NEAR EAST UNIVERSITY

GRADUATE SCHOOL OF SCIENCES PSYCHOLOGY DEPARTMENT
APPLIED (CLINICAL) PSYCHOLOGY MASTER PROGRAM

MASTER THESIS

THE RELATIONSHIP BETWEEN OBSESSIVE BELIEFS, OBSESSION SUBTYPES AND RELIGIOUS ATTITUDES AMONG OBSESSIVE COMPULSIVE DISORDER PATIENTS

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The Relationship Between Obsessive Beliefs, Obsession Subtypes and Religious Attitudes Among Obsessive Compulsive Disorder Patients

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ÖZET

Obsesif Kompulsif Bozukluk tanılı hastalarda Obsesif İnançlar, Obsesyon Alttipleri ve Dini Tutum arasındaki ilişki

Hazırlayan:Nurdan AKÇİT

Ekim, 2015

Bu araştırmanın amacı Obsesif Kompulsif Bozukluk tanısı alan hastaların obsesif inançları, obsesyon alttipleri ile dini tutumları arasındaki ilişki ve sağlıklı kontrol grubu ile karşılaştırılmasıdır. Araştırmada 18-65 yaş grubu hedef alınarak, 50 OKB tanısı almış hasta grubu ve 50 sağlıklı kontrol grubu olmak üzere toplamda 100 katılımcı ile gerçekleştirilmiştir. Katılımcılara ilk olarak, Gönüllü Olur Formu verilerek araştırmanın amacı anlatılmış ve onay alınmıştır. Sonrasında ise Demografik Bilgi Formu, Obsesif İnançlar Ölçeği (OİÖ), Padua Envanteri (PE), Maudsley Obsesif Kompulsif Ölçeği (MOKÖ) ve Dini Tutum Ölçeği (DTÖ) kullanılarak veriler toplanmıştır. Verilerin toplanması sonrasında elde edilen verilerin istatistiksel analizleri gerçekleştirilmiştir. Veriler SPSS programında T-Test ve Korelasyon uygulanarak sonuçlar elde edilmiştir.

Yapılan araştırma sonucunda sosyodemografik bilgiler ve ölçek alttipleri hasta ve kontrol grubu arasında karşılaştırılarak yapılan daha önceki benzer araştırma sonuçlarıyla benzerlik göstermiştir. OİÖ altölçek değerleri birbirleri ile karşılaştırılmış yüksek bir korelasyon tespit edilmiştir. OİÖ altölçekleri ile MOKE arasında bazı altölçeklerde zayıf negatif korelasyon bulunurken, bazı altölçeklerde güçlü negatif korelasyon görülürken, ruminasyon altölçeği OİÖ altölçeklerinin hepsi ile güçlü bir korelasyon olduğu tespit edilmiştir. OİÖ altölçekleri ile PE altölçekleri arasında zayıf ve güçlü korelasyon olduğu görülmüştür. MOKE altölçekleri ve PE altölçekleri arasında zayıf ve güçlü korelasyon tespit edilmiştir. PE altölçekleri ile kendisi karşılaştırılarak zayıf ve güçlü korelasyon bulunurken, PE alttipleri ve DTÖ alttipleri arasında zayıf ve orta korelasyon tespit edilmiştir. DTÖ alttipleri ise kendi alttipleriyle karşılaştırılarak güçlü korelasyon olduğu tespit edilmiştir.

Anahtar Sözcükler: Obsesif İnançlar, Obsesyon Altölçekler, Dini tutum, Obsesif Kompulsif Bozukluk

ABSTRACT

The Relationship Between Obsessive Beliefs,Obsession Subtypes and Religious Attitudes Among Obsessive Compulsive Disorder Patients

Prepared by: Nurdan AKÇİT

October, 2015

The goal of this study is to investigate the relationship between obsessive beliefs, obsession subtypes and religious attitudes of OCD patients and to compare them with healthy controls. 50 patients diagnosed with OCD and 50 healthy controls were taken in the study . They were between the age range of 18 to 65.

First, a form of voluntariness was given to the participants, they were informed about the purpose of the study and their approvals were received. Afterwards, the data was collected, making them fill Demographic Information Form, Obsessive Beliefs Questionnaire (OBQ), Padua Inventory (PI), Maudsley Obsessive Compulsive Scale (MOCS) and Religious Attitude Scale (RAS). After the data collection, acquired data was analyzed statistically. The data was analysed with SPSS software, with the applications of T-Test and Correlation.

Sociodemographic information and research results on the scale subscales were similar to the results from previous similar study comparing the patient and control groups. Correlations between subscales score were examined by comparing with each other. OBQ subscales have been identified itself with a high correlation is compared. OBQ weak negative correlation was found between some subscales of subscales with the MOCI, some subscales of strong negative correlation was seen it was found that rumination is a strong correlation between all the subscale of OBQ subscales. OBQ between PI subscales were found to be weak and strong correlation. MOCI subscales between PI subtypes weak and strong correlation was detected is found. PE subscales compared with each other weak and strong correlation was found. PI subscales between RAS subscales weak and moderate correlation is found. RAS subscales comparing with each other was strong correlation was found.

KeyWords: Obsessive Beliefs, Obsession Subscales, Religious Attitude, Obsessive Compulsive Disorder.

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ABBREVIATIONS

OCD –Obsessive Compulsive Disorder

OBQ –Obsessive Beliefs Questionaire

PI-Padua Inventory

MOCI-Maudsley Obsessive Compulsive Inventory

RAS- OK- Religious Attitude Scale

APA-American Psychological Association

ICD- International Statistical Classification of Diseases and Related Health Problems

DSM-The Diagnosticand Statistical Manual of Mental Disorders

OCCWG-Obsessive Compulsive Cognitions Working Group

INTRODUCTION

Obsessive-Compulsive Disorder (OCD) is an anxiety disorder which effects patients' lives considerably. With reference to conducted researches, it's the fourth prevalent mental disorder. This disorder has been qualified as one of the most significant disorders which disables daily performance and cause feelings of inadequacy by World Health Organization (Doron ve Kyrios, 2005). Additionally, OCD was frequently diagnosed in recent years, which has brought about a rise in the number of researches on this issue. Therefore, within the scope of this study the literature about Obsessive-Compulsive Disorder has been examined.

In this chapter; firstly specifications of Obsessive-Compulsive Disorder, obsessive beliefs, obsession subtypes, religious attitudes have been researched. Results were compared with ones of the control group to explain dynamic and cognitive theories about arising of indications and to clarify the relation with OCD. Thereafter, obsessive beliefs, obsession subtypes, religious attitude definitions which take active roles in Obsessive-Compulsive Disorder have been included. Finally, purposes of the study and researching questions have been given.

1.1 OBSESSIVE-COMPULSIVE DISORDER (OCD)

Obsessive-Compulsive Disorder (OCD) is a disease that has come to be known for nearly three hundred years. Despite being diagnosed for the first time in medical literature in early 1900s, it's been discussed as an individual clinical syndrome in early 2000s (Steketee GS, 1993).

The word "obsession" comes from Latin "obsideratum/obsidere" words that means siege. Obsession is repetitive thoughts and images. Besides, *compulsion* is ritual motions or behaviors that are exhibited to prevent the anxieties caused by obsession. Most seen obsessions are cleaning obsessions. There are control and symmetry/neat obsessions later than that. The probability of having the disorder among every twenty people is 2 percent.

In subsections, Obsessive-Compulsive Disorder diagnosis, its epidemiology (prevalence), its dispersion between genres, beginning age, comorbid of the disorder, its subtypes and etiology were explained.

1.1.1 OCD DIAGNOSIS

Diagnostic And Statistical Manual Of Mental Disorders (DSM-V, 2014) defines Obsessive-Compulsive Disorder as a disorder which includes obsessions and compulsions.

Obsessions are repetitive thoughts, impulses and images that causes significant distress for the individual. On the other hand, compulsions are repetitive behaviors or mental actions that the person feels forced to act in reaction to obsessions or some rules to which they feel obliged. The disorder is involved to DSM 5 (APA 2013) below "Obsessive-Compulsive Disorder" title and involved to ICD-10 under "Neurotic, stress-related and somatoform disorders" category as a different diagnosis from the other anxiety disorders.

To be diagnosed with OCD, the person must have obsessions, compulsions or both and those symptoms must take their time too much or cause impairment in their functionalities. DSM-V and ICD-10 criterion for OCD diagnosis are shown below:

DSM-V Diagnostic Criteria for OCD

A. Either obsessions or compulsions

Obsessions as defined by (1) and (2)

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted and that usually cause marked anxiety or distress.
2. The person attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions as defined by (1) and (2)

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

B. The obsessions or compulsions are time consuming (for example, take more than 1 hour a day), or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

D. The content of the obsessions or compulsions is not restricted to the symptoms of another mental disorder (e.g., excessive worries about real life problems in Generalized Anxiety Disorder; preoccupation with food or ritualized eating behavior in an Eating

Disorder; hair pulling in Trichotillomania; stereotypes in Stereotypic Movement Disorder; preoccupation with appearance in Body Dysmorphic Disorder; preoccupation with drugs in a Substance Use Disorder; preoccupation with having a serious illness in Hypochondriasis; preoccupation with sexual urges or fantasies in a Paraphilia or compulsive sexual behavior; preoccupation with gambling or other behaviors in behavioral addictions or impulse control disorders; guilty ruminations in Major Depressive Disorder; paranoia or thought insertion in a Psychotic Disorder).If Hoarding Disorder and Skin-Picking Disorder are added to DSM-V, they will also need to be mentioned in criterion C.

Specify whether OCD beliefs are currently characterized by

1. Good or fair insight: Recognizes that OCD beliefs are definitely or probably not true, or that they may or may not be true

2. Poor insight: Thinks OCD beliefs are probably true

3. Delusional beliefs: Completely convinced OCD beliefs are true

Specify if: Tic-related OCD: The individual has a personal life time history of a chronic tic disorder.

ICD-10 Obsessive-Compulsive Disorder Criterion

A. Either obsessions or compulsions (or both), present on most days for a period of at least two weeks.

B. Obsessions (thoughts, ideas or images) and compulsions (acts) share the following features, all of which must be present:

(1) They are acknowledged as originating in the mind of the patient, and are not imposed by outside persons or influences.

(2) They are repetitive and unpleasant, and at least one obsession or compulsion must be present that is acknowledged as excessive or unreasonable.

(3) The subject tries to resist hem (but if very long-standing, resistance to some obsessions or compulsions may be minimal). At least one obsession or compulsion must be present which is unsuccessfully resisted.

(4) Carrying out the obsessive thought or compulsive act is not in itself pleasurable. (This should be distinguished from the temporary relief of tension or anxiety).

C. The obsessions or compulsions cause distress or interfere with the subject's social or individual functioning, usually by wasting time.

D. Most commonly used exclusion criteria: not due to other mental disorders, such as schizophrenia and related disorders (F2), or mood [affective] disorders (F3).

The diagnosis may be specified by the following four character codes

- Predominantly obsessional thoughts and ruminations
- Predominantly compulsive acts
- Mixed obsessional thoughts and acts
- Other obsessive-compulsive disorders
- Obsessive-compulsive disorder, unspecified

1.1.2 PREVALENCE OF OCD (EPIDEMIOLOGY)

In 1980s the studies about OCD reported that the disorder was rarely seen and refractory to treatment.

In contrast, referring to today's epidemiologic study findings OCD has been classified as the fourth most seen mental disorder. Phobia, substance-use disorders and depression are the three most seen disorders beyond OCD, respectively.

Conducted studies have shown that prevalence rate of obsessive-compulsive indications is higher than the prevalence rate of OCD (Fullana ve oth., 2010; Grabe, Meyer, Hapke, Rumpf, Freyberger ve Dilling 2000). To the study of Fullana and others which was conducted with 2804 participants in 2010 lifelong prevalence rate for any obsessive-compulsive indication scale (dirtiness/washing, harm/control, symmetry/neat, sexual/religious, somatic obsessions, morals obsessions) was found as 13 percent. At the same study prevalence rate for non-clinical samples was calculated as 9,6 percent. Besides, it's been seen that prevalence rate of OCD was 0,5 percent and prevalence rate of indication

scales is 2 percent, as a result of a study which was performed with non-clinical samples (Grabe and oth., 2000).

Lifelong prevalence varies depending on the countries. The lowest rates were found in Taiwan (0,5 % - 0,9 %) and India (0,6 %), while the same rate was found between 2,6 % and 3,2 % across the North and Central Europe. Not being precise, it's been mentioned that lifelong frequency of the disorder is around 1 – 2 percent (Clark, 2004).

1.1.3 DISTRIBUTION OF OCD BETWEEN GENDERS AND BEGINNING AGE

Average beginning age of the disorder is between 21,9 and 35,5. However, the disease could emerge at any age, especially ages between 10 – 24 are the most risky ones. For 65 percent of the patients, beginning age is below 25. In contrast, it's over 35 for 15 percent of the patients.

In large amount of studies, it's been found that OCD is seen among females more than males. On the other hand, beginning age of the disorder for males is smaller than the age of females (Clark, 2004).

Although the effect of genre on the process of the disease is unclear, depending on some findings females tend to have washing and cleaning behaviors more than males; on contrary, male show more sexual obsessions than females (Lensi and oth.).

Millet and oth. (2004) have found that the disease progresses gradually at the early ages while at later ages it arises suddenly related to stressful lifestyle in their study in which they researched into the relation between phenomenology of the disease and beginning age.

1.1.4 OTHER MENTAL DISORDERS SEEN WITH OBSESSIVE-COMPULSIVE DISORDER (COMORBIDITY)

As distress disorders, co-morbidity rates are mentioned to be high. It's stated that OCD has a close relationship with depression and frequency of being seen together with depression or dysthymia is 30 to 50 percent (Clark, 2004).

To ECA studies, two-third of people who has OCD also has another psychiatric disorder. They have agoraphobia (39 %), bad alcohol use (34 %), major depression (32 %), dysthymia (26 %), social phobia (19 %), panic disorder (14 %) and bipolar disorder (10 %) respectively.OCD and co-morbid disorder rates in Rasmussen and Eisen's research were reported as: major depression (67 %), simple phobia (22 %) and social phobia (18 %). There are some studies in which anorexia nervosa is seen beside OCD at the rate of 10 to 17 percent.

Personality disorder could be seen with OCD. An individual personality disorder which belongs to OCD doesn't exist. Okasha and oth. mentioned that the most seen co-morbid diagnosis is "undefined personality disorder". After that; borderline personality disorder, obsessive-compulsive personality disorder, avoidant personality disorder, histrionic personel disorder come respectively.

