symptoms Monitoring Form
6	• Coping Strategies for Stress • Self Instruction Techniques • Distraction Techniques • Relaxation Techniques	• Coping Strategies Monitoring Form • O-C Symptoms Monitoring Form
7	• Effective Communication Skills	• Feelings Response: Homework Sheet (Bratton et al., 2006)
8	• Implementation of measures	

2.3.3. Post-assessment Phase

The 8th session of the psycho-education program was planned as a post assessment session for mothers. In the last session, it is requested that mothers to complete PARI again. Simultaneously, LOI and STAI were applied to children again. Finally, post-assessment phase for both mother and children were completed.

For comparison, mothers and children in waiting-list control group repeated the LOI, STAI and PARI. The psycho-education process of waiting-list control group, still in progress.

2.4. Data Analysis

Prior to analysis, the subscales of PARI, which are dependency, egalitarianism and democratic attitude, rejection of the homemaking role, marital conflict and authoritarianism, subscales of LOI which are general obsessive, dirt-contamination, numbers-luck and school, A-State and A-Trait, and child depression symptoms were examined through IBM SPSS program for accuracy of data entry, missing values, fit between their distributions and the assumptions of multivariate analysis.

All missing values replaced by the mean. No univariate outliers detected. By using Mahalonobis distance with $p < .01$, derived from leverage scores, 8 multivariate cases were identified as multivariate outliers. 8 multivariate outliers were deleted, leaving 97 cases for analysis.

2.4.1. Descriptive Statistic

Descriptive statistics including means, standard deviations and range of the measures screened.

2.4.2. Preliminary Research Analyses

In present study, to explore the relationship between parental attitudes and child's subclinical obsessive-compulsive symptoms, Pearson Correlation analysis was conducted among variables: dependency, egalitarianism and democratic attitude, rejection of the homemaking role, marital conflict, authoritarianism, total negative attitudes, cleanliness and tidiness, repetition and indecision, special words and numbers, checking, A-State and A-Trait anxiety symptoms.

2.4.3. Main Research Analyses

First of all non-parametric tests were used because of small sample size in both psycho-education and waiting-list control groups. Chi-square Test was conducted to examine differences between socio-demographic characteristics of psycho-education group and waiting-list control group. Furthermore, Mann-Whitney *U* test was used to compare pre-test measures of two groups. Then to examine the changes in negative maternal attitudes and subclinical OCD symptoms of children after 8-week psycho-education program and to compare these changes with waiting-list control group, Wilcoxon Signed-Ranked Test was also conducted.

CHAPTER 3

RESULTS

3.1. Descriptive Statistic

3.1.1. Measure Characteristics

All descriptive statistics of the measures were given in Table 3.1.

Table 3.1. Descriptive Information of the Measures

Measures	*M*	*SD*	*Range*
PARI	127.84	15.89	87 - 172
LOI-CV	28.11	13.93	4 - 67
A-State	30.57	6.29	20 - 51
A-Trait	35.42	6.81	21- 57
CDI	10.35	6.01	1- 27

Note: PARI: Parental Attitude Research Instrument, LOI-CV: Leyton Obsessional Inventory Child Version, A-State and A-Trait: State-Trait Anxiety Inventory for Children, CDI: Child Depression Inventory

3.2. Preliminary Analysis

Firstly, in order to investigate the relationship between obsessive-compulsive symptoms, anxiety symptoms and depressive symptoms in children, Pearson correlation analysis was conducted.

According to results, obsessive-compulsive symptoms was positively correlated with trait anxiety symptoms r (95) = .37, $p < .01$ indicating that obsessive compulsive symptoms increases as trait anxiety symptoms increases. Obsessive-compulsive symptoms was also positively correlated with depressive symptoms r (95) = .34, $p < .01$ indicating that obsessive compulsive symptoms increases as depressive symptoms increases. However, there was no significant relationship between obsessive-compulsive symptoms and state anxiety symptoms.

On the other hand, state anxiety symptoms positively correlated with trait anxiety symptoms r (95) = .36, $p < .01$ indicating that state anxiety symptoms increases as trait anxiety symptoms increases. There was also significant relationship between state anxiety symptoms and depressive symptoms, r (95) = .48, $p < .01$ indicating that state anxiety symptoms increases as depressive symptoms increases.

Trait anxiety symptoms was positively correlated with depressive symptoms, r (95) = .48, $p < .01$ indicating that trait anxiety symptoms increases as depressive symptoms increases. Table 3.2 displays the correlation between those measures.

Table 3.2. Correlations between Measures

	1	2	3	4
1 LOI-CV				
2 A-State	.15			
3 A-Trait	.37**	.36**		
4 CDI	.34**	.48**	.48**	

Note: LOI-CV: Leyton Obsessional Inventory, A-State and A-Trait Anxiety Inventory, CDI: Child Depression Inventory
*p< .05; **p<.01

Secondly, Pearson correlation analysis was also performed between parental attitudes, anxiety symptoms and obsessive-compulsive symptoms to test hypothesis 1 that indicates a significant relationship between subclinical childhood obsessive-compulsive symptoms and parental attitudes. For that purpose, total score of negative attitudes in PARI and subscales of PARI, which are dependency, egalitarianism and democratic attitude, rejection of the homemaking role, marital conflict, authoritarianism, at the same time, total interference score in LOI-CV, total score in LOI-CV and subscales of LOI-CV; cleanliness and tidiness, repetition and indecision, special words and numbers, checking and finally A-state and A-trait anxiety symptoms were included to correlation analysis.

According to results of correlation analysis as shown in table 3.3, marital conflict was positively correlated with total interference score in LOI-CV, r (95) = .23, p< .05 indicating that as the marital conflict increases among parents, interference of obsessive-compulsive symptoms in children increases as well. Marital conflict was also positively correlated with total score in LOI-CV, r (95) = .24, p< .05 indicating that as the marital conflict increases among parents, obsessive-

compulsive symptoms in children increases as well. When the relationship between marital conflict and sub factors of LOI-CV examined, results showed that, marital conflict was also positively correlated with, cleanliness and tidiness, r (95) = .22, $p<$ .05, repetition and indecision, r (95) = .22, $p<$ .05 and special words and numbers, r (95) = .21, $p<$ .05. On the other hand, there were no other significant relationships between sub scales of PARI and sub scales of LOI-CV. Marital conflict positively correlated with A-Trait anxiety symptoms, r (95) = .24, $p<$ .05 indicating that as the marital conflict increases among parents, anxiety symptoms in children increases as well.

Furthermore, authoritarianism positively correlated with A-Trait anxiety symptoms, r (95) = .25, $p<$ .05 indicating that as the mother's strict and authoritarian attitudes increases, anxiety symptoms in children increases as well.

Table 3.3. Correlations between Relevant Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1 PARI FAC1														
2 PARI FAC2	-.01													
3 PARI FAC3	.42**	.01												
4 PARI FAC4	.29**	-.04	.51**											
5 PARI FAC5	.74**	012	.47**	.31**										
6 T-PARI	.85**	-.01	.75**	.57**	.87**									
7 INT-LOI	.04	-.03	.08	.23*	.09	.12								
8 T-LOI	.06	-.03	.10	.24*	.12	.15	.98**							
9 A-STATE	-.07	-.10	.02	.10	.20	.07	.17	.16						
10 A-TRAIT	.11	-.19	.11	.24*	.25*	.22*	.33**	.37**	.36**					
11 LOI FAC1	.09	.00	.12	.22*	.08	.14	.94**	.93**	.15	.28**				
12 LOI FAC2	.03	-.01	.01	.22*	.04	.07	.76**	76**	.15	.34**	.61**			
13 LOI FAC3	.01	-.14	.05	.21*	.10	.10	.74**	.73**	.15	.32**	.55**	.63**		
14 LOI FAC4	.05	-.02	.01	.12	.10	.04	.84**	.82**	.13	.25*	.69**	.55**	.61**	

Note: PARI FAC1: dependency, PARI FAC2: egalitarianism and democratic attitude, PARI FAC3: rejection of the homemaking role, PARI FAC4: marital conflict, PARI FAC5: authoritarianism, T-PARI: total scores of negative attitudes, INT-LOI: total interference scores of LOI-CV, T-LOI: total scores of LOI-CV, A-STATE: state anxiety, A-TRAIT: trait anxiety, LOI FAC1: cleanliness and tidiness, LOI FAC2: repetition and indecision, LOI FAC3: special words and numbers, LOI FAC4: checking

*p<.05;**p<.01

Additionally, A-Trait anxiety symptoms positively correlated with cleanliness and tidiness, r (95) = .28, $p < .01$, repetition and indecision, r (95) = .34, $p < .01$ and special words and numbers, r (95) = .32, $p < .01$ and checking r (95) = .34, $p < .05$.

In conclusion, results also indicated that there were a positive and significant correlation between total of parental negative attitudes and A-Trait anxiety symptoms, r (95) = .22, $p < .05$ indicating that child's anxiety symptoms increases as the mother's negative attitudes increases.

3.3. Main Analysis

First of all, Chi-square Test and Mann-Whitney *U* test was conducted to examine differences between psycho-education group and waiting-list-control group. Chi-square Test was used to compare socio-demographic characteristics (educational status, working status and marital status) of mothers in both the groups. The result of the Chi-square analysis indicated that there were no significant differences ($p > .05$) between socio-demographic characteristics of the mothers in psycho-education group and waiting-list-control group. In order to compare differences between psycho-education group and waiting-list-control group Mann-Whitney *U* test was also conducted. Results of Mann-Whitney U test did not indicate any statistically significant differences ($p > .05$) between psycho-education group and waiting-list-control group according to their pre-assessments. Results of the Mann-Whitney *U* test of mother related variables were shown in Table 3.4 and Mann-Whitney *U* test results of children related variables were shown in Table 3.5.

Table 3.4. The Comparison of Mother Related Variables between Psycho-education Group and Waiting-list Control Group by Pre-test Results

	Psycho-education (N=7)	Waiting-list-control (N=7)		
	Mean Rank	Mean Rank	*U*	*p*
PARI FAC1	8.86	6.14	15.000	.222
PARI FAC2	6.36	8.64	16.500	.298
PARI FAC3	6.86	8.14	20.000	.556
PARI FAC4	8	7	21.000	.649
PARI FAC5	8.14	6.86	20.000	.561
Total PARI	8.71	6.29	16.000	.277

Note: PARI FAC1: dependency, PARI FAC2: egalitarianism and democratic attitude, PARI FAC3: rejection of the homemaking role, PARI FAC4: marital conflict, PARI FAC5: authoritarianism, T-PARI: total scores of negative attitudes *p<. 05

Table 3.5. The Comparison of Children Related Variables between Psycho-education Group and Waiting-list Control Group by Pre-test Results

	Psycho-education (N=7)	Waiting-list-control (N=7)		
	Mean Rank	Mean Rank	*U*	*p*
SYM-LOI	7.50	7.50	24.500	1
INT-LOI	6.71	8.29	19.000	.479
T-LOI	6.86	8.14	20.000	.564
LOI FAC1	7.29	7.71	23.000	.847
LOI FAC2	5.79	9.21	12.500	.116
LOI FAC3	6.64	8.36	18.500	.434
LOI FAC4	7.21	7.79	22.500	.794
A-STATE	8	7	21.000	.654
A-TRAIT	8	7	21.000	.654

Note: SYM-LOI: total symptom score of LOI-CV, INT-LOI: total interference scores of LOI-CV, T-LOI: total scores of LOI-CV, LOI FAC1: cleanliness and tidiness, LOI FAC2: repetition and indecision, LOI FAC3: special words and numbers, LOI FAC4: checking, A-STATE: state anxiety, A-TRAIT: trait anxiety *p<. 05

Secondly, to examine effectiveness of 8-week psycho-education program in both maternal attitudes and in subclinical OCD symptoms of children, Wilcoxon Signed-Ranked Test was also conducted.

Results of the test showed that, 8-week psycho-education program elicit statistically significant change between pre- and post- assessments of mothers in

psycho-education group. Findings indicated that there was a statistically significant difference in total scores of negative attitudes (Z= -2.201, p= .028), dependency (Z= -2.375, p= .018) and authoritarian attitude (Z= -2.371, p= .018) and posttest scores of these variables showed significant decrease. On the other hand, there were no statistically significant changes in marital conflict, egalitarianism and democratic attitude and rejection homemaking role.

On the contrary, results of the mothers in waiting-list control group showed that, authoritarian attitude (Z= -2.388, p= .017) and total of negative attitudes (Z= -1.696, p= .090) significantly increase in post assessment. Other variables did not show significant change in post assessment. Means and standard deviations of pretest and posttest scores related with mothers were given in Table 3.6.

Results of the Wilcoxon Signed-Ranked Test also showed that, in psycho-education group, 8-week psycho-education program elicit statistically significant change in OCD and anxiety symptoms of children. There were statistically significant change in interfere score of OCD symptoms (Z= -2.371, p= .018), total score of OCD symptoms (Z= -2.366, p= .018), total score of cleanliness and tidiness (Z= -2.201, p= .028), total score of checking (Z=-2.156, p= .031), state anxiety symptoms (Z= -2.366, p= .018) and trait anxiety symptoms (Z= -2.207, p= .027). All of these scores showed significant decrease in post assessments. There were no statistically significant changes in total score of repetition and indecision and total score of special words and numbers.

Results of the children in waiting-list control group showed that, repetition and indecision (Z= -2.041, p= .041) and special words and numbers (Z= -1.807, p= .071) significantly decrease in post assessment. Other variables did not show significant change in post assessment. Means and standard deviations of pretest and posttest scores related with children were given in Table 3.7.

Table 3.6. Means and Standard Deviations of Pretest and Posttest Scores of Mothers in Psycho-education Group and Waiting-list-control Group

	Psycho-education (N=7) X±S		Waiting-list-control (N=7) X±S	
	Pretest	Posttest	Pretest	Posttest
PARI FAC1	48.86 ± 6.14	40.29 ± 5.02*	45.14 ± 6.56	45.86 ± 7.60
PARI FAC2	25.29 ± 2.81	27.29 ± 2.36	26.29 ± 1.89	26 ± 1.91
PARI FAC3	31.57 ± 4.50	29.14 ± 4.63	32.29 ± 7.29	33 ± 7.21
PARI FAC4	16.71 ± 2.62	14.71 ± 2.56	16.29 ± 3.59	16.43 ± 5.02
PARI FAC5	45.29 ± 7.76	37.57 ± 4.82*	40.57 ± 8.97	44.14 ± 8.98*
Total PARI	142.43 ± 17.71	121.71 ± 11.72*	134.29 ± 21.31	139.43 ± 24.35*

Note: PARI FAC1: dependency, PARI FAC2: egalitarianism and democratic attitude, PARI FAC3: rejection of the homemaking role, PARI FAC4: marital conflict, PARI FAC5: authoritarianism, T-PARI: total scores of negative attitudes
*p<. 05

Table 3.7. Means and Standard Deviations of Pretest and Posttest Scores of Children in Psycho-education Group and Waiting-list-control Group

	Psycho-education (N=7) X±S		Waiting-list-control (N=7) X±S	
	Pretest	Posttest	Pretest	Posttest
SYM-LOI	16.43 ± 1.90	14.57 ± 2.50	16.50 ± 2.02	14.43 ± 2.87
INT-LOI	31 ± 6.24	17.57 ± 7.95*	35.43 ± 8.01	27.86 ± 10.66
T-LOI	47.86 ± 7.38	32.14 ± 8.31*	51.93 ± 9.68	42.29 ± 12.67
LOI FAC1	18.86 ± 2.85	9.14 ± 6.23*	19.57 ± 5.12	15.29 ± 6.62
LOI FAC2	3.86 ± 1.95	3.14 ± .69	5.43 ± 1.39	3.86 ± 1.57*
LOI FAC3	2.71 ± 2.49	1.29 ± 2.36	3.43 ± 1.90	2.29 ± 1.70*
LOI FAC4	5.86 ± 1.57	4 ± 1.73*	7 ± 3.21	6.43 ± 4.79
A-STATE	35 ± 11.32	26.57 ± 7.89*	33 ± 8.04	31 ± 5.59
A-TRAIT	42.29 ± 9.53	35.86 ± 6.25*	40.07 ± 8.08	36 ± 5.94

Note: SYM-LOI: total symptom score of LOI-CV, INT-LOI: total interference scores of LOI-CV, T-LOI: total scores of LOI-CV, LOI FAC1: cleanliness and tidiness, LOI FAC2: repetition and indecision, LOI FAC3: special words and numbers, LOI FAC4: checking, A-STATE: state anxiety, A-TRAIT: trait anxiety *p<. 05

CHAPTER 4

DISCUSSION

The current study has two goals. First was to investigate the relationship between parental attitudes and subclinical childhood OCD in a Turkish sample. This investigation also helped to make real the second goal. So the main aim of the study was examine the effectiveness of specific 8-week psycho-education program.

In this section, findings of present study would be discussed in the light of previous literature. Furthermore, case reports of the psycho-education condition would be explained and discussed. Additionally, contributions and implications of current study and limitations, strengths and suggestions for future researches would be explained.

4.1. Relationship between Parental Attitudes and Subclinical OCD Symptoms in Children

The first hypothesis of the current study stated a significant relationship between maternal attitudes and child's subclinical obsessive-compulsive symptoms. For that purpose, relationship of variables was examined. Firstly, a significant relationship was found between marital conflict and children's obsessive-compulsive symptoms and its severity. As it mentioned before by March & Mulle (1998), this finding also revealed the marital conflict as a factor that has an effect on childhood obsessive-compulsive symptoms. At the same time, relationship between marital conflict and symptom severity shows consistency with the idea that disagreement between parents over the disorder can lead more distress in children and that affects the course and severity of OCD. On the other hand because unpredictability and distress are characteristics of obsessive-compulsive symptoms, it can lead higher tensions in family environment and it cause more family conflicts.