1.1.5 SUBTYPES OF OBSESSIVE-COMPULSIVE DISORDER

Symptoms of obsessive-compulsive disorder vary and two different persons may have symptoms in many different ways. The most common obsessions are aggression, damaging, getting dirty, symmetry, religion and neat. And the most seen compulsions are washing rituals, cleaning, checking, organizing, counting and hoarding behaviors (Pigott, 1998)

Because of the fact that the obsessive-compulsive symptoms have a wide variety, scientific studies have begun to be done for specifying their subtypes. Hence, for forecasting clinical course and developing effective therapeutic approaches it's been required to make the communication between specialists stronger and develop etiologic theories (McKay and oth., 2004).

Obsessive beliefs have been specified with OBQ-44 which was developed by OCCWG. Within this questionnaire, there are 44 items that are assessed as 7-point likert and that scales OCD and related beliefs of it. To assess the framework of the scale with factor analysis, related beliefs have been separated into three groups. A good internal consistency for this scale which consists of "Inflated responsibility/perceived threat of harm", perfectionism/intolerance of uncertainty" and "importance of thoughts/controlling thoughts" have been reported (3,12). OBQ-44 has been adapted to Turkish by Boysan and oth.

Four subscales have been found in a study in which normal sample was used. Those are "contamination, checking, deterioration in controlling mental activities and unrestrained motor behaviors" (Sanavio, 1988). On the other hand, it's been reached to five subscales in a study, using clinical subscales. Those subscales were "washing, checking, rumination, urges and precision" (Van Oppen, Hoekstra and Emmelkamp, 1995).

Four subscales were obtained by the factor analysis done in Maudsley Obsessive-Compulsive Inventory which was developed by Hodgson and Rachman (1977). Those are "cleaning, checking, doubting and slowness". While adapting it in Turkish three factors were found which were "cleaning/neatness, obsessive thoughts and checking/slowness" by adding 7 more questions (Erol and Savaşır, 1998).

1.2 ETIOLOGY OF OBSESSIVE-COMPULVE DISORDER

1.2.1 Genetic Factors

Proofs that genetic factors lead to occurrence of obsessive-compulsive disorder have been increasing. As results of the twin studies for OCD, higher rates have been detected among monozygotic twins than dizygotic twins. In family studies, effects of the disorder were found at 35 percent of the patients' first degree relatives.

It's suggested that genetic factors play a bigger role in having disorder at early ages (Bellodi L. ve oth. 1992, Pauls D.L ve oth. 1995).

To family studies, it's been stated that obsessive-compulsive disorder is seen among the patients' biologic relatives at a higher frequency than coincidence. Thus, family characteristic is considered to be feature of the disorder.

1.2.2 Biological Factors

Number of studies on the subject of neurobiology of OCD which was formerly considered to be a disease that has rather psychological etiology has been increased within the last years; and significant findings have been presented.

Especially studies are conducted in two fields

1. Brain screening studies support that there is orbitofrontal-limbic-basal ganglion malfunction at the disease.
2. Neuropharmacological studies give rise to thoughts that serotonergic system abnormalities are important for physiopathology of the disease.

1.2.3 Neurochemical Studies

Success of SSRI and clomipramine which is also successful serotonin on treatment of OCD, arising of antiobsessional effect independent from antidepressant effect and presence of relationship between 5-Hydroxyindoleacetic acid (5-HIAA) which is metabolite of serotonin as reaction to the drug and its level in cerebrospinal fluid give rise to thought that serotonergic system disorder lies behind.

1.2.4 Personality Factors

Premorbid obsessive characteristics have been detected among 15 – 45 percent of OCD patients. Nevertheless, personality characteristics are neither requisite nor sufficient for progress of OCD.

1.3 OBSESSIVE COMPULSIVE DISORDER DESCRİBİNG DİFFERENT THEORİES

1.3.1 Psychodynamic Theory

The person regresses to anal stage in the oedipal position instead of suppressing the anxiety, turning it into somatic syndrome as in hysteria or reflecting it as in phobia. While sexual urges and aggression combine with each other in oedipal stage, they separate from themselves with the regression of anal stage. Love and hate are not combined. The person feels strong ambivalence. Existence of two opposite emotions paralyzes the person how to move. Existence of anal fixations eases to regress into the anal stage.

Freud handled the situation as obsessive neurosis which is named OCD at the present time. To psychodynamic theory, OCD symptoms occur as a result of suppressed subliminal urges. It's been regressed to anal phase, which is related to strong ambivalence emotions, from oedipal phase as the product of anxiety created by those suppressed urges. Many of OCD patients might reject to participate in the treatment. Psychodynamic mean of that is about adherence to the secondary acquisitions with their symptoms.

The main issue in OCD is the effort of gaining control over the pressure of opposite urges. The person constantly fight against the thoughts and tendencies which come from inside. They never confess to those thoughts and tendencies, and perceive as if they can affect something with its magical power.

Psychoanalytic theory connects obsessive-compulsive neuroses with regression of psychic item to defensive pre oedipal anal-sadistic phase. Main defense mechanisms are suppression, isolation and undoing (Köroğlu E., 1997; Öztürk O., 2001).

1.3.2 Behavioral Theory

According to the behavioral model, thoughts, which are not scary intrinsically indeed and may come to everyone's mind (i.e. infection, getting ill), are connected with the person's anxiety emotions and gain disturbing characteristics. Occurrence of those thoughts in mind gets the person have anxiety. The person develops escape and avoidance behaviors to protect themselves from anxiety. Those escape and avoidance behaviors act a role as a reinforcer by reducing the anxiety. In addition, they try to reduce their anxiety by developing a range of compulsive behaviors. Owing to the fact that compulsive behaviors also reduce anxiety by acting as reinforcers, they give rise to augmentation of the same behaviors. By the reason of that strategies like escape, avoidance and compulsion are utilized only for handling with the anxiety; by rising of anxiety (frequency and strength of obsessive thoughts and belief in those thoughts) these strategies occur more often also (Rachman 1976, Rimm D.C 1977, Sungur M.Z 1990).

In behavioral approach, it's aimed to expose the person to the stimulus that stimulates the obsession and prevent escape and compulsion. When they can't do their compulsion they suppose that their anxiety will go on and on. However, even tough it takes a long time the anxiety disappears over time. Exposure is an effective method in behavioral theory.

1.3.3 Cognitive Theory

Cognitions are oral or pictographic events in the stream of consciousness. In psychopathologic cases, cognitions get sided systematically depending on distorted working of information processing system of the person who has mental problem. This case brings about nonfunctional behaviors. It's detected that a distortion of attention is discussed especially for the people with anxiety disorder (Blackburn, I.M., 1998).

According to cognitive theory, cognitive structure is comprised of three main layers. Automatic thoughts which take part within the person's daily life exist on the upper surface. Automatic thoughts are the special type cognitions that especially are important at emotional

disorders, though they appear in normal cases also. They are the person's expressions about themselves, their environment and setting or are their internal dialogues. These thoughts generally don't pass through a reasonable and systematic analysis and are spontaneous. They aren't reflection or products of motivated thoughts and are combined with certain senses depending on their meanings or scopes. Often they aren't noticed, only comorbid emotions are noticed. Automatic thoughts are accepted by the person without examining.

Automatic thoughts are uncovered with recording by focusing on cognitive stream at the moments when they have trouble because of the fact that they are connected with emotions. Every patient may have numerous automatic thoughts depending on their cognitive stream context (Wright J.H., 1988).

1.3.4 Cognitive-Behavioral Theory and Basic Approach

Obsessions are challenging cognitions. The person feels responsible for the content and appearance of them. They suppose that they might harm themselves or other people, unless they take action to prevent that situation. In other words, they struggle to neutralize the obsession to get rid of the responsibility. So, those neutralizing behaviors are compulsions. On the other hand, neutralizing behaviors increase obsession. Consequently, anxiety rises and symptoms intensify in a vicious circle by stimulating each other.

Taking responsibilities of obsessive thoughts increase anxiety and depression. The person struggles too much to control their thoughts, and this prompts the patients to spend their time and energy with obsession and compulsive behaviors continuously.

- Basic Approach
    1. To tell the unnecessity of trying to control the thoughts.
    2. To show that obsession doesn't reflect the reality about the life.
    3. To provide not undertaking the content of the obsession.
    4. To make them notice that halting cognitions reduces obsessions over time.

Within the context of cognitive models which express the etiology of OCD, six mistaken evaluation and belief domains have been produced. These are inflated responsibility, giving too much importance to thoughts, inflated threat of harm, giving importance to controlling of thoughts, intolerance to uncertainty and perfectionism.

Inflated Responsibility

Inflated responsibility can be explained as that the person believes themselves to prevent significant negative consequences. People who have the inflated responsibility perception have thoughts like failing in preventing a probable negative result is as mistaken as causing harm morally in an active way. Or they think like that ignoring a thought about a possible harm is unacceptable, no matter how less probable it is.

Importance of Thoughts

Another belief domain that is seen in OCD is importance of thoughts (thought-action fusion). It's defined as the belief that existence of a thought proves its importance. For instance, beliefs like "having a thought which is immoral is the same thing with doing it", "if I'm thinking of something I want it to happen", "thinking of a case enhances the probability of its happening", "if it didn't have a meaning that thought wouldn't come to my mind" are in controlling thoughts category.

Controlling Thoughts

Third belief domain that plays a role in OCD is controlling thoughts. Controlling thoughts can be defined as giving importance to controlling compulsive thoughts, images and urges extremely and believing that controlling those are possible and necessary. Controlling thoughts is based on the belief of the person needs to control their unwilling thoughts such as "if I could gain more control over my thoughts, I'd be in a better situation", "I can have a full control over my mind if I represent enough willpower", "going out of control of my thoughts may make me really sick".

Intolerance of Uncertainty

Intolerance of uncertainty is another type of belief domain seen in OCD. The belief of necessity of being certain, in other words the belief of absence of handling ability with unpredictable changes and difficulty of functioning in uncertain statements are defined as intolerance of uncertainty. Typical thoughts are sorted as "if I feel something uncertain, there is something going wrong.", "unless it's precise that I'm not a pedophilic, murderer or transgressor it would be mistake to continue as a normal person.", "anything which don't have absolute precision are unacceptable.".

Perfectionism

A different type of belief that plays a role in OCD is perfectionism. Perfectionism means tendency to supposing that every problem has a perfect solution and it's explained as the belief of doing something perfectly is both possible and necessary and even minimal faults can cause serious consequences. Perfectionism is supported by the belief that "if a perfect situation happened once, people should always try to reach to that situation".

1.4 OBSESSIVE COMPULSIVE COGNITIONS WORKING GROUP

Study of Obsessive Compulsive Cognitions Working Group that has conducted comprehensive studies on obsessive compulsive beliefs and developed scales was researched.

In Denmark, 1995, a group of researchers in World Cognitive Behavioral Therapy Congress came together with the purpose of evaluating cognitive theories about OCD and developing tools for specifying and measuring cognitive properties which can be effective in treatment.

Obsessive Compulsive Cognitions Working Group consists of 46 researchers from 9 nations. By meeting up many times, they have developed "Obsessive Beliefs Questionnaire" which measures obsessive beliefs and also developed "The Interpretations of Intrusions Inventory" which evaluates interpretations (Obsessive Compulsive Cognitions Working

Group, 1997). Obsessive Compulsive Cognitions Working Group has split cognitive bias which is supposed to be significant in OCD into three levels: intrusive thoughts, beliefs and interpretations.

Intrusive thoughts are unwilling thoughts, images and urges. When its severity reaches to clinical level it's qualified as obsessions. Beliefs are premises which are long standing and not situational. Beliefs might be peculiar to OCD; on the other hand, general beliefs of the person's own or their identity could be related to obsessive-compulsive symptoms. Besides, those beliefs may be seen in other disorders as well. And evaluations are about putting interpretation on a conclusive thought to emerge. Evaluations can be related to interpretation, expectation and other judgments (Obsessive Compulsive Cognitions Working Group, 1997).

Obsessive Compulsive Cognitions Working Group has specified belief domains from the viewpoints of being peculiar to OCD and their etiologic significance by reviewing the literature and defined 6 belief domains:

- Inflated Responsibility: Believing in the fact that the person has the power of emerging or preventing bad results
- Giving Importance to Thoughts Too Much: The belief that if a thought just exists even that fact shows its importance
- Inflated Threat of Harm: Inflating probability of occurrence or severity of a harm or danger
- Giving Importance to Controlling of Thoughts: To believe that controlling over intrusive thoughts, images and urges are important as well as possible
- Intolerance to Uncertainty: The necessity of being certain, the belief that handling with unpredictable changes is impossible and having difficulty against uncertain statements
- Perfectionism: Believing that every problem has a perfect solution, doing something perfectly is not only possible but also necessary and even tiniest faults may cause severe results

In the latest study of Obsessive Compulsive Cognitions Working Group, a shortened form of The Obsessive Beliefs Questionnaire has been produced. Discriminant validity of the scale was detected at significant level (OCCWG, 2005). Within this thesis, mentioned scale has been handled in detail because of the fact that it'd been used.

The scale, which was developed by Obsessive Compulsive Cognitions Working Group, has begun to be used in many studies. Taylor and oth. (2004) mentioned that the sample which consists of OCD patients split in two parts as scored high and low. They conclude that the people who had high scores and low scores don't differ in certain subtypes as cleaning or checking; on the other hand, they differ from each other in subtypes about harm. They interpreted the results as that the nonfunctional beliefs might have a role in only certain subtypes of OCD.

Calamari and oth. discussed the decidability of subtypes of OCD as to nonfunctional beliefs in their studies at which they examined Obsessive Beliefs Questionnaire. In that study, they reached to some results as that symmetry symptom group is relevant to perfectionism/certainty beliefs subtype. In addition, they mentioned that this fact needs to be supported by further researches to understand heterogeneity of OCD.

Tolin, Worhunsky and Malthy utilized the Obsessive Beliefs Questionnaire. They deduced that this scale could distinguish the patients in subscales of beliefs perfectionism/certainty and controlling thoughts from the ones who has anxiety disorder but doesn't have OCD. In contrast, they realized there is no distinctiveness in terms of sense of danger and inflated responsibility.

1.5 RELİGİOUS ATTİTUDES

Religiousness scale presented in this study has been developed as dependent on "attitude" doctrine. Simply, attitude is evaluating (as good or bad) humans, objects or thoughts (Aroson and oth., 2010). It's known that attitudes are related to genes indirectly and they emerge or die down within the frame of teaching principals (classical and operant conditioning). There are three different components of attitude as one of the fundamental subjects of social psychology: thoughts/knowing (thoughts and beliefs towards attitude object), emotion (emotional reactions towards attitude object) and behavior (behavioral patterns towards attitude object). These components are also named as cognitive, emotional and behavioral grounded attitudes. To illustrate, someone's behavioral scale of attitudes towards attitude object is evaluated with their behaviors which they had shown until that time (Aronson and oth., 2010). Normally it's presumed that those three components are related to and matching with each other (Myers, 1990). As an illustration, if someone thinks positive about the religion, it's supposed that they have positive emotions towards it.

Conducted researches have demonstrated that an attitude towards a general attitude object (e.g. religion itself) doesn't presume a more specific behavior about religion (e.g. salaat in Islam) widely; nevertheless, an attitude towards a specific attitude object does presume that attitude object widely (Myers, 1990). Thus, Myers mentions about three significant features for attitudes to presume behavior:

a) Decreasing the expression of attitude and the other effects on the behavior (e.g. environmental)
b) The attitude is to be specifically related with observed behavior
c) Attitude that would presume the behavior is to be important.

Another important point on the subject is the fact that attitude is designated by behavior. In other words, as attitudes may presume our behaviors, behavior may also specify our attitudes on a certain subject. Broadly speaking, "unless you live as you believe, you start believing as you live". Even when humans speak what they don't believe, they start believing in them by time to be consistent (or to avoid themselves being contradicted) (Myers, 1990).

Besides, attitudes split in two as implicit and explicit attitudes. Explicit attitudes include directly and consciously acted attitudes; in contrast, implicit attitudes are the ones of which the person is unaware and they include opposite of explicit attitudes. As an example, a person may have a negative attitude to some aspects of religionists even though they have a positive attitude to them normally.

1.6 TREATMENT OF OBSESSIVE-COMPULSIVE DISORDER

It's been mentioned that medication and cognitive-behavioral therapy are effective on treatment of obsessive-compulsive disorder.

1.6.1 Psychopharmacotherapy

Primarily used drugs are serotonin reuptake inhibitors.

Stages of the treatment

- As the first choice, cognitive therapy with a SSRI is applied.
- Second option is to apply cognitive therapy together with clomipramine that is a serotonergistic antidepressant or with another SSRI.
- If the respond to the treatment is not exact, enrichment therapy with lithium, buspirone, trazodone, clonazepam, alprazolam or levotiroxyn sodium together with cognitive therapy is applied.
- If there is no respond again a second SSRI is tried and cognitive therapy is applied.
- At patients with severe obstructive disease whose functionality is very low, if at least two drugs and enrichment therapy with cognitive therapy is unsuccessful for five years and unless the patient have severe personal disorder, neurosurgery can be applied.

1.6.2 Cognitive-Behavioral Therapy

The purpose of Cognitive-Behavioral Therapy is to provide the obsessive-compulsive disorder patients with facing their fears without acting their rituals and reducing their anxiety. This therapy focuses on reducing the inflated or catastrophes containing thoughts commonly seen at obsessive-compulsive disorder patients.

The purpose of the behavioral treatments is to make the patients face their thoughts which causes anxiety and avoidance behaviors and to prevent repetitive behaviors that are activated to diminish the anxiety caused by facing. The aim is to stop the anxiety which is generated by annoying thoughts and to make the patient get used to it. This treatment is also named as habituation.

Besides, the target of behavioral treatments is reducing the responsibility sensations which are caused by disturbing thoughts. When there aren't any feelings of responsibility, they won't require repetitive behaviors to neutralize and deactivate the disturbing thoughts. The purpose is to reduce the sense of thinking the thoughts as real and to investigate to what extent the threats, dangers and inflated responsibilities are true and to investigate the appearance of inflated senses of danger or threat as a result of which thought errors together with the patient. After detecting those cognitive errors transposing those thoughts which are non-functional with the functional ones is ensured. The patients who suppose that there will be a disaster as a result of their thoughts are to bring those thoughts to their minds instead of forgetting them, so once doing that it's quite helpful to see that there aren't any disasters that were dreaded.

Cognitive and behavioral therapies are a very important stage of the treatment. They occupy a significant place in preventing repetitive symptoms. Sometimes they can be practiced by oneself or together with medication.

1.7 RESEARCH OBJECTIVE

The objective of this study is examining (1) the obsessive beliefs supposed to have roles in Obsessive-Compulsive Disorder by theories and (2) subtypes of OCD; in addition, religious attitudes were discussed. The survey was conducted with 100 subjects who are comprised of 50 individuals diagnosed with OCD and 50 randomly chosen individuals with no diagnosis as control group. The relation between obsessive beliefs, subtypes and religious attitude among the patient group has been researched; on the other hand, symptoms of OCD were compared between the patients and the control group.

METHODS

2.1 PARTICIPANTS

Randomly chosen 50 voluntary patients who had obsessive compulsive disorder (OCD) and were getting treatment in Marmara Training and Research Hospital and 50 other healthy volunteers who would be the control group were taken as subjects of the preliminary study in which validity and reliability of Turkish forms of four scales was going to be used for the study. Disordered people participated to the study as voluntarily. The only reason for not being taken into the study as patients was being illiterate. The only criteria for participants to be included in the control group was that they had not been diagnosed with obsessive compulsive disorder. 32 percent of subjects were women on the contrary 78 percent were men.

2.2 PROCEDURE

The validity and reliability of Obsessive Beliefs Questionnaire, Maudsley Obsessive Compulsive Inventory, Padua Inventory and OK-Religious Attitude Scale were examined. First, the participants were asked to read and confirm the Form of Voluntariness. Then, Demographic Information Form was given to them to be filled. And next, the three scales developed for Obsessive-Compulsive Disorder and one scale for religious attitude were given to them to be filled non-sequentially. Given time to participants for filling the scales was about 50 minutes.

Research was directly conducted by the researcher. For conducting the survey, required permissions were taken from the relevant departments. With the confirmation of the Ethics Committee, 50 volunteer patients who had diagnosed with OCD were interviewed one by one in Marmara Research and Education Hospital. Other 50 subjects in the control group were chosen randomly.

2.3 INSTRUMENTS FOR COLLECTING DATA

Subjects were informed about the study, a form of voluntariness was presented to them and they were expected to submit it. For collecting personal data Demographic Information Form, furthermore, with the purpose of gathering data related to OCD Obsessive Beliefs Questionnaire, Padua Inventory, Maudsley Obsessive Compulsive Questionnaire and OK Religious Attitude Scale were used.

2.3.1 FORM OF VOLUNTARINESS

As the beginning, topic and purpose of the study were expressed within the context of the form. Thereafter, required information about subjects was notified. Finally, notifications about voluntariness and privacy were included.

2.3.2 DEMOGRAPHIC INFORMATION FORM

Demographic data among the specialties which is supposed to be relevant to the study was collected with this form subsequent to "Form of Voluntariness".

2.3.3 OBSESSIVE BELIEFS QUESTIONAIRE (OBQ)

Obsessive Belief Questionnaire was created by "Obsessive Compulsive Cognitions Working Group (OCCWG)" which was formed to specify the cognitive characteristics on the basics of OCD. In the 87-item scale which is for determining not only among clinical samples but also normal samples that are vulnerable to the disease consists of 6 belief domains. These are "perceived threat of harm, intolerance to uncertainty, importance of thoughts, controlling thoughts, responsibility and perfectionism".

The participants are asked to indicate how much they agree with the statements which represent the obsessive compulsive beliefs in a seven point likert scale.

Although the scale's reliability and internal consistency were satisfying in the studies on its psychometric properties, an overlapping was revealed on symptoms and belief domains (Obsessive Compulsive Cognitions Working Group / OCCWG, 2001, 2003).

Tolin and oth. (2006) have indicated a good internal consistency for these three factor structures. In this study, a form (OİÖ-44) which has been translated into Turkish from OBQ-44 by Boysan and oth. was used.

Forty four questions in obsessive beliefs questionnaire make 7 point likert type measurement. Total score of the questions numbered "2, 3, 4, 9, 10, 11, 12, 14, 18, 20, 25, 26, 31, 37, 40 and 43" forms "perfectionism/intolerance to uncertainty" subscale; while questions "7, 13, 21, 24, 27, 28, 30, 32, 35, 38, 42, 44" forms "importance of thoughts, controlling thoughts", questions "1, 5, 6, 8, 15, 16, 17, 19, 22, 23, 29, 33, 34, 36, 39, 41" forms "inflated responsibility/perceived threat of harm" subscale.

It's revealed that the scale is capable of differentiating OCD patients from the patients who have anxiety disorder and don't have OCD and from the normal samples, predicting severity of obsessive compulsive symptoms and distinguishing the different symptoms of OCD.

2.3.4 PADUA INVENTORY (PI)

PI consists of 60 items. Those items were chosen amongst 200 different symptoms which the patients diagnosed with OCD had defined. Each question comprises five answers and one of them is to be chosen. Every item is scored between 0 and 4. These five choices are "not at all", "a little", "quite a lot", "a lot" and "very much". While "0" score in every test item represents not having the symptom at all or not being disturbed, "4" scores correspond to being disturbed or having the symptom extremely.

Psychometric features of the original 60-question and the modified 41-question forms of Padua Inventory which estimates dispersion and severity of obsessive-compulsive symptoms have been researched. Internal consistency of the scale, test-retest reliability, factor structure, synchronous and distinctive validity were researched.

All subscales and items of both forms have shown high internal consistency and test-retest reliability. Total test and all subscales except impulses subscale represent a significant correlation with Yale Brown obsession-compulsion and its total scores.

Subscales and total scores for OCD patients were higher than healthy control subjects significantly. Results of both forms for OCD patients in subscales of "checking" and "cleaning" were higher than other groups'. In contrast, a significant difference couldn't be found in "impulses" subscale. Consequently, results of Turkish sample of Padua Inventory demonstrate that it's a reliable and valid scale.

2.3.5 MAUDSLEY OBSESSIVE-COMPULSIVE INVENTORY (MOCI)

MOCI is a self-report scale containing 30 items which was developed for estimating different obsessive-compulsive symptoms with binary answer choices (Yes/No) (Rachman and Hodgson, 1980). The original study consists of four factors that are "checking, cleaning, slowness and doubting". While adapting it in Turkish, Erol and Savaşır (1998) added 7 more items on rumination to it with the opinion that it wasn't sufficient to detect the obsessions and made the 37-item version. In the factor analysis of the Turkish version of the inventory, it's reported that there are three factors as cleaning/neatness (5, 6, 9, 15, 21, 23 and 35. items), checking/slowness (4, 10, 12, 20, 28 and 31. items) and obsessive thoughts (2, 8, 33, 34 and 37. items).

2.3.6 OK-RELIGIOUS ATTITUDE SCALE (RAS)

OK-Religious Attitude Scale has been prepared by considering three factors (knowledge, emotion and attitude) which are underlined by social psychology of attitude.

The author named the scale with his own surname with the purpose of being distinguishable from other religious attitude scales. It's been aimed to find out how the person's general view on religion was with the cognitive scale and how their attitudes were affected by religious values with the emotional scale. In addition to these three components of attitude , the attitude of the object to be measured by the fact that religion and faith in God also a central dimension in the relationship with God in a place this size because it has been added .

OK-Religious Attitude Scale has been designed for comprehending four subscales. Within the frame of these four subscales, the implementation has been begun with a pool which contains 16 items, as each subscale contains 4 of them, by utilizing the relevant studies in the literature for understanding the religious attitude. A religious attitude was developed that

consists of 8 items by deciding 2 items estimates each subscales the best in consideration of both confirmatory factor analysis and reliability item analysis.

Each of the items except demographic variables was measured by five point likert scale. This was made as submitting "strongly disagree", "somewhat disagree", "neither agree or disagree", "somewhat agree" and "strongly agree" statements as the answer of the question "How much do you agree or disagree with the following statements?".

2.4 ANALYSES PERFORMED

The data collected from the participants were coded on SPSS software. The data entries were rechecked before the analysis and premises of the analyses which were going to be done were tested.

Before the analyses of the main study, the analyses about reliabilities and validities of the scales were made and their factor structures were examined. After seeing that the results of the preliminary study were satisfying, it's proceeded to the analyses of the main research. Within the context of main study; first, T-Test was done in order to find a connection and correlation was done to make comparison. To start with, sociodemographic data; subsequently, the patient group and the control group were compared. Last of all, the relation of the scales to each other was researched.

RESULTS

In this study, the relation between obsessive beliefs, obsession subtypes and religious attitude was researched by comparing results with those of control group. In accordance with that purpose, T-Test and correlation were conducted by reporting the results of the statistical analyses.

3.1 STATISTICAL ANALYSIS OF SOCIODEMOGRAPHIC DATA COMPARED BETWEEN PATIENTS AND THE CONTROL GROUP

In this analysis, comparing the answers of the questions in Demographic Information Form was aimed. The analysis was carried out by evaluating the data of age, educational status, job, employment, marital status, number of children, living place, family structure, income level and religious attitude, which were asked in the form, of the patients and the control group.

Table 1. The Comparison Of Mean Score Of Age Between Groups.

	n (%)	m±sd	t(p)
Patient	50 (50.0)	32.30±9.38	-1,868
Control	50 (50.0)	36.34±12.08	(,065)

*p≤0.05 **p<0.001

When the mean of age of the patient and control group is compared with T-test analysis, no significant difference was found.

Table 2. The Comparison Of Gender Between Groups.

	Patient n (%)	Control n (%)	X^2 (p)
Female	34 (68.0)	29 (58.0)	1.073 (0.300)
Male	16 (32.0)	21 (42.0)	
Total	50 (100)	50 (100)	

*p≤0.05 **p<0.001

When the mean of gender of the patient and control group is compared with Chi-square analysis, no significant difference was found.

Table 3. The Comparison of Educational Status between Groups

	Patient n(%)	Control n(%)	Total n(%)	X^2 (p)
Literate	1 (2.0)	0 (0)	1 (1.0)	25,785 (,000)**
Elementary school	15 (30.0)	0 (0)	15 (15.0)	
Middle school	8 (16.0)	3 (6.0)	11 (11.0)	
High school	10 (20.0)	13 (26.0)	23 (23.0)	
College/University	15 (30.0)	29 (58.0)	44 (44.0)	
Other	1 (2.0)	5 (10.0)	6 (6.0)	
Total	50 100.0	50 100.0	100 100.0	

*p≤0.05 **p<0.001

When education level of the patient and control group is compared with Chi-square analysis, control group was found to have significantly higher educational level.