Secondly, current study also found a significant relationship between marital conflict and children's anxiety symptoms indicating that, an increase in marital conflict among parents associated with an increase in anxiety symptoms of children. This finding was supported by previous researches (Jekielek, 1998; Spence et al., 2002) that showed the relationship between marital conflict and childhood anxiety. In the parallel with the explanation of Emery (1982) that mentioned contribution of marital conflict on childhood anxiety disorders, parents' inconsistent and instable attitudes can have an effect on the course of childhood anxiety and OCD. On the other hand, when considering bidirectional relationship between childhood OCD and familial factors, it can be also thought that, living with a child who has obsessive-

compulsive symptoms leads more distress in family environment that end up with more marital conflict.

Contrary to expectations study did not found any relationship between mothers' authoritarian attitude and obsessive-compulsive symptoms of children. This result contradicts the reports of Timpano et al. (2010) that showed a significant relationship between obsessive-compulsive symptoms and authoritarian parenting style. But addition to that, Timpano et al. (2010) also reported, authoritarian attitude can associate with more severe cases in childhood OCD. Therefore, when considering the sample characteristics (nonclinical school sample) and targeted symptomatology (subclinical OCD symptoms) it can be thought that, current findings reflect and support the relationship between authoritarian attitude and clinical cases. More recently, this hypothesis also supported by Yamauchi et al. (2016) that stated no direct relations between maternal attitudes and child's compulsive-like behaviors**.**

On the other hand in parallel with previous researches (Wolfradt et al., 2003; Brown & Whiteside, 2008) present study revealed a significant relationship between authoritarian attitude and trait anxiety symptoms. According to Baumrind (2005) authoritarian attitude characterized with rigid parenting, strict rules, low warmth/nurturance, high demands and psychological/behavioral control. So current finding also supported meta-analytic research of McLoad et al. (2007) and the findings of Wolfradt et al. (2003) that stated an important role of excessive parental control, restricted autonomy and over involvement in child's anxiety symptoms. These conflicting findings related with the relationship between authoritarian

attitudes, childhood anxiety symptoms and obsessive-compulsive symptoms revealed the question once more whether parent's authoritarian attitudes lead childhood anxiety disorders or if it is a reaction to child's symptomatology. Addition to that, contradiction between findings might be explained with that authoritarian attitude has tendency to relate general anxiety symptomatology whereas it has not any relation with subclinical obsessive-compulsive symptomatology.

Findings did not indicate any relationship between dependency (overprotective attitude of mother) and neither anxiety symptoms nor obsessive-compulsive symptoms. This result is somewhat unexpected and contradicts reports of the previous researches (Barrett et al., 2002; Haciomeroglu & Karanci, 2013) stated that parents of children with OCD has tendency to be overprotective and less permitting for autonomy. On the other hand Alonso et al (2004) did not find any difference in overprotective attitudes of parents between healthy and OCD groups. In parallel with current study, Brown &Whiteside (2008) did not found any relation with overprotectiveness and children's anxiety.

4.2. Effectiveness of Psycho-education Program

The main aim of the present study was to examine the effectiveness of 8-week psycho-education program on maternal attitudes and subclinical OCD symptoms of children. Second hypothesis of the current study indicated significant reductions in negative maternal attitudes after 8-week psycho-education program. Findings of current study supported the second hypothesis and indicated decreases in negative attitudes of mothers in the psycho-education group. Firstly, mothers in

psycho-education group experienced reductions in all their negative attitudes, while they experienced increase their democratic attitude. Their PARI total score, overprotective and authoritarian attitude scores decreased significantly after 8-week psycho-education program. These findings shows similarity to limited previous studies (Peris et al., 2008; Piacentini et al., 2011 & Schlup et al., 2011) that indicated reduction in negative attitudes of parents like over criticism, overprotectiveness, over involvement, whereas increase in positive behaviors. Furthermore, in current study, mothers also supported these findings with their own reports during the sessions. During psycho-education they also observed their own negative attitudes in the dimensions of nagging, yelling, persuading, hostile looks, snide comments and laughing/joking at child with negative attitude monitoring form and tried to replace them with possible alternative behaviors. At the beginning, they mostly reported nagging, yelling and hostile look behaviors and at last they began to use their own coping strategies rather than their negative attitudes. As it mentioned in case reports that in the next section, some of the mothers reported reduction in their strictness about rules and punishments as well.

In other respects, even though reductions also observed in mother's rejection attitude towards to homemaking role and marital conflict, these changes were not significant. The homemaking role is highly related with responsibility that attributed to mothers by society in Turkey. Therefore content of the psycho-education might be insufficient to address that issue. On the other hand, especially relationship between marital conflict and childhood anxieties was supported by current study as in previous studies (Jekilelek, 1998 & Spence et al., 2002). It can be speculated that, significant changes in marital conflict did not obtain with psycho-education program

because the study restricted sample with only mothers. It is possible that, mothers transferred some of the knowledge about symptoms or negative attitudes to fathers, but it was not sufficient to produce significant changes regarding behaviors of fathers and conflict between spouses.

Third hypothesis of the study indicated significant reductions in psycho-education group as compared to waiting-list-control group regarding negative parental attitudes. Findings supported the third hypothesis and indicated that psycho-education group showed significant decreases in their negative attitudes while waiting-list control group did not show any positive changes. With this finding efficacy of psycho-education on negative attitudes of mothers was evaluated. Moreover, total scores of negative attitudes and authoritarian attitude scores of mothers in waiting-list control group showed increase in 8 weeks. It was previously (Black et al., 1998) evaluated that as the familial factors has an effect on childhood OCD; symptoms also affect family attitudes and functioning as well. So findings of waiting-list control group may be suggested that, attitudes of mothers became more negative against to compelling course of symptoms in time. It can be also speculated that, because mothers in waiting-list control group did not have any knowledge about symptoms, they were unable to understand child's behaviors and their blame and strictness increases in time. This prediction supported with a previous research (Black et al., 1998) that indicated caregivers of OCD patients experienced more anger, frustration, blame, family crisis etc. in time when compared to intervention and control groups.

Depending on the main aim of the current study, fourth hypothesis of the current study indicated significant reductions in subclinical OCD symptoms and anxiety symptoms of children after 8-week psycho-education program. This hypothesis partially supported. First, children showed significant decrease in interfere and total score of LOI, cleanliness/tidiness, and in checking after program. These findings shows consistency with the study of Ginsburg et al. (2011) in which specific parenting practices included in addition to other familiar techniques and reduction in OCD symptoms was obtained. Mothers in the psycho-education group also supported these findings with their own reports during the sessions. After psycho-education program two mothers reported decrease in children's cleaning compulsion whereas three of them reported decrease in checking compulsion of children. Even though current study did not contain any direct interventions for children, findings also showed similarity with previous studies (Water et al., 2001; Peris et al., 2012; Thompson-Hollonds et al., 2014) that compared child intervention and child intervention plus family involvement in some way. All in these previous studies family interventions caused more positive treatment outcomes. Furthermore, as in recent studies (Lebowitz et al., 2013& Gingsburg et al., 2011) this finding also supported the effect of parent only interventions on childhood OCD. Secondly children also showed significant decrease in state and trait anxiety symptoms. This was an expected result in the light of previous researches (Wolfradt et al., 2003 & Brown &Whiteside, 2008) that highlighted significant relationship between parental attitude and level of childhood anxiety. In this way, current research demonstrated that positive change in maternal attitudes leads decrease in child's anxiety.

Although there were reduction in the symptom score of LOI, repetition/indecision and special words/numbers, these changes were not significant. Taken together, findings about symptom, interfere and total scores may be suggested that the positive changes in maternal attitudes that obtained with psycho-education just had an effect on symptom severity rather than symptom presence. It will be possible to observe changes in the symptom presence with long-term follow-up. In other respects, special words and numbers are explained with counting compulsion, which means counting certain number or repeating words while doing something. Repetition also explains the repeated actions. For in both compulsion types, they can manifest themselves as mental acts rather than behaviors. So it can be speculated that, children can hide their related symptoms more easily therefore it is more difficult to intervene in these symptoms.

Fifth and last hypothesis of the study indicated significant reductions in psycho-education group as compared to waiting-list-control group regarding children's subclinical OCD and anxiety symptoms. Findings partially supported the fifth hypothesis and indicated that children in the psycho-education group showed more significant decrease in their subclinical OCD and anxiety symptoms as compared to waiting-list control group. Except the repetition/indecision and special words/numbers, children in waiting-list control group did not produce significant reduction in other factors of LOI and in state/trait anxiety symptoms. The unexpected result about reduction in repetition/indecision and special words/numbers can be related with nature of subclinical OCD. In subclinical OCD, obsessive and compulsive symptoms mostly exist in waxing and waning course and there is no severe functional impairments in ones life. It is also known that relationship between

subclinical OCD and clinical OCD is still controversial. Previous findings also indicated in follow ups, some of the participants with subclinical OCD symptoms moved to OCD, some of them remained their subclinical OCD symptoms and some of them did not show any OCD symptoms anymore without any interventions. Like in current study, natural reduction also observed in study of Zucker (2004) that examined effectiveness of an early intervention for subclinical OCD. It is still debatable that if this current finding represents the waxing and waning course of subclinical OCD or if these symptoms really remits without any intervention.