Table 4. The Comparison Of Marital Status Between Groups

	Patient n(%)	Control n(%)	Total n(%)	X^2 (p)
Married	26 (52.0)	22 (44.0)	48 (48.0)	2,200 (,532)
Single	21 (42.0)	24 (48.0)	45 (45.0)	
Widow	2 (4.0)	4 (8.0)	6 (6.0)	
Live separately	1 (2.0)	0 (0)	1 (1.0)	
Total	50 100.0	50 100.0	100 100.0	

*p≤0.05 **p<0.001

When the mean of marital status of the patient and control group is compared with Chi-square analysis, no significant difference was found.

Table 5. The Comparison Of Family Structure Between Groups

	Patient n(%)	Control n(%)	Total n(%)	X^2 (p)
Nucear families	39 (78.0)	45 (90.0)	84 (84.0)	4,695 (,096)
Extended families	11 (22.0)	4 (8.0)	15 (15.0)	
Broken families	0 (0)	1 (2.0)	1 (1.0)	
	50 100.0	50 100.0	100 100.0	

*p≤0.05 **p<0.001

When the mean of family structure of the patient and control group is compared with Chi-square analysis, no significant difference was found.

Table 6. The Comparison Of Living Place Between Groups

	Patient n(%)	Control n(%)	Total n(%)	X^2 (p)
Center / District	48 (96.0)	44 (88.0)	92 (92.0)	2,174 (,140)
Village / Rural areas	2 (4.0)	6 (12.0)	8 (8.0)	
Total	50 100.0	50 100.0	100 100.0	

*p≤0.05 **p<0.001

When the mean of living place of the patient and control group is compared with Chi-square analysis, no significant difference was found.

Table 7. The Comparison Of Job Between Groups

	Patient n(%)	Control n(%)	Total n(%)	X^2 (p)
Housewife	25 (50.0)	3 (6.0)	28 (28.0)	33,090 (,000)**
Officer	3 (6.0)	10 (20.0)	13 (13.0)	
Employee	11 (22.0)	23 (46.0)	34 (34.0)	
Student	6 (12.0)	6 (12.0)	12 (12.0)	
Tradesman	1 (2.0)	1 (2.0)	2 (2.0)	
Retired	0 (0)	6 (12.0)	6 (6.0)	
Unemployed	4 (8.0)	1 (2.0)	5 (5.0)	
Total	50 100.0	50 100.0	100 100.0	

*p≤0.05 **p<0.001

When job of the patient and control group is compared with Chi-square analysis, control group was found to have significantly higher job.

Table 8. The Comparison Of Employment Status Between Groups

	Patient n(%)	Control n(%)	Total n(%)	X^2 (p)
Working	14 (28.0)	36 (72.0)	50 (50.0)	35,588 (,000)**
Unemployment	10 (20.0)	5 (10.0)	15 (15.0)	
Retired	0 (0)	6 (12.0)	6 (6.0)	
Housewife	26 (53.0)	3 (6.0)	29 (29.0)	
Total	50 100.0	50 100.0	100 100.0	

*p≤0.05 **p<0.001

When employment status of the patient and control group is compared with Chi-square analysis, control group was found to have significantly higher employment status.

Table 9. The Comparison Of Income Status Between Groups

	Patient n(%)	Control n(%)	Total n(%)	X^2 (p)
850 and lower	8 (16.0)	1 (2.0)	9 (9.0)	16,818 (,002)*
850-1500	14 (28.0)	7 (14.0)	21 (21.0)	
1500-2000	15 (30.0)	10 (20.0)	25 (25.0)	
2000-3000	7 (14.0)	18 (36.0)	25 (25.0)	
3000 and higher	6 (12.0)	14 (28.0)	20 (20.0)	
Total	50 100.0	50 100.0	100 100.0	

*p≤0.05 **p<0.001

When income status of the patient and control group is compared with Chi-square analysis, control group was found to have significantly higher income status.

Tablo 10. The Comparison Of Religious Attitude Between Groups

	Patient n(%)	Control n(%)	Total n(%)	X^2 (p)
Muslim	48 (96.0)	44 (88.0)	92 (92.0)	
Other	1 (2.0)	0 (0)	1 (1.0)	
I do not belong to any religion	1 (2.0)	6 (12.0)	7 (7.0)	4,745 (,093)
Total	50 100.0	50 100.0	100 100.0	

*p≤0.05 **p<0.001

When the mean of religious attitude of the patient and control group is compared with Chi-square analysis, no significant difference was found.

Tablo 11. The Comparison Of Groups Between Number Of Children

	Patient n(%)	Control n(%)	Total n(%)	X^2 (p)
No children	23 (46.0)	33 (66.0)	56 (56.0)	
One children	9 (18.0)	6 (12.0)	15 (15.0)	
Two children	10 (20.0)	9 (18.0)	19 (19.0)	6,038 (,110)
Three children and older	8 (16.0)	2 (4.0)	10 (10.0)	
Total	50 100.0	50 100.0	100 100.0	

*p≤0.05 **p<0.001

When the mean of number of children the patient and control group is compared with Chi-square analysis, no significant difference was found.

3.2 The Compared Statistical Analyses Of The Scales Which Were Given To The Patients And The Control Group

Obsessive Beliefs Questionnaire, Maudsley Obsessive Compulsive Scale, Padua Inventory and Religious Attitude Scale, which were given to the subjects, have been compared. Following subscales were compared among the patients and the control group:

Obsessive Belief Questionnaire =	Responsibility / Threat Foresight
	Perfectionism / Certainty
	Importance of thought and control
Maudsley Obsessive compulsive Scale =	Checking
	Cleaning
	Rumination
	Doubt
Padua Inventory =	Cleaning
	Being caught up in thoughts
	Repetitive behaviors
	Counting
	Checking
	Impulses

Religious attitude = Cognition

Feeling

Behavior

God

Table 12. Comparison Of Mean Score Of OBQ Subscale Of Responsibility And Threat Foresight Between Groups

	n (%)	m±sd	t (p)
Patient	50	75.02 ± 17.70	4.434
Control	50	60.08 ± 15.95	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of obsessive belief question, responsibility and threat foresight subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of responsibility and threat foresight subscale and groups (p=0.000)**

The participant whose in patient group had higher responsibility and threat foresight mean scores than control group.

Table 13. Comparison Of Mean Score Of OBQ Subscales Of Perfectionism / Certainty Between Groups

	n (%)	m±sd	t (p)
Patient	50	79.50 ± 18.48	3.631
Control	50	66.22 ± 18.09	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of obsessive belief question, perfectionism / certainty subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of perfectionism / certainty subscale and groups (p=0.000)**

The participant whose in patient group had higher perfectionism / certainty subscale mean scores than control group.

Table 14. Comparison Of Mean Score Of OBQ Subscale Of The Importance Of Thoughts And Control Between Groups

	n (%)	m±sd	t (p)
Patient	50	50.16 ± 15.54	5,228
Control	50	36.04 ± 11.10	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of obsessive belief question, importance of thoughts and control subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of importance of thoughts and control subscale and groups (p=0.000)**

The participant whose in patient group had higher importance of thoughts and control mean scores than control group.

Table 15. Comparison Of Mean Score Of MOCI Subscale Checking Between Groups

	n (%)	m±sd	t (p)
Patient	50	12.60 ± 1.85	-10.446
Control	50	16.28 ± 1.67	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of maudsley obsessive compulsive scale, checking subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of checking subscale and groups (p=0.000)**

The participant whose in control group had higher checking mean scores than patient group.

Table 16. Comparison Of Mean Score Of MOCI Subscale Of Cleaning Between Groups

	n (%)	m±sd	t(p)
Patient	50	16.44 ± 2.93	-5,464
Control	50	19.08 ± 1.76	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of maudsley obsessive compulsive scale, cleaning subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of cleaning subscale and groups (p=0.000)**

The participant whose in control group had higher cleaning mean scores than patient group.

Table 17. Comparison The Mean Score Of MOCI Subscale Of Doubt Between Groups

	n (%)	m±sd	t (p)
Patient	50	8.76 ± 1.25	-8,186
Control	50	10.76 ± 1.19	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of maudsley obsessive compulsive scale, doubt subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of doubt subscale and groups (p=0.000)**

The participant whose in control group had higher doubt mean scores than patient group.

Table 18. Comparison Of Mean Score Of MOCI Subscale Of Rumination Between Groups

	n (%)	m±sd	t (p)
Patient	50	5,52 ± 1,25	-10,822
Control	50	7,62 ± 0,57	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of maudsley obsessive compulsive scale, rumination subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of rumination subscale and groups (p=0.000)**

The participant whose in control group had higher rumination mean scores than patient group.

Table 19. Comparison Of Mean Score Of PI Subscale Of Cleaning Between Groups

	n (%)	m±sd	t (p)
Patient	50	25.80 ± 10.72	3,310
Control	50	19.72 ± 7.34	(0.001)**

*p≤0.05 **p<0.001

In the present study the mean score of padua inventory, cleaning subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of cleaning subscale and groups (p=0.000)**

The participant whose in patient group had higher cleaning mean scores than control group.

Table 20. Comparison Of Mean Score Of PI Subscale Of Being Caught Up In Thoughts Between Groups

	n (%)	m±sd	t (p)
Patient	50	54.04 ± 15.32	9,944
Control	50	29.84 ± 7.84	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of padua inventory, being caught up in thoughts subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of being caught up in thoughts subscale and groups (p=0.000)**

The participant whose in patient group had higher being caught up in thoughts mean scores than control group.

Table 21. Comparison Of Mean Score Of PI Subscale Of Repetitive Behaviors Between Groups

	n (%)	m±sd	t (p)
Patient	50	22.68 ± 7.07	7,742
Control	50	13.98 ± 3.62	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of padua inventory, repetitive behaviors subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of repetitive behaviors subscale and groups (p=0.000)**

The participant whose in patient group had higher repetitive behaviors mean scores than control group.

Table 22. Comparison Of Mean Score Of PI Subscale Counting Between Groups

	n (%)	m±sd	t (p)
Patient	50	5.16 ± 3.05	3,707
Control	50	3.48 ± 0.97	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of padua inventory, counting subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of counting subscale and groups (p=0.000)**

The participant whose in patient group had higher counting mean scores than control group.

Table 23. Comparison Of Mean Score Of PI Subscale Of Checking Between Groups

	n (%)	m±sd	t (p)
Patient	50	23.26 ± 8.15	5,525
Control	50	15.74 ± 5.12	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of padua inventory, checking subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of checking subscale and groups (p=0.000)**

The participant whose in patient group had higher checking mean scores than control group.

Table 24. Comparison Of Mean Score Of PI Subscale Of Impulses Between Groups

	n (%)	m±sd	t (p)
Patient	50	18.40 ± 8.38	4,258
Control	50	13.12 ± 2.58	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of padua inventory, impulses subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of impulses subscale and groups (p=0.000)**

The participant whose in patient group had higher impulses mean scores than control group.

Table 25. Comparison Of Mean Score Of RAS Subscale Of Cognition Between Groups

	n (%)	m±sd	t(p)
Patient	50	9.62 ± 1.24	2,215
Control	50	8.80 ± 2.30	(0.030)*

*p≤0.05 **p<0.001

In the present study the mean score of religious attitude scale, cognition subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of cognition subscale and groups (p=0.030)*

The participant whose in patient group had higher cognition mean scores than control group.

Table 26. Comparison Of Mean Score Of RAS Subscale Of Feeling Between Groups

	n (%)	m±sd	t(p)
Patient	50	7.78 ± 2.26	5,237
Control	50	5.34 ± 2.39	(0.000)**

*p≤0.05 **p<0.001

In the present study the mean score of religious attitude scale, feeling subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of feeling subscale and groups (p=0.000)**

The participant whose in patient group had higher feeling mean scores than control group.

Table 27. Comparison Of Mean Score Of RAS Subscale Behavior Between Groups

	n (%)	m±sd	t (p)
Patient	50	7.38 ± 2.28	4,649 (0.000)**
Control	50	5.26 ± 2.27	

*p≤0.05 **p<0.001

In the present study the mean score of religious attitude scale, behavior subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of behaviour subscale and groups (p=0.000)**

The participant whose in patient group had higher behavior mean score than control group.

Table 28. Comparison Of Mean Score Of Religious Attitude Scale Subscale Of God And Groups

	n (%)	m±sd	t (p)
Patient	50	8.80 ± 1.68	2,678 (0.009)*
Control	50	7.64 ± 2.56	

*p≤0.05 **p<0.001

In the present study the mean score of religious attitude scale, god subscale and groups were compared by Independent Sample T-Test. It was found that there was statistically significant differences between the mean score of god subscale and groups (p=0.009)*

The participant whose in patient group had higher god mean scores than control group.

3.3 Results Of Correlation Analysis

In this section; scales, which were given to the patients, were examined by making correlations between themselves.

Table 29. Correlation of Subscales of OBQ with Each Other

	OBQ		
OBQ	Responsibility/Theat Foresight	Perfectionism/Certainty	Importance of thought and Control
Responsibility/Theat Foresight	--	r: ,728 p: ,000*	r: ,802 p: ,000*
Perfectionism/Certainty	r: ,728 p: ,000*	--	r: ,698 p: ,000*
Importance of thought and Control	r: ,802 p: ,000*	r: ,698 p: ,000*	--

*p≤0.05 **p<0.001

When the relation between the mean scores of subscales of OBQ is investigated with Person correlation analysis;strong positive correlation is found.

Table 30. Correlation of Subscales of OBQ with MOCI

	OBQ		
MOCI	Responsibility/Theat Foresight	Perfectionism/Certainty	Importance of thought and Control
Checking	r: -,240 p: ,094	r: -,257 p: ,072	r: -,184 p: ,200
Cleaning	r: -,247 p: ,084	r: -,351 p: ,012*	r: -,278 p: ,051
Rumination	r: -,408 p: ,003**	r: -,382 p: ,006**	r: -,387 p: ,005**
Doubt	r: -,384 p: ,006**	r: -,391 p: ,005**	r: -,339 p: ,016*

*p≤0.05 **p<0.001

When the relationship between the mean score of OBQ subscales with MOCI subscales is investigated with Person correlation analysis, mild negative correlation is found between Cleaning and Doubt subscales of MOCI with other 2 subscales of OBQ and also strong negative correlation is found between 'Rumination' subscales of with all other 3 subscales OBQ and strong negative correlation is found between ' Doubt' subscales with 'Responsibility/Theat Foresight' and 'Perfectionism/Certainty' subscales OBQ.

Table 31. Correlation of Subscales of OBQ with PI

	OBQ		
PI	Responsibility/Theat Foresight	Perfectionism/Certainty	Importance of thought and Control
Cleaning	r: ,315 p: ,026*	r: ,212 p: ,139	r: ,136 p: ,345
Being caught up in thought	r: ,670 p: ,000**	r: ,518 p: ,000**	r: ,529 p: ,000**
Repettive behavior	r: ,465 p: ,001**	r: ,471 p: ,001**	r: ,310 p: ,028*
Counting	r: ,318 p: ,025*	r: ,405 p: ,005**	r: ,318 p: ,024*
Checking	r: ,444 p: ,001**	r: ,339 p: ,016*	r: ,189 p: ,188
Impulses	r: ,499 p: ,000**	r: ,333 p: ,018*	r: ,495 p: ,000**

*p≤0.05 **p<0.001

When the relation between the mean scores of OBQ subscales with PI subscales is investigated with Person correlation analysis, mild positive correlation is found between Cleaning and Counting with 'Responsibility/Theat Foresight' , 'Repettive behavior, Counting' subscales with 'Importance of thought and Control' of with OBQ subscale and 'Checking ,Impulses' subscales with Perfectionism/Certainty with of OBQ subscale. Strong positive correlation is found between OBQ subscale 'Responsibility/Theat Foresight' with 'Being caught up in thought, Repettive behavior, Checking and Impulses' , 'Perfectionism/Certainty' with 'Being caught up in thought, Repettive behavior and Counting' and 'Importance of thought and Control' with 'Being caught up in thought and Impulses' is found.

Table 32. Correlation of Subscales of OBQ with RAS

	OBQ		
RAS	Responsibility/Theat Foresight	Perfectionism/Certainty	Importance of thought and Control
Cognition	r: ,168 p: ,243	r: ,095 p: ,510	r: ,083 p: ,564
Feeling	r: ,203 p: ,157	r: ,095 p: ,512	r: ,125 p: ,388
Behavior	r: -,211 p: ,141	r: -,272 p: ,056	r: -,278 p: ,050
God	r: ,019 p: ,897	r: -,101 p: ,484	r: -,132 p: ,362

*p≤0.05 **p<0.001

When the relation between the mean scores of OBQ subscales with RAS subscales is investigated with Pearson correlation analysis,not found between correlation.

Table 33. Correlation of Subscales of MOCI with Each Other

	MOCI			
MOCI	Checking	Cleaning	Rumination	Doubt
Checking	--	r: ,026 p: ,860	r: ,453 p: ,001**	r: ,371 p: ,008**
Cleaning	r: ,026 p: ,860	--	r: -,041 p: ,775	r: ,263 p: ,065
Rumination	r: ,453 p: ,001**	r: -,041 p: ,775	--	r: ,433 p: ,002**
Doubt	r: ,376 p: ,008**	r: ,263 p: ,065	r: ,433 p: ,002**	--

*p≤0.05 **p<0.001

When the relation between the mean scores of subscales of MOCI is investigated with Pearson correlation analysis, strong positive correlation Rumination, Doubt and Checking is found.

Table 34. Correlation of Subscales of MOCI with PI

	MOCI			
PI	Checking	Cleaning	Rumination	Doubt
Cleaning	r: ,069 p: ,635	r: -,625 p: ,000**	r: ,011 p: ,940	r: -,222 p: ,212
Being caught up in thought	r: -,254 p: ,075	r: -,142 p: ,324	r: -,492 p: ,000**	r: -,435 p: ,002**
Repettive behavior	r: -,222 p: ,122	r: -,271 p: ,057	r: -,133 p: ,357	r: -,416 p: ,003**
Counting	r: -,335 p: ,017*	r: ,099 p: ,493	r: -,199 p: ,166	r: -,400 p: ,004**
Checking	r: -,493 p: ,000**	r: -,042 p: ,050	r: -,278 p: ,050	r: -,341 p: ,015*
Impulses	r: -,188 p: ,191	r: -,311 p: ,028*	r: -,311 p: ,028*	r: -,334 p: ,018*

*p≤0.05 **p<0.001

When the relation between the mean scores of MOCI subscales with PI subscales is investigated with Pearson correlation analysis, strong negative correlation is found between 'Cleaning – Cleaning , Checking-Checking , Being caught up in thought – Rumination' and 'Doubt' MOCI subscale with Being caught up in thought, Repettive behavior and Counting PI subscales is found. Mild negative correlation is found between 'Impulses' PI subscale with 'Cleaning, Rumination, Doubt' and 'Checking' MOCI subscale with ' Counting , Doubt PI subscales .

Table 35. Correlation of Subscales of MOCI with RAS

	MOCI			
RAS	Checking	Cleaning	Rumination	Doubt
Cognition	r: -,058 p: ,687	r: -,060 p: ,681	r: -,002 p: ,991	r: ,006 p: ,968
Feeling	r: -,026 p: ,856	r: -,192 p: ,183	r: -,031 p: ,831	r: -,127 p: ,380
Behavior	r: -,215 p: ,133	r: -,093 p: ,522	r: ,251 p: ,079	r: ,161 p: ,265
God	r: ,000 p: 1,000	r: -,131 p: ,364	r: ,197 p: ,171	r: ,093 p: ,520

*p≤0.05 **p<0.001

When the relation between the mean scores of MOCI subscales with RAS subscales is investigated with Pearson correlation analysis, not found between correlation.

Table 36. Correlation of Subscales of PI with Each Other

	PI					
PI	Cleaning	Being caught up in thought	Repetitive behavior	Counting	Checking	Impulse
Cleaning	---	r: ,356 p: ,011*	r: ,497 p: ,000**	r: ,014 p: ,923	r: ,310 p: ,028*	r: ,167 p: ,245
Being caught up in thought	r: ,356 p: ,011*	---	r: ,574 p: ,000**	r: ,324 p: ,022*	r: ,653 p: ,000**	r: ,596 p: ,000**
Repetitive behavior	r: ,497 p: ,000*	r: ,574 p: ,000*	---	r: ,428 p: ,002**	r: ,560 p: ,000**	r: ,418 p: ,003**
Counting	r: ,014 p: ,923	r: ,324 p: ,022*	r: ,428 p: ,002**	---	r: ,189 p: ,188	r: ,382 p: ,006**
Checking	r: ,310 p: ,028*	r: ,653 p: ,000**	r: ,560 p: ,000**	r: ,189 p: ,188	---	r: ,342 p: ,015*
Impulses	r: ,167 p: ,245	r: ,597 p: ,000**	r: ,418 p: ,000**	r: ,382 p: ,006**	r: ,342 p: ,015*	---

*p≤0.05 **p<0.001

When the relation between the mean scores of subscales of PI is investigated with Pearson correlation analysis; mild positive correlation between 'Cleaning with Being caught up in thought, Checking, Repettive behavior' , 'Impulses with Checking' , 'Repettive behavior with Cleaning ,Being caught up in thought' and 'Counting with Being caught up in thought' is found. Strong positive correlation between is found 'Counting with Impulses' , 'Being caught up in thought with Checking , Impulses' and 'Reppettive behavior with all other 6 subscales of PI.

Table 37. Correlation of Subscales of PI with RAS

	PI					
RAS	Cleaning	Being caught up in thought	Repettive behavior	Counting	Checking	Impulses
Cognition	r: ,008 p: ,956	r: -,115 p: ,427	r: -,121 p: ,403	r: -,161 p: ,264	r: ,042 p: ,771	r: -,212 p: ,319
Feeling	r: ,159 p: ,270	r: ,012 p: ,934	r: -,096 p: ,506	r: -,075 p: ,607	r: ,082 p: ,572	r: -,141 p: ,330
Behavior	r: ,132 p: ,360	r: ,310 p: ,029*	r: -,341 p: ,015*	r: -,296 p: ,037*	r: -,179 p: ,215	r: -,326 p: ,021*
God	r: ,110 p: ,447	r: -,162 p: ,262	r: -,012 p: ,932	r: -,205 p: ,154	r: ,031 p: ,832	r: -,321 p: ,023*

*p≤0.05 **p<0.001

When the relation between the mean scores of PI subscales with RAS subscales is investigated with Pearson correlation analysis; mild negative correlation is found between Being caught up in thought, Repettive behavior and Impulses subscales of PI with Behaviour subscale of RAS and moderate negative correlation is found between Counting subscale of PI with Behavior subscale of RAS.

Table 38. Correlation of Subscales of RAS with Each Other

	RAS			
RAS	Cognition	Feeling	Behavior	God
Cognition	---	r: ,499 p: ,000**	r: ,368 p: ,009**	r: ,598 p: ,000**
Feeling	r: ,449 p: ,000**	---	r: ,570 p: ,000**	r: ,644 p: ,000**
Behavior	r: -,368 p: ,009**	r: ,570 p: ,000**	---	r: ,473 p: ,001**
God	r: ,598 p: ,000**	r: ,644 p: ,000	r: ,473 p: ,001**	---

*p≤0.05 **p<0.001

When the relation between the mean scores of subscales of RAS is investigated with Pearson correlation analysis; strong positive correlation is found but Behavior with Cognition between strong negative correlation is found.

DISCUSSION

This study was maintained to examine the relationship between obsessive beliefs and religious attitude and to compare with the control group.

Fifty patients diagnosed with Obsessive-Compulsive Disorder (OCD) and 50 healthy people, as the control group, were involved in the study, voluntarily. Results of the Epidemiologic Catchment Area (ECA) Survey conducted in the USA and within the context of which subjects were chosen from houses and corporations were submitted by Crum and Anthony in the literature. As a result of this study, significant correlations were not found with sociodemographic factors such as race, ethnic group, education, marital status, job or age.

Similarly, significant correlations were not found with sociodemographic factors such as age, gender, family structures, marital status, religious attitude, number of children and accommodation in this study. On the other hand, significant correlations were detected with certain sociodemographic factors such as educational status, job, working and income level. Reason of this was thought to be a significance caused by the inequality in the patient group and the control group.

Among more than one-third of the adult patients, symptoms begin before fifteen. Although symptoms which begin before 5 years old have been reported, average starting age of OCD is the age range of 7 to 12 among children according to the researches in this area. To another study, it is proposed that OCD mostly onsets early adulthood. It is mentioned that average disease onset of OCD is between 20 and 24 and that approximately eighty per cent of the patients have the symptoms before their thirty five (Jenike, 2001).

However, they can be seen in childhood and adolescence also. It has adverse affects on their educational successes as their relationships between their peers and families (Carter and Pollock, 2000). The average age has been estimated as 32,30 in this study.

While some studies mention that OCD is more common among females, there are other studies which claim that there is no difference between the both sexes. Yiğittürk and others notified the female/male ratio as 1,52; Okasha and others as 0,45; Tezcan and others as 2,75 in their studies. In this study, women comprised sixty eight per cent of the patients, whereas thirty two per cent for men.

In the studies from the literature, any significances or differences with subjects' educational status were not mentioned. But in this study, the fact that the patients group comprised primary school graduates more than the control group while there were more college and university graduates among the control group is supposed to lead to that result.

Although marital status was not demonstrated as significant in many follow-up studies, the fact that being married is increasing the remission probability significantly was stated in a more recent study which was conducted with 107 OCD patient participants (Steketee G.S ve oth., 1999). Likewise, statistically significant correlation wasn't detected by comparing patient and control groups in this study.

Family structure, which wasn't often questioned, had also been examined in former studies and no notified differences observed in those. Too, any affect or significant difference of marital status related with obsessive-compulsive disorder wasn't found between the control group and the patient group as a result of this study.

Any information or notification of difference wasn't found among the former relevant studies and the literature about the living place. Also, statistically significant difference wasn't detected between obsessive-compulsive disorder and living place by comparing patient and control groups in this study.

Any significant difference and especially any affect of jobs on OCD didn't take place in literature. As a consequence of Epidemiologic Catchment Area (ECA) Survey conducted in the USA, Crum and Anthony mentioned that they couldn't find any significant correlation with occupation. As far as this study is concerned, number of unemployed participants was much higher in the control group in contrast to patients'.

So, it's supposed that the big difference between job status of the patient and the control groups has given rise to the significant difference in this study.

As with job status, employment also didn't take place in literature studies as an affective factor for OCD. When it comes to this study, the fact that number of unemployed participants was much higher in the control group in contrast to patients' is supposed to have led to the significant difference in this study. For the reason that this study wasn't conducted with the patients confined to bed, functionality isn't expected to effect the employment. Therefore, it's thought that the significant differential of income status was caused by the vast inequality between the two groups.

Conducted researches and literature studies show that religious distinctions don't create effective or significant differences on OCD. Religious variations didn't indicate a significant difference between the patient and the control groups.

Lastly among the demographic information, there isn't any proof that number of children makes effective or significant differences on OCD. Too, number of children didn't differ statistical significantly between the patient and the control groups.

The patients group and the control group have been compared with the subscales of the performed scales in this study. It was expected that total scores of the subscales of OCD patients to be higher than those of the control group.

First, scores of the three subtypes of Obsessive Beliefs Questionnaire - "Perfectionism/Certainty", "Importance of Thought and Control" and "Responsibility/Threat Foresight" subscales - were compared between the two groups. Correspondingly, higher scores from the participants in the patients group have been detected. High consistence has been found between data of the study and the original three-factor structure tested by performing confirmatory factor analysis in Obsessive Beliefs Questionnaire (OBQ-44) Turkish reliability and validity practicing. OCD patients stated significantly high scores with regard to the control group. Depending on this result, research outcomes have been supported by ours. As a consequence of multi-group analysis, three-factor structure has been verified by Obsessive-Compulsive Cognitive Working Group (OCCWG, 2005).

Unexpectedly, total score of the participants from the control group were higher than the patients'. It's been proposed that the explanations of this result might be existence of only two choices ("yes" or "no") in this scale and answering by supposing them as more general questions in contrast to other scales' questions. Some facts were submitted that Maudsley Obsessive Compulsive Scale has certain notable limits, such as some of the questions aren't aimed at obsessive-compulsive symptoms, "yes/no" questions don't allow for assessing the intensity of the answers and it gives a lot of importance to cleaning and checking compulsions (Taylor, 1995).

In Padua inventory, the total result of the patients group was detected as higher than the control group, as expected, by comparing them depending on its six different subscales. This scale targeted to evaluate the severity of obsessions and compulsions, by grouping them. Conclusion has verified the highness of the scores of the patient group, which had been projected.