In conclusion, with all of these findings efficacy of psycho-education on children's subclinical OCD and anxiety symptoms was partially evaluated. But to clarify issues and strengthen the efficacy of psycho-education program on negative attitudes of mother and on the symptoms of children, a longitudinal follow up is necessary.

4.3. The Case Reports Discussion of Psycho-education Condition

Although findings about presence of children's symptoms obtained with measures, mothers also reported about these symptoms in more detail during the psycho-education process. So it is thought that it would be more meaningful for study to discuss all of these reports, separately. On the other hand, it is asked mothers to observe and monitor the symptomatology of their children with monitoring forms during the process but detail information about symptoms could not obtain from these monitoring forms. Mothers tended to conceal the symptoms of children in the written forms. In spite of that, they felt free to talk about these symptoms during

face-to-face communications. It is speculated, although issues about confidentiality was explained at the beginning of process, it was possible that mothers still had worries for publication of their personal information in the dissertation study. Therefore all of the information about each cases that presented in the following section based on notes of researcher during the psycho-education sessions.

In general, it is observed that most of the symptoms are increase or decrease its severity or disappear with time instead of being permanent. The severity of the symptoms varied case to case but in most cases symptoms did not cause any impairments in child's life. On the other hand, just in third case, symptoms became more severe during the process and teachers also reported impairments in school achievement. Just this case was referred to mental health professionals at the end of the program.

In cases, symptoms are characterized as washing and cleaning, checking, repeating, symmetry, hoarding and praying. It is also reported that in some cases mothers or another relative also has obsessive-compulsive like symptoms that strengthen the effect of genetic factors on OCD symptoms. Furthermore, majority of the mothers reported the tendency of fathers to accommodate child's symptoms, which leads disagreement and conflict between spouses. These reports support the findings about relationship between marital conflict and symptoms of children. More detailed information about cases was given in following sections.

4.3.1. Case 1

First case is eight-year old girl who attending 4th grade. At the beginning of the psycho-education program it was stated that, she wanted to be washed all of her

toys and her clothes right after she take off them. She also obsessed with pulling up her socks until they became the same high. She had worries about going to toilet in the public or in the visits and always avoid going to toilet outside her house. On the other hand she had excessive interest in her weight and had repetitive hand washing. Mother also interested in her daughter's weight excessively and she inculcated child to go on a diet.

Mother also reported her own compulsive-like behaviors about cleaning and mentioned about her contamination fears. At the end of the process mother stated decrease in child's excessive hand washing.

4.3.2. Case 2

Second case is ten-year-old boy who attending 4th grade. At the start, his most obvious compulsive symptom was collecting objects like useless school papers. He was unable to throw-up them, and he conflicted with her mother about them. Sometimes he was recurrently wanted to pray, but it was hard for mother to distinguish that behavior from usual religious rituals. This is because he came from a devout family; all of his family members interested in religious, furthermore, family rules and punishments also related with religion in most of the times. On the other hand, he wanted his mothers to recheck his homework at least three times. During the sessions mother reported her strict rules in parenting and also complained about her husband's tendency to bend rules. At the end of the process mother reduced her strictness and gave up to accommodate child's checking behavior. She also reported decrease in child's repetitive praying and checking behavior.

4.3.3. Case 3

Third case is nine year old girl who attending 4th grade. At the beginning, it was stated that, she had worries about going to toilet in the public. She was so sensitive to orders of objects in her house and never wanted to replace them. Before went to sleep, most nights she repeatedly organized her school bags. During the sessions mother reported her own compulsive-like behaviors about cleaning and mentioned about their OCD diagnosed relatives. Late in the sessions, it was reported that she started to be late to school because she needed to control her clothes and school stuff. Apart from that, mother observed that she walks around the all of rooms in the house before they go out. Mother suspected that she counts a certain number and controls something while she walk around the rooms. It is also stated that she started to carry some piece of glass, because she had fear of to be kidnapped and tied with a rope, in case of this scenario she planned to use glass piece to cut the rope. In the end, although her symmetry and cleaning compulsions showed little decrease the last reports of mothers directed researcher to refer child to mental health services.

4.3.4. Case 4

Fourth case is eight-year-old boy and attending 4th grade. Mother did not report any compulsive like behaviors during the process. But mother had strict discipline rules, high expectations about success and respect and she compared him with his friends most of time. It can be speculated that her strict attitude could be increase his worries, and it is possible that he tried to hide his symptoms. Although mother did not report any compulsive like behaviors in children, at the end of sessions mother benefited from the effective communication training and reported more positive relationship with her child and also showed tendency to bend her strict rules.

4.3.5. Case 5

Fifth case is nine year old boy who attending 3rd grade. His symptoms were not obvious. Mother reported that, excessive time spending in the toilet but they did not know what he did exactly. At the same time, in some nights he wanted to stay and hide under his blanket about 5 minutes and says that he afraid of something. That mother also benefited from the effective communication training and reported decrease in time that spent in toilet with less criticism and nagging.

4.3.6. Case 6

Sixth case is nine years old girl, attending in 3rd grade. At the beginning of sessions it was reported that, she had a respiratory disorder when she was toddler and during that period her room was cleaned and ventilated every night. Since that day, although she recovered, every night she wanted to clean and ventilate her room. Furthermore, she asked her mother to do same things in her little brother. She was repeatedly seeking reassurance and asks her mother if she was okay. Every night before she went to sleep, she asked her parents to control door lock, and sometimes when she unsure she checked the door locks in herself. Before they went out, she wanted her mother to lock the door three times. During the sessions mother also reported that her elder daughter also have similar checking symptoms. After the sessions, mother stopped to accommodate her cleaning and checking rituals and she reported that her child became less insistent about cleaning. On the other hand, it was not observed any significant changes in checking compulsion. It can be speculated that participation of elder sister to checking compulsion made difficult to interfere that behavior.

4.3.7. Case 7

Seventh case also ten years old girl, attending 4th grade. At beginning it was reported that, she was so sensitive about the order of the house. She tended to organize the stuffs of the household. When one of the relatives got sick, she rejected to leave that relative. Everyday she wanted to change her underwear before she goes to school. On the other hand, she wanted to sleep without her underwear. She checked her homework repeatedly and if she got low mark in an exam, she punished herself (e.g. not talking with anyone all day). Mother also had high expectations about child's success. With psycho-education, it was tired to normalize mother's high expectation. At the end of the sessions, mother reported decrease in child's anxiety about her exams and in her checking behaviors.

4.4. Contributions and Implications of the Study

To researcher's knowledge this is the first study in Turkish literature that examine relationship between childhood subclinical obsessive-compulsive symptoms and parental attitudes and also first study that assess efficacy of a psycho-education program related with this issue. The results suggest that maternal attitudes are the one of the related factors with subclinical childhood OCD. So current findings add important considerations to the examination of the relationship between childhood obsessive-compulsive symptoms and parental attitudes to Turkish literature.

In the light of the current findings several potential clinical implications emerge. Current findings add to growing sense that maternal attitudes should be considered treatment of childhood OCD. Findings support that during clinical

assessments of childhood OCD it is important to get more comprehensive information about family attitudes. Although there is a need to follow up both mothers' attitudes and children's symptoms for longer period of time to assess long-term effectiveness of psycho-education program, current findings provide crucial information to clinicians about working with parents in treatment of childhood OCD.

Clinicians could consider including parents to treatments more actively and should add more extended psycho-education about parental attitudes in order to produce more positive treatment outcomes. Study also highlighted the importance of considering intervention models that beyond the traditional psycho-educations. It showed that, rather than just providing knowledge to parents about obsessive-compulsive symptoms, its development and maintenance, adding specific parent components to psycho-education elicited positive outcomes in symptomatology of children and in negative attitudes of mothers. Last and foremost, it is clearly known that resistance is one of the most challenging issues in child therapies. Like the previous studies of Lebowitz (2013) and Alcazar (2017), current study also presents different intervention model for child clients who resist and refuse individual treatments.

4.5. Strengths and Limitations of the Study and Suggestions for Future Researches

One of the strength of this study is the inclusion of 8-10 years of children that known in literature as onset of childhood OCD. Because most of researches (Karno et al., 1988; do Rosario-Campos et al., 2001; Geller, 2006) have a consensus on that, adults who get OCD diagnosis in their adulthood also had OCD symptoms in their

childhood, current study can facilitate to follow up development and maintenance of OCD symptoms in children.

Other strength of the study is about examination of subclinical sample. Even though relationship between subclinical OCD and clinical OCD is still controversial, some of the studies (Valline-Bassile et al., 1996; Black, 2008; Black, 2013) demonstrated the possibility that subclinical OCD can be precursor of OCD. In this aspect, it can be considered that current study also showed a preventive effort in a nonclinical sample.

In general, many parents find it difficult to involve therapy sessions because of their intensive work hours, household tasks or bias about parent sessions. But in present study full attendance was provided within 8 weeks. It is also known that, it can be difficult to arrange and coordinate session schedules and conduct sessions in group environment. In spite of that, current study conducted as group psycho-education program with mothers rather than individual sessions.

Unlike some of the previous studies (Waters et al., 2001; Barrett et al., 2004& Farrell et al., 2010), current study had comparison group and this facilitated to determine that which specific component of the psycho-education led to change in maternal attitudes. Furthermore, changes in the process were examined by looking change in negative attitudes of mothers and OCD symptomatology. So direct effect and importance of psycho-education was observed in psycho-education group and it will be observed in waiting-list control group as well.

There is need to address number of limitations and future directions too. First of all, in current study, the measure that examines the maternal attitudes was chosen from limited Turkish adaptation studies. Although PARI is one of the best measures that assess maternal attitudes, it is not directly point at the parental attitudes (especially expressed emotion) related with childhood OCD. For example, Peris et al. (2008) developed The Parental Attitudes and Behavior Scale (PABS), which is an OCD specific parental attitudes scale and demonstrated validity and reliability of the scale. Further researches should work on the adaption of OCD related parental attitude tool like PABS. Using OCD specific parental attitudes scale can help to observe direct relationship between childhood OCD and parental attitudes.

Because the sample comprised of nonclinical subjects in present study, it should be replicated with clinical OCD sample to observe the relationship between parental attitudes and obsessive-compulsive symptoms more clearly. The generalizability of the present study was also limited because of the sample size. Therefore future studies will be needed to enlarge the sample size.

On the other hand, in some cases mothers also reported OCD like symptoms in themselves or in first-degree relatives. But current study did not examine parental psychopathology or its effect on parenting attitudes and child symptoms. This limitation means that the answers of the potential question whether parental psychopathology is responsible for parenting style or child symptomatology is still debatable. In considering the genetic vulnerability of OCD and the association between parental psychopathology and parenting, future research should also examine psychopathology of the parents to increase efficacy of the studies.

Current study also focuses on the parents' self reports on their parental attitudes. Considering the possible discrepancies between children and parents' self reports on parental attitudes, future studies should attach importance to child's self reports too.

On the other hand just mothers involved in the study. This also limits the generalizability of the current results to entire family attitudes. At the same time according to current findings marital conflict has a relation with childhood OCD and psycho-education cannot elicit significant change in this dimension. This finding also demonstrates the importance of father involvement to process. So, future researches could involve all family members to process.

Lastly, as it mentioned before, longitudinal follow up is also needed to strengthen the efficacy of psycho-education program.

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APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

1. Çocuğunuzun Okulunun adı : _____

2. Çocuğunuz Kaçıncı sınıfta: _____

3. Çocuğunuzun Cinsiyeti: ( ) Kız ( ) Erkek

4. Çocuğunuzun Yaşı: _____

Çocuğunuzun Doğum tarihi:____(gün)/____(ay)/_____(yıl)

5. Çocuğunuz daha önce psikolojik ya da psikiyatrik destek aldı mı

( ) Evet ( ) Hayır

- Evet ise, hangi konuda destek aldığını kısaca belirtiniz:

---

6. Çocuğunuzun şuanda kullanmakta olduğu psikiyatrik ilaç var mı

( ) Evet ( ) Hayır

- Evet ise, ilacın adını belirtiniz : _____

7. Kaç Çocuğunuz Var : _____

Varsa diğer çocuklarınızın cinsiyeti ve yaşları :

1. Çocuk ( ) Kız ( ) Erkek Yaş _____
2. Çocuk ( ) Kız ( ) Erkek Yaş _____
3. Çocuk ( ) Kız ( ) Erkek Yaş _____
4. Çocuk ( ) Kız ( ) Erkek Yaş _____
5. Çocuk ( ) Kız ( ) Erkek Yaş _____
6. Çocuk ( ) Kız ( ) Erkek Yaş _____

8. Evde kimlerle yaşadığınızı belirtiniz : _____

9. Anne sağ mı ( ) Evet ( ) Hayır Baba sağ mı ( ) Evet ( ) Hayır

10. Anne-Baba birlikte mi ( ) Evet ( ) Hayır

11. Annenin Yaşı:____

12. Annenin Mesleği :_____

13. Annenin Öğrenim Durumu : ( )Okuma-yazma bilmiyor ( )İlkokul

( )Ortaokul ( ) Lise ( )Yüksekokul ( )Üniversite ( )Yüksek lisans ve üstü

14. Anne daha önce psikolojik ya da psikiyatrik destek aldı mı

( ) Evet ( ) Hayır

- Evet ise, hangi konuda destek aldığını kısaca belirtiniz:

---

15. Annenin şuanda kullanmakta olduğu psikiyatrik ilaç var mı

( ) Evet ( ) Hayır

- Evet ise, ilacın adını belirtiniz : _____

16. Babanın Yaşı:____

17. Babanın Mesleği :_____

18. Babanın Öğrenim Durumu : ( )Okuma-yazma bilmiyor ( )İlkokul

( )Ortaokul ( ) Lise ( )Yüksekokul ( )Üniversite ( )Yüksek lisans ve üstü

19. Baba daha önce psikolojik ya da psikiyatrik destek aldı mı

( ) Evet ( ) Hayır

- Evet ise, hangi konuda destek aldığını kısaca belirtiniz:

---

20. Babanın şuanda kullanmakta olduğu psikiyatrik ilaç var mı

( ) Evet ( ) Hayır

- Evet ise, ilacın adını belirtiniz : _____

21. Ailenin aylık ortalama geri : ( ) 0-999 ( ) 1000-1999 ( ) 2000- 2999

( ) 3000 ve üstü

APPENDIX B

PARENTAL ATTITUDES RESEARCH INSTRUMENT

Aşağıda verilen ifadeleri okuyup, şu şekilde değerlendiriniz;

Kesinlikle Katılmıyorum	Katılıyorum	Katılmıyorum	Kesinlikle katılıyorum
1	2	3	4

	Kesinlikle Katılmıyorum	**Katılmıyorum**	**Katılıyorum**	**Kesinlikle Katılıyorum**
1. Çocuk yorucu veya zor işlerden korunmalıdır.	1	2	3	4
2. Çocuklarıyla kaygıları hakkında konuşan ebeveynler bazen onları kendi haline bırakmak gerektiğini düşünemezler.	1	2	3	4
3. Çocuk boşa geçen dakikaların bir daha hiç geri gelmeyeceğini ne kadar çabuk öğrenirse, kendisi için o kadar iyi olur.	1	2	3	4
4. Bir anne çocuğunun düş kırıklığına uğramaması için elinden geleni yapmalıdır.	1	2	3	4
5. Çocuk ne kadar erken yürümeyi öğrenirse o kadar iyi eğitilebilir.	1	2	3	4
6. Çocuk yetiştirmek sinirlendirici bir iştir.	1	2	3	4
7. Çocuğun hayatta öğrenmesi gereken o kadar çok şey vardır ki, zamanını boşa geçirmesi affedilemez.	1	2	3	4
8. Babalar, biraz daha şefkatli olsalar, anneler çocuklarıyla ilgili görevlerini daha iyi yaparlar.	1	2	3	4
9. Çocuk yetiştirmenin kötü taraflarından birisi, zamanı istediğiniz gibi kullanamamaktır.	1	2	3	4
10. Sıkı kurallarla yetiştirilen çocuklar çok daha iyi birer yetişkin olurlar.	1	2	3	4
11. Bir anne çocuğunun mutluluğu için kendi mutluluğunu feda edebilmelidir.	1	2	3	4
12. Aktif bir çocuk büyük bir olasılıkla mutlu bir kişi olacaktır.	1	2	3	4
13.Büyükler çocukların şakalarına güler, onlara eğlendirici öyküler anlatırsa evdeki düzen daha düzgün, daha akıcı olur.	1	2	3	4
14. Çocuğun düşündüğü her şeyi bilmek, bir annenin görevidir.	1	2	3	4
15. Anne babalar çocuklarına, sorgusuz sualsiz kendilerine sadık kalmalarını öğretmelidirler.	1	2	3	4
16. Bütün genç anneler, bebek bakımında beceriksiz olacaklarından korkarlar.	1	2	3	4