Finally, with comparison of the four subscales of Religious Attitude, although the total score of the patient group was higher than the control group, it's been observed that the difference of the two groups was not much considerable with one another. This scale, developed by considering notion of the attitude, assesses humans, objects or thoughts as positive or negative (Aronson and oth.).

The fact that the distinction between OCD patients and the control group appears to be small leads to the thought of the disease is not much connected with religion.

Obsessive Beliefs Questionnaire consists of three subscales that are: "Perfectionism/Certainty", "Importance of Thought and Control" and "Responsibility/Threat Foresight" subscales. To start with, "Perfectionism/Certainty" subscale has been compared to other subtypes of this scale and a significant correlation has been found between them. Significant correlation has been found with "Cleaning", "Rumination" and "Doubt" subscales of Maudsley Obsessive Compulsive Scale. With subscales of Padua Inventory, again, significant correlation has been found with "Being Caught Up in Thoughts", "Repetitive Behaviors", "Counting", "Checking" and "Impulses".

However, a significant correlation hasn't been detected between "Perfectionism/Certainty" subscale and any of Religious Attitude subscales.

When it comes to "Importance of Thought and Control" subscale, it's been observed that there was a significant correlation with the other subtypes of its own scale. In contrast, there wasn't significant correlation between it and any of Maudsley Obsessive Compulsive Scale subtypes. With subscales of Padua Inventory, significant correlation has been found with "Being Caught Up in Thoughts", "Repetitive Behaviors", "Counting", and "Impulses" subscales. As the previous subscale, significant correlation hasn't been detected with Religious Attitude subscales. With "Responsibility/Threat Foresight" subscale, significant correlation of the other subtypes of its own scale was available. Significant correlation has been found with "Rumination" and "Doubt" subscales of Maudsley Obsessive Compulsive Scale. Significant correlation was seen between "Responsibility/Threat Foresight" subscale and all subscales of Padua Inventory. On the contrary, significant correlation hasn't been detected with any subscale of Religious Attitude in this study.

As to a study, significant correlations were detected between "Importance of Thought and Control" with "Impulses" subscale; "Responsibility/Threat Foresight" with "Rumination" subscale; "Perfectionism/Certainty" with "Checking", "Rumination" and "Doubt" subscales.

Maudsley Obsessive Compulsive Scale is comprised of four subscales. These are "Checking", "Cleaning", "Rumination" and "Doubt" subscales. Firstly, "Checking" subscale was compared with the other subtypes of Maudsley Obsessive Compulsive Scale and significant correlations have been found with "Rumination" and "Doubt". Correlation wasn't found between "Checking" and subtypes of Obsessive Beliefs Questionnaire. Significant correlations were found with "Counting" and "Checking" of Padua Inventory. But, significant correlation hasn't been detected with any subscale of Religious Attitude in this study.

As far as "Cleaning" is concerned, significant correlations have been found with three of the of the other ones, "Checking", "Rumination" and "Doubt" subscales. Significant correlation has been detected with only "Perfectionism/Certainty" subscale of Obsessive Beliefs Questionnaire.

In Padua Inventory, all of the subscales had a significant correlation with "Cleaning", except for "Cleaning" of Padua Inventory. Nevertheless, significant correlation hasn't been detected with any subscale of Religious Attitude.

Afterwards, "Rumination" subscale was compared with the other subtypes of Maudsley Obsessive Compulsive Scale and significant correlations have been found with "Checking" and "Doubt". Significant correlations have been detected with all three subscales of Obsessive Beliefs Questionnaire. Also, significant correlations were seen between "Rumination" with both "Being Caught Up in Thoughts" and "Impulses" subscales of Padua Inventory. As former ones, significant correlation hasn't been detected with any of Religious Attitude subscales in this study.

Finally, "Doubt" subscale was compared with the other subtypes of its own scale and significant correlations have been found with "Checking" and "Rumination". Significant correlations have been detected with all three subscales of Obsessive Beliefs Questionnaire and with also five of Padua Inventory subscales which are "Being Caught Up in Thoughts", "Repetitive Behaviors", Counting", "Checking" and "Impulses". No significant correlation has been found between "Doubt" and any of Religious Attitude subscales.

Padua Inventory is comprised of six subscales. These are "Cleaning", "Being Caught Up in Thoughts" and "Repetitive Behaviors", "Counting", "Checking" and "Impulses" subscales. At first, "Cleaning" subscale was compared with the other subtypes of Padua Inventory and significant correlations have been found with "Being Caught Up in Thoughts", "Repetitive Behaviors" and "Checking". There was a significant correlation just with "Responsibility/Threat Foresight" among the subscales of Obsessive Beliefs Questionnaire. Also, significant statistical correlation was detected with only "cleaning" subscale of Maudsley Obsessive Compulsive Scale. However, significant correlation hasn't been detected with any subscale of Religious Attitude.

Being Caught Up in Thoughts subscale was compared with subscales of the other subscales. It had significant correlation with all other subtypes of Padua Inventory. It's been found that there were significant statistical correlations between "Being Caught Up in

Thoughts" subscale and all three subscales of Obsessive Beliefs Questionnaire subscales. Significant correlation with "Rumination" and "Doubt" subscales were found by comparing Being Caught Up in Thoughts subscale with subscales of Maudsley Obsessive Compulsive Scale. Significant correlation hasn't been detected with any subscale of Religious Attitude.

Then, "Repetitive Behaviors" subscale was compared with the other subtypes of Padua Inventory and significant correlations have been found with "Cleaning" and "Being Caught Up in Thoughts", "Counting", "Checking" and "Impulses". Significant correlations have been detected with all three subscales of Obsessive Beliefs Questionnaire. And, significant correlations were seen with "Rumination" and "Doubt" subscales of Maudsley Obsessive Compulsive Scale. Also, significant correlation has been detected with only "Behavior" subscale among Religious Attitude subscales in this study.

Significant correlations have been detected with "Cleaning", "Being Caught Up in Thoughts", "Repetitive Behaviors", and "Impulses" subscales, by comparing "Counting" to the other subtypes of Padua Inventory. Again, significant correlations have been detected with all three subscales of Obsessive Beliefs Questionnaire. Significant correlations were found with "Checking" and "Rumination" subscales of Maudsley Obsessive Compulsive Scale. Also, significant correlation has been detected with only "Behavior" subscale among Religious Attitude subscales.

Next, "Checking" subscale was compared with the other subtypes of its own scale and significant correlations have been found with "Cleaning" and "Being Caught Up in Thoughts", "Repetitive Behaviors" and "Impulses". Significant correlations have been detected with "Perfectionism/Certainty" and "Responsibility/Threat Foresight" subscales of Obsessive Beliefs Questionnaire. Significant correlations were found between "Checking" with "Checking" and "Rumination" subscales of Maudsley Obsessive Compulsive Scale. Significant correlation hasn't been detected with any subscale of Religious Attitude.

Last of all, "Impulses" subscale was compared with the other subtypes of its own scale and significant correlations have been found with all of the other subscales. Too, significant correlations have been detected with all three subscales of Obsessive Beliefs Questionnaire.

Significant correlations with "Rumination" and "Doubt" subscales were found by comparing "Impulses" subscale with subtypes of Maudsley Obsessive Compulsive Scale. And, a significant correlation has been detected with only "Behavior" subscale among Religious Attitude subscales in this study.

Making comparison in other studies, Julien et al (2006)

	OCCWG(2005)	Tolin et al(2008)
Responsibility / Threat Foresight	Washing , Rumination	Washing , Rumination
Perfectionism / Certainty	Precision , Checking	Precision , Impulses
Importance of Thought and Control	----------	Impulses

	Tolin et al (2003)	Emmelkamp ve Aardema (1999)
Responsibility/Threat Foresight	Washing , Rumination	Checking
Perfectionism / Certainty	----------	Washing
Importance of Thought and Control	Rumination, Impulses	Rumination,Checking, Washing,Impulses

Religious Attitude consists of four subscales which are "Cognition", "Feeling", "Behavior" and "God" subscales. To start with, "Cognition" subscale has been compared to other subtypes of this scale and significant correlations have been found between all of them. However, significant correlation hasn't been found between "Cognition" and any subscales of Obsessive beliefs Questionnaire, Maudsley Obsessive Compulsive Scale or Padua Inventory.

"Feeling" subscale has been compared to other subtypes of this scale and significant correlations have been found with "Cognition", "Behavior" and "God" subscales. However,

again, significant correlation hasn't been found between "Feeling" and any subscales of Obsessive beliefs Questionnaire, Maudsley Obsessive Compulsive Scale or Padua Inventory.

"Behavior" subscale has been compared to other subtypes of Religious Attitude and significant correlations have been found with "Cognition", "Feeling" and "God" subscales. Also, significant correlations were seen between "Behavior" with "Being Caught Up in Thoughts", "Repetitive Behaviors", "Counting" and "Impulses" subscales of Padua Inventory. Any significant correlations haven't been found with any subscales of Obsessive beliefs Questionnaire or Maudsley Obsessive Compulsive Scale.

To finish, "God" subscale has been compared to other subtypes of Religious Attitude and significant correlations have been found with "Cognition", "Feeling" and "Behavior" subscales. There was a significant correlation with only "Impulses" subscale of Padua Inventory. Significant correlations haven't been found with any subscales of Obsessive beliefs Questionnaire or Maudsley Obsessive Compulsive Scale.

Since any study has not been conducted concerning a relevant subject with this study, it wasn't possible to compare the results with any others.

CONCLUSION

The relations between obsessive beliefs of the patients diagnosed with Obsessive Compulsive Disorder, obsession subscales and religious attitude were investigated; in addition, comparison of them with those of the healthy control group was made in this study. For this purpose, comparison of performed scales was made for both voluntary participants who are comprised of healthy people and OCD patients.

In the current study, hypothesis presentation supplies relation with specific belief domains for OCD subtypes. In this study, performed statistical analysis methods supplies the specific belief domains of OCD symptom subtypes but there aren't equivalent results of these methods. Since participants couldn't be categorized in OCD symptom subtypes, assessing specific belief domains in OCD symptom subtypes is not based on reality. It's deduced that main OCD symptom subtypes defined in literature can be conceptualized to at least one category instead of some dimensional models. Any study has been never researched group differences on belief domains by categorizing and making analysis of variance based upon OCD symptom subtypes of participants. Still, methods and criterion to specify OCD symptom subtypes remain unclear.

By comparing the results, it was observed that the patients group had higher scores than the control group. Scores of OCD patients were found high as a result of the comparison of Obsessive Beliefs Questionnaire, Padua Inventory and Religious Attitude Scale subtypes. On the contrary, the control groups scores were higher in Maudsley Obsessive Compulsive Scale subtypes. The reasons for this are supposed to be the facts that the scale ("yes/no" questions) don't measure the intensity of the answers and the questions are not predictor adequately due to their broadly asking styles instead of emphasizing the disease. It was detected that subscales which can be assessed as interrelated showed significant correlations with each other when the subtypes were compared among the patients diagnosed with obsessive-compulsive disorder. Contrary to what was expected, significant correlations between Religious Attitude Scale subtypes and the other subscales were smaller. Long term follow-up studies are needed to reach more clarifying results on this point.

First of the limitations of the study is related to its samples. Samples of the research consisted of only people who is living in Istanbul as the control group and only patients from Marmara Education and Research Hospital who had been diagnosed with obsessive compulsive disorder as the patients group. Since they were chosen from only one city, samples can be defined as limited. The inequality of numbers of male and female samples may give rise to thought that there is a limitation. What's more, taking only literate volunteers into the study may be a limitation. Given that OCD is a heterogenic disease the questions in the scales might be inadequately specific. Certain belief domains can be more resistant in clinical researches. As a result of that, they may give rise to thought to be relation variety between belief domain and its treatment. It's thought to be important limitations about beliefs to come into activity that assessment of belief with just one questionnaire could be a drawback and the relation of OCD with researching nonfunctional thoughts. When the findings that are not compatible with literature compared in terms of methods used it's seen that different data collection instruments were used also. Data was collected from the participants via certain scales in the given study. If further studies include interview and experimental methods, they will contribute to the literature.

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APPENDIX

GÖNÜLLÜ OLUR FORMU

Bu çalışma, Yakın Doğu Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji Yüksek Lisans Programı çerçevesinde düzenlenen bir çalışmadır. Bu çalışma, Marmara Üniversitesi Pendik Eğitim Ve Araştırma Hastanesi'nde Obsesif Kompulsif Bozukluk (OKB) tanısı almış kişiler içerisinden rastgele seçilen 50 hasta ve 50 sağlıklı kontrol grubu ile yapılacaktır.

Bu çalışmanın amacı; Obsesif Kompulsif Bozukluğu olan hastalardaki obsesif inançları, obsesyon alttiplerini ve dini tutumlar arasındaki ilişkileri araştırmaktır. Çalışmada bir demografik form ve dört tane ölçek kullanılacaktır. Demografik bilgi formu sizin yaş, cinsiyet gibi özellikleriniz hakkındaki soruları içermektedir. Ölçekler ise; obsesif inançlar, obsesyon alttipleri ve dini tutum ile ilgili sorular içermektedir.

Gönüllülerin bu çalışmadaki sorumlulukları vakit ayırarak ölçeklerini boş bırakmadan doldurmaktır. Bu çalışma gönüllülük esasına dayanmaktadır. Gönüllülerin araştırmaya katılımı isteğe bağlı olup, araştırma herhangi bir risk taşımamaktadır. Gönüllüler istedikleri zaman herhangi bir cezaya maruz kalmadan araştırmaya katılmayı reddedebilir veya araştırmadan çekilebilirler. Araştırmada öngörülen süre 50 dk'dır.

Bu araştırmanın hiçbir aşamasında isminiz kullanılmayacaktır. Araştırmada toplanan bilgiler bireysel olarak değil , tüm katılımcıların ortalama puanları alınarak hesaplanacak ve değerlendirilecektir. Araştırma tamamen bilimsel amaçlarla düzenlenmiştir. Size ait bilgiler kesinlikle gizli tutulacaktır. Soruların doğru bir cevabı yoktur. Anketleri eksiksiz olarak cevaplamak bu araştırma sonuçlarının toplum için yararlı bilgi olarak kullanılmasını sağlayacaktır. Çalışmayla ilgili herhangi bir bilgi almak isterseniz, akcit.nurdan02@gmail.com veya 0533 580 24 56 numaralı telefondan iletişime geçebilirsiniz.`

" Bilgilendirilmiş Gönüllü Olur Formundaki tüm açıklamaları okudum. Bana, yukarıda konusu ve amacı belirtilen araştırma ile ilgili yazılı ve sözlü açıklama aşağıda adı belirtilen psikolog tarafından yapıldı. Araştırmaya gönüllü katıldığımı, istediğim zaman gerekçeli veya gerekçesiz olarak araştırmadan ayrılabileceğimi biliyorum. Söz konusu araştırmaya, hiçbir baskı ve zorlama olmaksızın kendi rızamla katılmayı kabul ediyorum."