	Kesinlikle Katılmıyorum	Katılmıyorum	Katılıyorum	Kesinlikle Katılıyorum
17. Eğer anneler çocuklarıyla tüm gün birlikte olmak zorunda kalırlarsa, çocuklar bir annenin sinirini bozabilirler.	1	2	3	4
18. Anne ve babalar her zaman çocuklarının kendilerine uymasını beklememeli, biraz da kendileri çocuklarına uymalıdır.	1	2	3	4
19. Eğer anneler dileklerinin kabul edileceğini bilselerdi, babaların daha anlayışlı olmalarını dilerlerdi.	1	2	3	4
20.Çocuğa ne olursa olsun kavga etmekten kaçınması gerektiği öğretilmelidir.	1	2	3	4
21. Çocuklar bencil olduklarında, hep bir şeyler istediklerinde, annenin tepesinin atması çok normaldir.	1	2	3	4
22.Eg□er çocuklar ailedeki kuralları uygun bulmuyorlarsa, bunu söylemeleri için anne baba tarafından teşvik edilmelidirler.	1	2	3	4
23. Anneler çok kere çocuklarına bir dakika daha dayanamayacakları duygusuna kapılırlar.	1	2	3	4
24. Çocuğu sıkı terbiye edersiniz sonra size teşekkür eder.	1	2	3	4
25.Küçük bir çocuk, cinsellik konusundaki konuşmalardan uzak tutulmalıdır.	1	2	3	4
26. Bir annenin çocuğunun hayatı hakkında her şeyi bilmesi hakkıdır. Çünkü çocuğu onun bir parçasıdır.	1	2	3	4
27. Uyanık bir anne-baba çocuğunun tüm düşüncelerini öğrenmeye çalışmalıdır.	1	2	3	4
28. Çocuklar, anne babalarının kendileri için neleri feda ettiklerinin farkına varmalıdırlar.	1	2	3	4
29. Eğer çocukların şikayetlerini söylemelerine izin verilirse şikayetleri hiç bitmez.	1	2	3	4
30. Sağlam ve iyi bir karakter sıkı disiplin ile olur.	1	2	3	4
31. Genç bir kadın gençken yapmak istediği çok şey olduğundan dolayı, anne olunca kendisini baskı altında hisseder.	1	2	3	4

	Kesinlikle Katılmıyorum	Katılmıyorum	Katılıyorum	Kesinlikle Katılıyorum
32. Anneler çocukları için hemen hemen bütün zevklerini feda ederler.	1	2	3	4
33. Babalar daha az bencil olsalardı, kendilerine düşen görevi yaparlardı.	1	2	3	4
34. İyi bir anne çocuğunu hayatın ufak tefek güçlüklerinden korumalıdır.	1	2	3	4
35. Çocuğa anne ve babasına herkesten daha çok saygı göstermesi gerektiği öğretilmelidir.	1	2	3	4
36. Çocuk hiçbir zaman ailesinden sır saklamamalıdır.	1	2	3	4
37. Çocuklardan sık sık ödün vermelerini, anne babaya uymalarını istemek adil değildir	1	2	3	4
38. Çoğu anne bebeğine bakarken onu incitmekten korkar.	1	2	3	4
39. Çocuğa başı derde girdiğinde kavga etmek yerine ailesine veya öğretmenlerine başvurması gerektiği öğretilmelidir.	1	2	3	4
40. Anne baba arasında tartışarak çözülemeyecek bazı konular vardır.	1	2	3	4
41. Ev idaresinde en kötü şeylerden birisi de, kadının kendisini evinde hapsedilmiş gibi hissetmesidir.	1	2	3	4
42. Hiçbir kadından yeni doğmuş bir bebeğe tek başına bakması beklenmemelidir.	1	2	3	4
43. Oğlan ve kız çocuklarının birbirlerini tamamen çıplak görmelerine izin verilmemesi çok önemlidir.	1	2	3	4
44. Çocukların sorunlarıyla ilgilenmenin bir sıkıntısı da, çocukların sizin ilginizi çekmek için birçok hikaye uydurmalarıdır.	1	2	3	4
45. Eğer anne babalar çocukları ile şakalaşıp beraber eğlenirlerse, çocuklar onların öğütlerini dinlemeye daha çok istekli olurlar.	1	2	3	4
46. Anneleri kendileri yüzünden zorluk çektiği için çocuklar, annelerine karşı daha anlayışlı olmadırlar.	1	2	3	4
47. Çocuk eninde sonunda anne-babasından daha akıllı olamayacağını öğrenir.	1	2	3	4

	Kesinlikle Katılmıyorum	Katılmıyorum	Katılıyorum	Kesinlikle Katılıyorum
48. Eğer bir anne çocuklarını iyi yetiştiremiyorsa belki de bu, babanın kendine düşen görevi iyi yapmamasından ileri geliyordur.	1	2	3	4
49. Genç bir anne için ilk bebeğin bakımı sırasında yalnız kalmaktan kötü bir şey olamaz.	1	2	3	4
50. Bir çocuğun diğer bir çocuğa vurması hiçbir şekilde hoşgörüyle karşılanamaz.	1	2	3	4
51. Anne babalar çocuklarına hayatta ilerleyebilmeleri için hep bir şeyler yapmaları ve boşa zaman geçirmemeleri gerektiğini öğretmelidirler.	1	2	3	4
52. Akıllı bir kadın yeni bir bebeğin doğumundan önce ve sonra yalnız kalmamak için elinden geleni yapar.	1	2	3	4
53. Evde olup bitenleri sadece anne bildiği için, ev hayatını onun planlaması lazımdır.	1	2	3	4
54. Bazen bir kadının kendi haklarına sahip olabilmesi için, kocasını terslemesi gerekir.	1	2	3	4
55. Bütün zamanını çocuklarıyla geçirmek, bir kadının kanadı kırılmış kus gibi hissetmesine neden olur.	1	2	3	4
56. Eğer anne kollarını sıvar, bütün yükü sırtına alırsa tüm aile rahat eder.	1	2	3	4
57.Çocuklar cesaretlerini kırabilecek tüm zor işlerden uzak tutulmalıdır.	1	2	3	4
58. Çocuklar aslında sıkı disiplin altında mutlu olurlar.	1	2	3	4
59. Çocukların partileriyle, flörtleriyle ve eğlenceleriyle ilgilenen anne babalar onların iyi yetişmelerini sağlarlar.	1	2	3	4
60. Anne ve babaya sadakat her şeyden önce gelir.	1	2	3	4

APPENDIX C

LEYTON OBSESSIONAL INVENTORY CHILD VERSION

Aşağıda seninle ilgili olabilecek 20 soru bulunmaktadır. Bu soruların her birini okuyup, sana uygun olup olmadıklarını düşündükten sonra eğer sana uygunsa **EVET** 'i eğer uygun değilse **HAYIR**'ı işaretle. Sana uygun olduğunu düşündüğün ve **EVET**,'i işaretlediğin her soru için yanında bulunan **0, 1, 2** ve **3** numaralarındaki sana en uygun olan maddeyi işaretle. 0, 1, 2 ve 3 numaralarının ne anlama geldiği aşağıda belirtilmiştir.

0- Bu alışkanlık, beni yapmak istediğim diğer şeylerden alıkoymuyor.
1- Bu alışkanlık, beni biraz engelliyor ya da çok az zamanımı alıyor.
2- Bu alışkanlık, beni yapmak istediğim diğer şeylerden alıkoyuyor ve zamanımın bir kısmını alıyor.
3- Bu alışkanlık, beni yaptığım birçok şeyden alıkoyuyor ve çok fazla zamanımı alıyor.

HAYIR diye işaretleme yaptığın sorularda başka bir işaretleme yapmana gerek yok.

		ENGELLEMİYOR	BİRAZ ENGELLİYOR	ENGELLİYOR	ÇOK ENGELLİYOR
1. Sıklıkla yapmak zorunda olmadığınızı bile bile bazı şeyleri yapmaya kendinizi mecbur hisseder misiniz ?	HAYIR EVET	0	1	2	3
2. Düşünceler ya da kelimeler aklınızdan tekrar tekrar geçer mi ?	HAYIR EVET	0	1	2	3
3. Bazı şeyleri tekrar tekrar kontrol eder misiniz ?	HAYIR EVET	0	1	2	3
4. Kirden, kirli şeylerden nefret eder misiniz ?	HAYIR EVET	0	1	2	3
5. Başkasının dokunduğu ya da kullandığı bir şeyin sizin için artık kirlenmiş olduğunu düşünür müsünüz?	HAYIR EVET	0	1	2	3
6.Yeterince temiz olup olmadığınız konusunda endişelenir misiniz ?	HAYIR EVET	0	1	2	3
7.Ellerinizin temiz olmasına çok özen gösterir misiniz ?	HAYIR EVET	0	1	2	3
8.Gece yatarken eşyalarınızı mutlaka düzgün biçimde kaldırır mısınız ?	HAYIR EVET	0	1	2	3
9. Okulda arkadaşlarınız sıranızı karıştırırsa öfkelenir misiniz ?	HAYIR EVET	0	1	2	3
10. Ev ya da okul ödevlerinizi doğru yaptığınızdan emin olana kadar onları kontrol ederek fazla zaman harcar mısınız ?	HAYIR EVET	0	1	2	3

11. Tamamen doğru olduğundan emin olmadan önce belli bir sayıda tekrar tekrar yaptığınız şeyler var mıdır ?	HAYIR EVET	0	1	2	3
12. Sürekli olarak saydığınız ya da aklınızdan geçirdiğiniz sayılar var mıdır?	HAYIR EVET	0	1	2	3
13. Bazı şeyleri tekrar tekrar yaptığınız için okul ödevleriniz ya da günlük işlerinizi bitirmekte güçlük çeker misiniz ?	HAYIR EVET	0	1	2	3
14. İçinizden birçok kere tekrarladığınız ve bazı şeyleri o sayı kadar yaptığınız özel sayınız var mıdır?	HAYIR EVET	0	1	2	3
15. Hiç kimse kötü olduğunu düşünmediği halde yaptığınız bazı şeylerden dolayı kendinizi kötü hisseder misiniz?	HAYIR EVET	0	1	2	3
16. Bazı şeyleri tam olarak hissettiğiniz gibi yapamayınca üzülür müsünüz ?	HAYIR EVET	0	1	2	3
17. Karar vermede güçlük çeker misiniz?	HAYIR EVET	0	1	2	3
18. Yaptığınız şeyleri doğruluğundan emin olmadığınız için tekrar tekrar yapar mısınız ?	HAYIR EVET	0	1	2	3
19. Şanssızlıktan korunmak için özel olarak yaptığınız bir davranış veya söylediğiniz bir söz var mıdır ?	HAYIR EVET	0	1	2	3
20. Şanssızlık ya da kötülüklerden kurtulmak için kullandığınız özel sayılar ya da kelimeler var mıdır?	HAYIR EVET	0	1	2	3

APPENDIX D

STATE-TRAIT ANXIETY INVENTORY FOR CHILDREN

Kızların ve erkeklerin kendilerini anlattıkları bazı cümleler aşağıda verilmiştir. Her cümleyi dikkatle oku ve şu anda nasıl hissettiğine karar ver. Daha sonra, seni en doğru anlatan ifadenin önündeki parantezler arasına (X) işareti koy. Yanlış veya doğru cevap diye bir şey yoktur. Her hangi bir cümle üzerinde fazla zaman geçirme.