PSİKOLOG

NURDAN AKÇİT

Gönüllünün Adı/ Soyadı/ Tarih / İmza

SOSYODEMOGRAFİK VERİ FORMU

Yaşınız:

Cinsiyet
a)erkek b)kadın

Eğitim Durumu
a)Okur-Yazar
b)İlkokul
c)Ortaokul
d)Lise
e)Yüksekokul veya üniversite
f)Diğer.....

Medeni Durumunuz
a) evli
b) bekar
c) dul
d) ayrı yaşıyor

Çocuk sayısı: .....

Nasıl bir ailede doğup büyüdünüz
a)Çekirdek Aile (anne- baba- çocuk(lar))
b)Geniş Aile
c)Parçalanmış Aile(anne yada baba yok)

Şu an yaşadığınız yer?
a)merkez/ilçe
b)köy/kırsal bölge

Meslek grubunuz:
a)Ev Hanımı
b)Memur
c)İşci
d)Öğrenci
e)Esnaf
f)Emekli
g)İşsiz

Çalışma durumu:
a)Çalışıyor
b)İşşiz
c)Emekli
d)Ev Hanımı

Gelir düzeyiniz:
a) 850 ve altı
b) 850-1500
c) 1500-2000
d)2000-3000
e)3000 ve üstü

Dini tutumunuz
a) Müslüman
b)Hıristiyan
c)Yahudi/ Musevi
d) diğer.....
e)Herhangi bir din mensubu değilim

OBSESİF İNANIŞLAR ENVANTERİ

Her bir ifade için, nasıl düşündüğünüzü en iyi tanımlayan cevaba karşılık gelen rakamı seçiniz. İnsanlar birbirinden farklı olduğu için envanterde doğru veya yanlış cevap yoktur. Sunulan ifadenin, tipik olarak yaşama bakış açınızı yansıtıp yansıtmadığına karar vermek için sadece çoğu zaman nasıl olduğunuzu göz önünde bulundurunuz.

Derecelendirme için aşağıdaki ölçeği kullanınız:

1	2	3	4	5	6	7
Kesinlikle katılmıyorum	Katılmıyorum	Biraz katılmıyorum	Ne katılıyorum ne katılmıyorum	Biraz Katılıyorum	Katılıyorum	Tamamen Katılıyorum

Derecelendirme yaparken, ölçekteki orta değeri işaretlemekten (4) kaçınmaya çalışınız; bunun yerine, inanış ve tutumlarınızla ilgili ifadeye genellikle katılıp katılmadığınızı belirtiniz.

1. Sıklıkla çevremdeki şeylerin tehlikeli olduğunu düşünürüm	1 2 3 4 5 6 7
2. Birşeyden tamamıyla emin değilsem, kesin hata yaparım	1 2 3 4 5 6 7
3. Benim standartlarıma göre, herşey mükemmel olmalıdır	1 2 3 4 5 6 7
4. Değerli biri olmam için yaptığım herşeyde mükemmel olmalıyım	1 2 3 4 5 6 7
5. Herhangi bir fırsat bulduğumda, olumsuz şeylerin gerçekleşmesini önlemek için harekete geçmeliyim	1 2 3 4 5 6 7
6. Zarar verme/görme olasılığı çok az olsa bile, ne yapıp edip onu engellemeliyim	1 2 3 4 5 6 7
7. Bana göre, kötü/uygunsuz dürtülere sahip olmak aslında onları gerçekleştirmek kadar kötüdür	1 2 3 4 5 6 7
8. Bir tehlikeyi önceden görmeme karşın bir harekette bulunmazsam, herhangi bir sonuç için suçlanacak kişi konumuna ben düşerim	1 2 3 4 5 6 7
9. Birşeyi mükemmel biçimde yapamayacaksam hiç yapmamalıyım	1 2 3 4 5 6 7
10. Her zaman sahip olduğum tüm potansiyelimi kullanmalıyım	1 2 3 4 5 6 7
11. Benim için, bir durumla ilgili tüm olası sonuçları düşünmek çok önemlidir	1 2 3 4 5 6 7
12. En ufak hatalar bile, bir işin tamamlanmadığı anlamına gelir	1 2 3 4 5 6 7
13. Sevdiğim insanlarla ilgili saldırgan düşüncelerim veya dürtülerim varsa, bu gizlice onları incitmeyi istediğim anlamına gelir	1 2 3 4 5 6 7
14. Kararlarımdan emin olmalıyım	1 2 3 4 5 6 7
15. Her türlü günlük aktivitede, zarar vermeyi engellemede başarısız olmak kasten zarar vermek kadar kötüdür	1 2 3 4 5 6 7
16. Ciddi problemlerden (örneğin, hastalık veya kazalar) kaçınmak benim açımdan sürekli bir çaba gerektirir	1 2 3 4 5 6 7
17. Benim için, zararı önlememek zarar vermek kadar kötüdür	1 2 3 4 5 6 7

1 Kesinlikle katılmıyorum	2 Katılmıyorum	3 Biraz katılmıyorum	4 Ne katılıyorum ne katılmıyorum	5 Biraz Katılıyorum	6 Katılıyorum	7 Tamamen Katılıyorum

18. Bir hata yaparsam üzüntülü olmalıyım	1	2	3	4	5	6	7
19. Diğerlerinin, kararlarım veya davranışlarımdan doğan herhangi bir olumsuz sonuçtan korunduğundan emin olmalıyım	1	2	3	4	5	6	7
20. Benim için, herşey mükemmel olmazsa işler yolunda sayılmaz	1	2	3	4	5	6	7
21. Müstehcen düşüncelerin aklımdan geçmesi çok kötü bir insan olduğum anlamına gelir	1	2	3	4	5	6	7
22. . İlave önlemler almazsam, ciddi bir felaket yaşama veya felakete neden olma ihtimalim, diğer insanlara kıyasla daha fazladır	1	2	3	4	5	6	7
23. Kendimi güvende hissetmek için, yanlış gidebilecek herhangi bir şeye karşı olabildiğince hazırlıklı olmalıyım	1	2	3	4	5	6	7
24. Tuhaf veya iğrenç düşüncelerim olmamalı	1	2	3	4	5	6	7
25. Benim için, bir hata yapmak tamamen başarısız olmak kadar kötüdür	1	2	3	4	5	6	7
26. En önemsiz konularda bile herşey açık ve net olmalıdır	1	2	3	4	5	6	7
27. Din karşıtı bir düşünceye sahip olmak, kutsal şeylere karşı saygısız davranmak kadar kötüdür	1	2	3	4	5	6	7
28. Zihnimdeki tüm istenmeyen düşüncelerden kurtulabilmeliyim	1	2	3	4	5	6	7
29. Diğer insanlara kıyasla, kendime veya başkalarına kazara zarar vermem daha muhtemeldir	1	2	3	4	5	6	7
30. Kötü düşüncelere sahip olmak tuhaf veya anormal biri olduğum anlamına gelir	1	2	3	4	5	6	7
31. Benim için önemli olan şeylerde en iyi olmalıyım	1	2	3	4	5	6	7
32. İstenmeyen bir cinsel düşünce veya görüntünün aklıma gelmesi onu gerçekten yapmak istediğim anlamına gelir	1	2	3	4	5	6	7
33. Davranışlarımın olası bir aksilik üzerinde en küçük bir etkisi varsa sonuçtan ben sorumluyum demektir	1	2	3	4	5	6	7
34. Dikkatli olsam da kötü şeylerin olabileceğini sıklıkla düşünürüm	1	2	3	4	5	6	7
35. İstenmeyen biçimde zihnimde beliren düşünceler, kontrolü kaybettiğim anlamına gelir	1	2	3	4	5	6	7
36. Dikkatli olmadığım takdirde zarar verici hadiseler yaşanabilir	1	2	3	4	5	6	7
37. Birşey tam anlamıyla doğru yapılıncaya kadar üzerinde çalışmaya devam etmeliyim	1	2	3	4	5	6	7
38. Şiddet içerikli düşüncelere sahip olmak, kontrolü kaybedeceğim ve şiddet göstereceğim anlamına gelir	1	2	3	4	5	6	7
39. Benim için bir felaketi önlemekte başarısız olmak ona sebep olmak kadar kötüdür	1	2	3	4	5	6	7
40. Bir işi mükemmel biçimde yapmazsam insanlar bana saygı duymaz	1	2	3	4	5	6	7
41. Yaşamımdaki sıradan deneyimler bile tehlike doludur	1	2	3	4	5	6	7
42. Kötü bir düşünceye sahip olmak, ahlaki açıdan kötü bir şekilde davranmaktan çok da farklı değildir	1	2	3	4	5	6	7
43. Ne yaparsam yapayım, yaptığım iş yeterince iyi olmayacaktır	1	2	3	4	5	6	7
44. Düşüncelerimi kontrol edemezsem cezalandırılırım	1	2	3	4	5	6	7

PADUA ENVANTERİ

Aşağıdaki ifadeler hemen herkesin günlük yaşamında karşılaştığı düşünce ve davranışları tanımlamaktadır. Lütfen her bir ifade için size en uygun görünen ve bu tür davranış ya da düşüncelerin oluşturabileceği rahatsızlık derecesine en uygun olan tek bir seçeneği işaretleyiniz.

		Hiç	*Çok az*	*Çok*	*Epeyce Çok*	*Aşırı*
1	Paraya dokunduğumda ellerimi kirlenmiş hissederim	0	1	2	3	4
2	Vücut salgıları ile (ter, tükürük, idrar , v.b. gibi) Hafif bir temasla bile giysilerim kirlenebileceğini veya bir şekilde zarar görebileceğimi düşünürüm.	0	1	2	3	4
03	Yabancıların veya belirli insanların dokunduğunu biliyorsam, bir nesneye dokunmakta zorlanırım.	0	1	2	3	4
4	Çöpe veya kirli şeylere dokunmakta zorlanırım.	0	1	2	3	4

5	Mikrop kapmaktan ve hastalıklardan korktuğum için umumi tuvaletleri kullanmaktan kaçınırım.	0	1	2	3	4
6	Bulaşıcı hastalıktan korktuğum için halka açık telefonları kullanmaktan kaçınırım.	0	1	2	3	4
7	Ellerimi gereğinden daha sık ve daha uzun süre yıkarım.	0	1	2	3	4
8	Bazen sadece kirlendiğim ya da mikrop kaptığımı düşünerek derhal yıkanır veya temizlenirim	0	1	2	3	4
9	Bir şeye dokunduğumda "mikrop kaptığımı" düşünerek, derhal yıkanır veya temizlenirim.	0	1	2	3	4
10	Bir hayvanın bana dokunması halinde, kendimi kirli hisseder ve derhal yıkanmam veya üstümdeki giysileri değiştirmem gerekir.	0	1	2	3	4

11	Kaygılar ve üzüntüler aklıma geldiğinde, onlar hakkında güvenebildiğim birisiyle konuşmadan rahat edemem.	0	1	2	3	4
12	Konuşurken aynı şeyleri veya aynı cümleleri birkaç kez tekrarlama ihtiyacı duyarım.	0	1	2	3	4
13	İnsanların söyledikleri ilk seferinde anladığım halde birkaç kez tekrar ettirme ihtiyacı duyarım.	0	1	2	3	4
14	Giyinirken, soyunurken ve yıkanırken, özel bir sırayı takip etme zorunluluğu hissederim.	0	1	2	3	4
15	Yatmadan önce belirli şeyleri belirli bir sırayla yapmak zorundayım.	0	1	2	3	4
16	Yatmadan önce giysilerimi özel bir şekilde asmak veya katlamak zorundayım.	0	1	2	3	4
17	Belirli sayıları nedensiz yere tekrarlama zorunluluğu hissederim.	0	1	2	3	4

18	Bir şeyleri doğru olarak yapıldığından emin olana kadar, birkaç kez tekrarlamak zorundayım.	0	1	2	3	4
19	Bir şeyleri gereğinden daha sık kontrol etme eğilimindeyim.	0	1	2	3	4
20	Ocağı, muslukları ve elektrik düğmelerini kapattıktan sonra tekrar tekrar kontrol ederim.	0	1	2	3	4
21	Tam olarak kapalı olduğundan emin olmak için, kapıları, pencereleri, çekmeceleri kontrol etmek uğruna eve geri dönerim.	0	1	2	3	4

MAUDSLEY OBSESİF KOMPULSİF ÖLÇEĞİ

Aşağıdaki cümleleri dikkatle okuyunuz. Size uygunsa 'DOĞRU' yu eğer uygun değilse 'YANLIŞ'ı daire içine alınız. Lütfen soruların hepsini cevaplandırınız.

1. Bana bir hastalık bulaşır korkusuyla herkesin kullandığı telefonları kullanmaktan kaçınırım. DOĞRU YANLIŞ
2. Sık sık hoşa gitmeyen şeyler düşünür, onları zihnimden uzaklaştırmakta güçlük çekerim. DOĞRU YANLIŞ
3. Dürüstlüğe herkesten çok önem veririm. DOĞRU YANLIŞ
4. İşleri zamanında bitiremediğim için çoğu kez geç kalırım. DOĞRU YANLIŞ
5. Bir hayvana dokununca hastalık bulaşır diye kaygılanırım. DOĞRU YANLIŞ
6. Sık sık havagazını, su musluklarını ve kapıları birkaç kez kontrol ederim. DOĞRU YANLIŞ
7. Değişmez kurallarım vardır. DOĞRU YANLIŞ
8. Aklıma takılan nahoş düşünceler hemen her gün beni rahatsız eder. DOĞRU YANLIŞ
9. Kaza ile bir başkasına çarptığımda rahatsız olurum. DOĞRU YANLIŞ
10. Her gün yaptığım basit günlük işlerden bile emin olamam. DOĞRU YANLIŞ
11. Çocukken annem de babam da beni fazla sıkmazlardı. DOĞRU YANLIŞ
12. Bazı şeyleri tekrar tekrar yaptığım için işimde geri kaldığım oluyor. DOĞRU YANLIŞ
13. Çok fazla sabun kullanırım. DOĞRU YANLIŞ
14. Bana göre bazı sayılar son derece uğursuzdur. DOĞRU YANLIŞ
15. Mektupları postalamadan önce onları tekrar tekrar kontrol ederim. DOĞRU YANLIŞ
16. Sabahları giyinmek için uzun zaman harcarım. DOĞRU YANLIŞ

17. Temizliğe aşırı düşkünüm. DOĞRU YANLIŞ

18. Ayrıntılara gereğinden fazla dikkat ederim. DOĞRU YANLIŞ

19. Pis tuvaletlere giremem. DOĞRU YANLIŞ

20. Esas sorunum bazı şeyleri tekrar tekrar kontrol etmemdir. DOĞRU YANLIŞ

21. Mikrop kapmaktan ve hastalanmaktan korkar ve kaygılanırım. DOĞRU YANLIŞ

22. Bazı şeyleri birden fazla kontrol ederim. DOĞRU YANLIŞ

23. Günlük işlerimi belirli bir programa göre yaparım. DOĞRU YANLIŞ

24. Paraya dokunduktan sonra ellerimi kirli hissederim. DOĞRU YANLIŞ

25. Alıştığım işi yaparken bile kaç kere yaptığımı sayrım. DOĞRU YANLIŞ

26. Sabahları elimi yüzümü yıkamak çok zamanımı alır. DOĞRU YANLIŞ

27. Çok miktarda mikrop öldürücü ilaç kullanırım. DOĞRU YANLIŞ

28. Her gün bazı şeyleri tekrar tekrar kontrol etmek bana zaman kaybettirir.DOĞRU YANLIŞ

29.Geceleri giyeceklerimi katlayıp asmak uzun zamanımı alır. DOĞRU YANLIŞ

30. Dikkatle yaptığım bir işin bile tam doğru olup olmadığına emin olamam.
DOĞRU YANLIŞ

31. Kendimi toparlayamadığım için günler, haftalar, hatta aylarca hiçbir şeye el sürmediğim olur. DOĞRU YANLIŞ

32. En büyük mücadelelerimi kendimle yaparım. DOĞRU YANLIŞ

33. Çoğu zaman büyük bir hata ya da kötülük yaptığım duygusuna kapılırım.
DOĞRU YANLIŞ

34.Sık sık kendime birşeyleri dert edinirim. DOĞRU YANLIŞ

35.Önemsiz ufak şeylerde bile karar verip işe girişmeden önce durup düşünürüm.
DOĞRU YANLIŞ

36.Reklamlardaki ampuller gibi önemsiz şeyleri sayma alışkanlığım vardır.DOĞRU YANLIŞ

37.Bazen önemsiz düşünceler aklıma takılır ve beni günlerce rahatsız eder. DOĞRU YANLIŞ

Ok-Dini Tutum Ölçeği

Aşağıdaki soruları okuyarak size en yakın olan cümlenin işaretlenmesi istenmektedir.

- Dinin gereksiz olduğunu düşünüyorum.

  a)Hiç Katılmıyorum b)Az Katılıyorum c)Yarı Yarıya Katılıyorum d)Çoğuna Katılıyorum e)Tamamına Katılıyorum

- Dinî inancın insanlara yararından çok zararı olduğunu düşünüyorum.

  a)Hiç Katılmıyorum b)Az Katılıyorum c)Yarı Yarıya Katılıyorum d)Çoğuna Katılıyorum e)Tamamına Katılıyorum

- Ezan, dua veya ayet gibi dinî okumaları dinlediğimde duygulanırım.

  a)Hiç Katılmıyorum b)Az Katılıyorum c)Yarı Yarıya Katılıyorum d)Çoğuna Katılıyorum e)Tamamına Katılıyorum

- Dinî etkinliklere katıldığımda gerçekten zevk alırım.

  a)Hiç Katılmıyorum b)Az Katılıyorum c)Yarı Yarıya Katılıyorum d)Çoğuna Katılıyorum e)Tamamına Katılıyorum

- Yaşantımın dini değerlere uygun olup olmadığına dikkat ederim.

  a)Hiç Katılmıyorum b)Az Katılıyorum c)Yarı Yarıya Katılıyorum d)Çoğuna Katılıyorum e)Tamamına Katılıyorum

- İnandığım dinin gereklerini yerine getirmeye çalışırım.

  a)Hiç Katılmıyorum b)Az Katılıyorum c)Yarı Yarıya Katılıyorum d)Çoğuna Katılıyorum e)Tamamına Katılıyorum

- Zor zamanlarda Allah'ın bana yardım ettiğini düşünüyorum.

  a)Hiç Katılmıyorum b)Az Katılıyorum c)Yarı Yarıya Katılıyorum d)Çoğuna Katılıyorum e)Tamamına Katılıyorum

- Allah'ın bana çok yakın olduğunu hissediyorum

  a)Hiç Katılmıyorum b)Az Katılıyorum c)Yarı Yarıya Katılıyorum d)Çoğuna Katılıyorum e)Tamamına Katılıyorum

KLİNİK ARAŞTIRMALAR ETİK KURULU KARAR FORMU

ARAŞTIRMANIN AÇIK ADI.	"Obsesif Kompulsif bozukluk (OKB) tanılı hastalarda obsesif inançlar, obsesyon alttipleri ve dini tutum arasındaki ilişki"
VARSA ARAŞTIRMANIN PROTOKOL KODU	

ETİK KURUL BİLGİLERİ	ETİK KURULUN ADI	ZEYNEP KAMİL KADIN VE ÇOCUK HASTALIKLARI EĞİTİM VE ARAŞTIRMA HASTANESİ KLİNİK ARAŞTIRMALAR ETİK KURULU
	AÇIK ADRESİ:	Zeynep Kamil Mah. Op.Dr.Burhanettin Üstünel Sok. No:4/3 Üsküdar 34668
	TELEFON	0216 391 06 80
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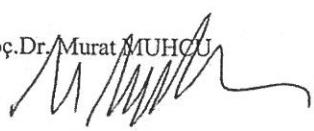
BAŞVURU BİLGİLERİ	KOORDİNATÖR/SORUMLU ARAŞTIRMACI UNVANI/ADI/SOYADI	Psikolog Nurdan AKÇİT			
	KOORDİNATÖR/SORUMLU ARAŞTIRMACININ UZMANLIK ALANI	Klinik Psikoloji			
	KOORDİNATÖR/SORUMLU ARAŞTIRMACININ BULUNDUĞU MERKEZ	Yakın Doğu Üniversitesi			
	VARSA İDARİ SORUMLU UNVANI/ADI/SOYADI				
	DESTEKLEYİCİ				
	PROJE YÜRÜTÜCÜSÜ UNVANI/ADI/SOYADI (TÜBİTAK vb. gibi kaynaklardan destek alanlar için)				
	DESTEKLEYİCİNİN YASAL TEMSİLCİSİ				
	ARAŞTIRMANIN FAZI VE TÜRÜ	FAZ 1	☐		
		FAZ 2	☐		
		FAZ 3	☐		
		FAZ 4	☐		
		Gözlemsel ilaç çalışması	☐		
		Tıbbi cihaz klinik araştırması	☐		
		İn vitro tıbbi tanı cihazları ile yapılan performans değerlendirme çalışmaları	☐		
		İlaç dışı klinik araştırma	☒		
		Diğer ise belirtiniz			
	ARAŞTIRMAYA KATILAN MERKEZLER	TEK MERKEZ ☒	ÇOK MERKEZLİ ☐	ULUSAL ☐	ULUSLARARASI ☐

Etik Kurul Başkanının
Unvanı/Adı/Soyadı: Doç.Dr. Murat MUHCU
İmza:



Not: Etik kurul başkanı, imzasının yer almadığı her sayfaya imza atmalıdır.

KLİNİK ARAŞTIRMALAR ETİK KURULU KARAR FORMU

ARAŞTIRMANIN AÇIK ADI	"Obsesif Kompulsif bozukluk (OKB) tanılı hastalarda obsesif inançlar, obsesyon alttipleri ve dini tutum arasındaki ilişki"
VARSA ARAŞTIRMANIN PROTOKOL KODU	

	Belge Adı	Tarihi	Versiyon Numarası	Dili
DEĞERLENDİRİLEN BELGELER	ARAŞTIRMA PROTOKOLÜ			Türkçe ☐ İngilizce ☐ Diğer ☐
	BİLGİLENDİRİLMİŞ GÖNÜLLÜ OLUR FORMU			Türkçe ☒ İngilizce ☐ Diğer ☐
	OLGU RAPOR FORMU			Türkçe ☐ İngilizce ☐ Diğer ☐
	ARAŞTIRMA BROŞÜRÜ			Türkçe ☐ İngilizce ☐ Diğer ☐

	Belge Adı		Açıklama
DEĞERLENDİRİLEN DİĞER BELGELER	SİGORTA	☐	
	ARAŞTIRMA BÜTÇESİ	☒	
	BİYOLOJİK MATERYEL TRANSFER FORMU	☐	
	İLAN	☐	
	YILLIK BİLDİRİM	☐	
	SONUÇ RAPORU	☐	
	GÜVENLİLİK BİLDİRİMLERİ	☐	
	DİĞER:	☐	
KARAR BİLGİLERİ	Karar No: 20	Tarih: 06.03.2015	
	Yukarıda bilgileri verilen başvuru dosyası ile ilgili belgeler araştırmanın/çalışmanın gerekçe, amaç, yaklaşım ve yöntemleri dikkate alınarak incelenmiş ve uygun bulunmuş olup araştırmanın/çalışmanın başvuru dosyasında belirtilen merkezlerde gerçekleştirilmesinde etik ve bilimsel sakınca bulunmadığına toplantıya katılan etik kurul üye tam sayısının salt çoğunluğu ile karar verilmiştir. İlaç ve Biyolojik Ürünlerin Klinik Araştırmaları Hakkında Yönetmelik kapsamında yer alan araştırmalar/çalışmalar için Türkiye İlaç ve Tıbbi Cihaz Kurumu'ndan izin alınması gerekmektedir.		

KLİNİK ARAŞTIRMALAR ETİK KURULU	
ETİK KURULUN ÇALIŞMA ESASI	İlaç ve Biyolojik Ürünlerin Klinik Araştırmaları Hakkında Yönetmelik, İyi Klinik Uygulamaları Kılavuzu
BAŞKANIN UNVANI / ADI / SOYADI:	Doç.Dr. Murat MUHCU

Unvanı/Adı/Soyadı	Uzmanlık Alanı	Kurumu	Cinsiyet		Araştırma ile ilişki		Katılım *		İmza
Başkan Doç.Dr. Murat MUHCU	Kad. Hast. ve Doğum	Zeynep Kamil Kadın ve Çocuk Hastalıkları Eğitim ve Araştırma Hastanesi	E☐	K☐	E☐	H☒	E☒	H☐	
Doç.Dr. Murat APİ	Kad. Hast. ve Doğum	Zeynep Kamil Kadın ve Çocuk Hastalıkları Eğitim ve Araştırma Hastanesi	E☐	K☐	E☐	H☒	E☒	H☐	
Prof. Dr. Ayşenur CELAYİR	Çocuk Cerrahisi	Zeynep Kamil Kadın ve Çocuk Hastalıkları Eğitim ve Araştırma Hastanesi	E☐	K☐	E☐	H☒	E☐	H☐	
Prof. Dr. Arif Aktuğ ERTEKİN	Kad. Hast. ve Doğum	Üsküdar Üniversitesi	E☐	K☐	E☐	H☒	E☒	H☐	
Doç. Dr. Güner KARATEKİN	Neonatoloji	Zeynep Kamil Kadın ve Çocuk Hastalıkları Eğitim ve Araştırma Hastanesi	E☐	K☐	E☐	H☒	E☒	H☐	
Doç. Dr. Çetin ÇAM	Kad. Hast. ve Doğum	Zeynep Kamil Kadın ve Çocuk Hastalıkları Eğitim ve Araştırma Hastanesi	E☐	K☐	E☐	H☐	E☐	H☐	
Uzm. Dr. Handan ÇETİNER	Patoloji	Zeynep Kamil Kadın ve Çocuk Hastalıkları Eğitim ve Araştırma Hastanesi	E☐	K☐	E☐	H☐	E☐	H☐	
Uzm. Dr. Meral İNALHAN	Çoc. Sağ.ve Hast.	Zeynep Kamil Kadın ve Çocuk Hastalıkları Eğitim ve Araştırma Hastanesi	E☐	K☐	E☐	H☒	E☒	H☐	
Sağ. Bak. Hizm. Müdürü Dr. Yeliz DOĞAN MERİH	Doğum ve Kadın Hastalıkları	Zeynep Kamil Kadın ve Çocuk Hastalıkları Eğitim ve Araştırma Hastanesi	E☐	K☒	E☐	H☒	E☒	H☐	
Doç.Dr. Hülya CABADAK	Biyofizik	Marmara Üniversitesi	E☐	K☒	E☐	H☐	E☐	H☐	
Doç. Dr. Fulya İlçin GÖNENÇ	Hukuk	Medipol Üniversitesi	E☐	K☒	E☐	H☒	E☒	H☐	
Doç. Dr. Günay CAN	Halk Sağlığı	Cerrahpaşa Tıp Fakültesi	E☒	K☐	E☐	H☐	E☐	H☐	
Yard. Doç.Dr. Ahmet Özer ŞEHİRLİ	Farmakoloji	Marmara Üniversitesi	E☒	K☐	E☐	H☒	E☒	H☐	
Yard.Doç.Dr. Ayten ARIKAN	Tıp Tarihi ve Tıp Etiği	Yeni Yüzyıl Üniversitesi	E☐	K☒	E☐	H☒	E☒	H☐	
Huriye ÖLGE	Emekli	Emekli	E☐	K☒	E☐	H☒	E☒	H☐	

*:Toplantıda Bulunma

Etik Kurul Başkanının
Unvanı/Adı/Soyadı: Doç.Dr. Murat MUHCU
İmza:

Not: Etik kurul başkanı, imzasının yer almadığı her sayfaya imza atmalıdır.

RESUME

Personal Information

Name Surname: Nurdan Akçit

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Educational Status

Undergraduate: Girne American University, Psychology Department, 2013.

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Work Experience: 2010- Colour Land Prep School, Development internship.

2011- Hacettepe University Hospital, in the Department of Psychiatry Service (internship)

2012- Hacettepe University İhsan Doğuramacı Children Hospital, Department of Child Psychiatry and Forensic Medicine Internship

2012- İdeal Aile Counselling Center, Internship

2012- Ankara Atatürk Eğitim ve Araştırma Hospital, in the Department of Psychiatry Service, Internship.

2014-2015 Marmara Üniversitesi Eğitim ve Araştırma Hospital, in the Department of Psychiatry Service and Polyclinic Internship.

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Date: 06.10.2015