Tam şu anda, bu dakikada nasıl hissettiğini en iyi anlatan ifadeyi seçmeyi unutma.

1.	Kendimi ( ) çok sakin hissediyorum ( ) sakin hissediyorum	( ) sakin hissetmiyorum
2.	Kendimi ( ) çok öfkeli hissediyorum ( ) öfkeli hissediyorum	( ) öfkeli hissetmiyorum
3.	Kendimi ( ) çok huzurlu hissediyorum ( ) huzurlu hissediyorum	( ) huzurlu hissetmiyorum
4.	Kendimi ( ) çok sinirli hissediyorum ( ) sinirli hissediyorum	( ) sinirli hissetmiyorum
5.	Kendimi ( ) çok huzursuz hissediyorum ( ) huzursuz hissediyorum	( ) huzursuz hissetmiyorum
6.	Kendimi ( ) çok dinlenmiş hissediyorum ( ) dinlenmiş hissediyorum	( ) dinlenmiş hissetmiyorum
7.	Kendimi ( ) çok ürkmüş hissediyorum ( ) ürkmüş hissediyorum	( ) ürkmüş hissetmiyorum
8.	Kendimi ( ) çok rahatlamış hissediyorum ( ) rahatlamış hissediyorum	( ) rahatlamış hissetmiyorum
9.	Kendimi ( ) çok endişeli hissediyorum ( ) endişeli hissediyorum	( ) endişeli hissetmiyorum
10.	Kendimi ( ) çok hoşnut hissediyorum ( ) hoşnut hissediyorum	( ) hoşnut hissetmiyorum
11.	Kendimi ( ) çok korkmuş hissediyorum ( ) korkmuş hissediyorum	( ) korkmuş hissetmiyorum

12.	Kendimi ( ) çok mutlu hissediyorum ( ) mutlu hissediyorum ( ) mutlu hissetmiyorum
13.	Kendimden ( ) çok eminim ( ) kendimden eminim ( ) emin değilim
14.	Kendimi ( ) çok iyi hissediyorum ( ) iyi hissediyorum ( ) iyi hissetmiyorum
15.	Kendimi ( ) çok başım dertte hissediyorum ( ) başım dertte hissediyorum ( ) başım dertte hissetmiyorum
16.	Bir şeylerin beni ( ) çok rahatsız ettiğini hissediyorum ( ) rahatsız ettiğini hissediyorum ( ) rahatsız ettiğini hissetmiyorum
17.	Kendimi ( ) çok keyifli hissediyorum ( ) keyifli hissediyorum ( ) keyifli hissetmiyorum
18.	Kendimi ( ) çok dehşete kapılmış hissediyorum ( ) dehşete kapılmış hissediyorum ( )dehşete kapılmış hissetmiyorum
19.	Kafamda ( ) her şeyi çok karmakarışık hissediyorum ( ) karmakarışık hissediyorum ( )karmakarışık hissetmiyorum
20.	Kendimi ( ) çok neşeli hissediyorum ( ) neşeli hissediyorum ( ) neşeli hissetmiyorum

Kızların ve erkeklerin kendilerini anlattıkları bazı cümleler aşağıda verilmiştir. Her cümleyi dikkatle oku ve hangisinin senin için en doğru olduğuna karar ver. “hemen hemen hiç” mi, “bazen” mi yoksa “sık sık” mı? Daha sonra, seni en doğru anlatan ifadenin önündeki parantezler arasına (X) işareti koy. Yanlış veya doğru cevap diye bir şey yok. Herhangi bir cümle üzerinde fazla zaman geçirme. Genellikle nasıl hissettiğini anlatan ifadeyi seçmeyi unutma.

1. Yanlış yapacağım diye endişelenirim.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
2. Ağlayacak gibi olurum.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
3. Kendimi mutsuz hissederim.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
4. Karar vermekte güçlük çekerim.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
5. Sorunlarla yüz yüze gelmek bana zor gelir.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
6. Çok fazla endişelenirim.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
7. Evde sinirlerim bozulur.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
8. Utangacım.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
9. Sıkıntılıyım.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
10. Aklımdan, engelleyemediğim önemsiz düşünceler geçer ve beni rahatsız eder.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
11. Okul beni endişelendirir.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
12. Ne yapacağıma karar vermekte zorluk çekerim.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
13. Kalbimin hızlı hızlı çarptığını fark ederim.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
14. Nedenini bilmediğim korkularım vardır.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
15. Anne-babam için endişelenirim.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
16. Ellerim terler.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
17. Kötü bir şeyler olacak diye endişelenirim.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
18. Geceleri uykuya dalmakta güçlük çekerim	( ) hemen hemen hiç	( ) bazen	( ) sık sık
19. Karnımda bir rahatsızlık hissederim.	( ) hemen hemen hiç	( ) bazen	( ) sık sık
20. Başkalarının benim hakkımda ne düşündükleri beni endişelendirir.	( ) hemen hemen hiç	( ) bazen	( ) sık sık

APPENDIX E

CHILDREN'S DEPRESSION INVENTORY

Aşağıda seninle ilgili olabilecek maddeler bulunmaktadır. Bu maddelerin her birini okuyup, sana uygun olanların yanında 1,2 ve 3 sayılarından sadece birini yuvarlak içine al.

A.)	1.Kendimi arada sırada üzgün hissederim. 2.Kendimi sık sık üzgün hissederim. 3.Kendimi her zaman üzgün hissederim.
B.)	1.İşlerim hiçbir zaman yolunda gitmeyecek. 2.İşlerimin yolunda gidip gitmeyeceğinden emin değilim. 3. İşlerim yolunda gidecek.
C.)	1.İşlerimin çoğunu doğru yaparım. 2.İşlerimin çoğunu yanlış yaparım. 3.Her şeyi yanlış yaparım.
D.)	1.Birçok şeyden hoşlanırım. 2. Bazı şeylerden hoşlanırım. 3.Hiçbir şeyden hoşlanmam.
E.)	1.Her zaman kötü bir çocuğum. 2.Çoğu zaman kötü bir çocuğum. 3.Arada sırada kötü bir çocuğum.
F.)	1.Arada sırada başıma kötü bir şeyler geleceği düşünürüm. 2.Sık sık başıma kötü bir şeyler geleceğini düşünürüm. 3.Başıma çok kötü şeyler geleceğinden eminim.
G.)	1.Kendimden nefret ederim. 2.Kendimi beğenmem. 3.Kendimi beğenirim.
H.)	1.Bütün kötü şeyler benim hatam. 2.Kötü şeylerin bazıları benim hatam. 3.Kötü şeyler genellikle benim hatam.
I.)	1.Kendimi öldürmeyi düşünmem. 2.Kendimi öldürmeyi düşünürüm ama yapmam. 3.Kendimi öldürmeyi düşünüyorum.
İ)	1.Her gün içimden ağlamak gelir. 2.Birçok günler içimden ağlamak gelir. 3.Arada sırada içimden ağlamak gelir.

J.)	1.Her şey her gün beni sıkar. 2.Her şey sık sık beni sıkar. 3.Her şey arada sırada beni sıkar.
K.)	1.İnsanlarla beraber olmaktan hoşlanırım. 2.Çoğu zaman insanlarla birlikte olmaktan hoşlanmam. 3.Hiç bir zaman insanlarla birlikte olmaktan hoşlanmam.
L.)	1.Herhangi bir şey hakkında karar verememem. 2.Herhangi bir şey hakkında karar vermek zor gelir. 3.Herhangi bir şey hakkında kolayca karar veririm.
M.)	1.Güzel/yakışıklı sayılırım. 2.Güzel/yakışıklı olmayan yanlarım var. 3.Çirkinim.
N.)	1.Okul ödevlerimi yapmak için her zaman kendimi zorlarım. 2.Okul ödevlerimi yapmak için çoğu zaman kendimi zorlarım. 3.Okul ödevlerimi yapmak sorun değil.
O.)	1.Her gece uyumakta zorluk çekerim. 2.Birçok gece uyumakta zorluk çekerim. 3.Oldukça iyi uyurum.
Ö.)	1.Arada sırada kendimi yorgun hissederim. 2.Birçok gün kendimi yorgun hissederim. 3.Her zaman kendimi yorgun hissederim.
P.)	1.Hemen her gün canım yemek yemek istemez. 2.Çoğu gün canım yemek yemek istemez. 3.Oldukça iyi yemek yerim.
Q.)	1.Ağrı ve sızılardan endişe etmem. 2.Çoğu zaman ağrı ve sızılardan endişe ederim. 3.Her zaman ağrı ve sızılardan endişe ederim.
R.)	1.Kendimi yalnız hissetmem. 2.Çoğu zaman kendimi yalnız hissederim. 3.Her zaman kendimi yalnız hissederim.
S.)	1.Okuldan hiç hoşlanmam. 2.Arada sırada okuldan hoşlanırım. 3.Çoğu zaman okuldan hoşlanırım.
T.)	1.Birçok arkadaşım var. 2.Birçok arkadaşım var ama daha fazla olmasını isterdim. 3.Hiç arkadaşım yok.
U.)	1.Okul başarım iyi. 2.Okul başarım eskisi kadar iyi değil. 3.Eskiden iyi olduğum derslerde çok başarısızım.

Ü.) 1. Hiçbir zaman diğer çocuklar kadar iyi olamıyorum. 2. Eğer istersem diğer çocuklar kadar iyi olurum. 3.Diğer çocuklar kadar iyiyim.
V.) 1. Kimse beni sevmez. 2.Beni seven insanların olup olmadığından emin değilim. 3.Beni seven insanların olduğundan eminim.
Y.) 1. Bana söyleneni genellikle yaparım. 2. Bana söyleneni çoğu zaman yaparım. 3.Bana söyleneni hiçbir zaman yapmam
Z.) 1. İnsanlarla iyi geçinirim. 2. İnsanlarla sık sık kavga ederim. 3.İnsanlarla her zaman kavga ederim

APPENDIX F

APPROVAL OF BAHCESEHIR UNIVERSITY COMITEE FOR RESEARCH AND PUBLISHING

Bahçeşehir Üniversitesi
Bilimsel Araştırma ve Yayın Etiği Komisyonu

RAPOR

Bilimsel Araştırma ve Yayın Etiği Komisyonu'nun 14 Ocak 2016 tarihli toplantısında aşağıda tanımı verilen araştırma projesi incelenmiş, bilimsel araştırma ve yayın etiğine aykırı unsur içermediği anlaşılmıştır.

Proje Adı : **"Anne Tutumlarına Yönelik Psikoeğitim Çalışmasının Çocukluk Çağı Obsesif Kompulsif Bozukluğu Semptomlarına Etkisi"**

Tez Öğrencisi : Ecem Akıncı
Tez Danışmanı : Yrd. Doç. Dr. Oya Mortan Sevi
Rapor Tarihi : 14 Ocak 2016

Prof.Dr. Canan Çelik Karaaslanlı
Mühendislik ve Doğa Bilimleri Fakültesi
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Yrd.Doç. Dr. Mehmet Değirmenci
Sağlık Bilimleri Fakültesi

Yrd.Doç.Dr. Meltem Vatan Kaptan
Mimarlık ve Tasarım Fakültesi

APPENDIX G

PERMISSION OF KOCAELI CITY NOTIONAL EDUCATION DIRECTORATE

T.C.
KOCAELİ VALİLİĞİ
İl Milli Eğitim Müdürlüğü

Sayı : 99332089/605/13405942 28/11/2016
Konu: Araştırma İzni
(Ecem AKINCI)

VALİLİK MAKAMINA
KOCAELİ

Bahçeşehir Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji yüksek lisans öğrencisi Ecem AKIN' nin " Anne Tutumlarına Yönelik Psikoeğitim Çalışmasının Çocukluk Çağı Obsesif Kompulsasif Bozukluğu Semptomlarına Etkisi" konulu araştırma çalışmasını İlimiz İzmit ve Başiskele ilçesi İlkokullarında uygulama talebi, ilgili Üniversitenin 04/11/2016 tarih ve 3506 sayılı yazıları ile bildirilmektedir.

Adı geçenin söz konusu çalışmasına esas olmak üzere, ekte sunulan çalışmayı İlimiz İzmit ve Başiskele ilçesi İlkokullarında uygulama talebi komisyonumuzca uygun görülmüş olup, İlçe Milli Eğitim Müdürlükleri ve Okul Müdürlüklerinin denetim ve gözetiminde yapmaları Müdürlüğümüzce de uygun görülmektedir.

Makamlarınızca da uygun görüldüğü takdirde olurlarınıza arz ederim.

Fehmi Rasim ÇELİK
İl Millî Eğitim Müdürü

OLUR
..../11/2016

Hacı Mehmet KARA
Vali a.
Vali Yardımcısı

Aynur SARIOĞLU
Şef
Güvenli Elektronik İmzalı
Aslı ile Aynıdır.
02.12.2016

Körfez Mah. Ankara Karayolu Cad.No:129 Valilik Binası B Blok Kat:3 KOCAELİ Bilgi için: E. SAĞLAM YAVUZ
Elektronik Ağ: www..kocaelimem.meb.gov.tr Tel: (0262) 3005871
E-posta: stratejigelistirme41@meb.gov.tr

Bu evrak güvenli elektronik imza ile imzalanmıştır. http://evraksorgu.meb.gov.tr adresinden 7dd8-c11e-3791-9054-379d kodu ile teyit edilebilir.

APPENDIX H

INFORMATION FORM

Sayın Veli,

Ekteki anketler çocuklarda görülen bazı kaygı belirtilerini ve anne tutumlarını araştıran bir çalışma kapsamında size gönderilmiştir. Bu çalışma iki aşamadan oluşmakta olup; anketlerin doldurulmasının ardından, belirlenen anneler yapılması hedeflenen eğitim programına davet edilecektir. Araştırmacı ilk aşamanın ardından, konuyla ilgili detaylı bilgiyi iletmek üzere annelerle iletişime geçecektir.

Ekteki onam formunu dikkatlice okumanız ve araştırmaya katılmayı kabul etmeniz halinde anketleri doldurarak araştırmacıya ulaştırmanız rica olunur.

Not: Paylaşacağınız tüm kişisel bilgileriniz okul yönetimi ve sınıf öğretmenleri de dahil kimseyle paylaşılmayacak olup, araştırmacı tarafından tamamen gizli tutulacaktır.

Konuyla ilgili tüm sorularınız için iletişim bilgilerinden araştırmacıya ulaşabilirsiniz.

Psikolog Ecem AKINCI

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APPENDIX I

CONSENT FORM

BİLGİLENDİRİLMİŞ ONAM FORMU

Bu çalışma Bahçeşehir Üniversitesi Klinik Psikoloji Yüksek Lisans Programı tez çalışması amacıyla Klinik Psikolog Dr Oya Mortan Sevi danışmanlığında, Psikolog Ecem Akıncı tarafından yürütülmektedir. Bu araştırmanın amacı anne tutumlarıyla çocukların düşünce ve davranışları arasındaki ilişkiyi incelemektir.

Araştırma kapsamında öğrencilerden dört, annelerinden ise bir ölçek ile bir kişisel bilgi formu doldurması istenmektedir.

Bu çalışmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Çalışmanın amacına ulaşması için sizden beklenen, bütün soruları eksiksiz, kimsenin baskısı veya telkini altında olmadan, size en uygun gelen şekilde içtenlikle cevaplamanızdır.

Bu formu okuyup onaylamanız, araştırmaya katılmayı kabul ettiğiniz anlamına gelecektir. Ancak, çalışmaya katılmama veya katıldıktan sonra herhangi bir anda çalışmayı bırakma hakkına da sahipsiniz. Bu çalışmadan elde edilecek bilgiler tamamen araştırma amacı ile kullanılacak olup kişisel bilgileriniz gizli tutulacaktır. Araştırmaya katılımınız için teşekkür ederim. Çalışma ile ilgili bir sorunuz olduğu takdirde aşağıdaki e-mail adresi üzerinden araştırmacı ile iletişime geçebilirsiniz.

Psikolog Ecem Akıncı

Bahçeşehir Üniversitesi

Sosyal Bilimler Enstitüsü

Klinik Psikoloji Yüksek Lisans Öğrencisi

ecem_akinci@hotmail.com

Yukarıda yer alan ve araştırmadan önce katılımcıya verilmesi gereken bilgileri okudum ve katılmam istenen çalışmanın kapsamını ve amacını, gönüllü olarak üzerime düşen sorumlulukları anladım. Bu koşullarda söz konusu araştırmaya kendi isteğimle katılmayı ve velisi olduğum.....'nın da/de araştırmaya katılımını kabul ediyorum.

Annenin adı soyadı: Babanın adı soyadı :

Telefon numarası:

İmza: İmza: