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**INSTITUTE OF SOCIAL SCIENCES**

**DEPARTMENT OF PSYCHOLOGY**

**MASTER IN CLINICAL PSYCHOLOGY WITH THESIS**

# EXPLORING EMOTION REGULATION IN OCD: A FOCUS ON INTRAPERSONAL AND INTERPERSONAL STRATEGIES ACROSS OCD, RELATIONSHIP AND PARTNER FOCUSED OCD

**BY**

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# ÖZET

**SOYSAL, Demet Esra, OKB'de Duygu Düzenleme: Genel ve Romantik İlişki Temelli OKB Belirtilerinde Birey İçi ve Kişiler Arası Stratejilerin İncelenmesi, Başkent Üniversitesi, Sosyal Bilimler Enstitüsü, Klinik Psikoloji Tezli Yüksek Lisans Programı, 2025.**

Bu çalışma, duygu düzenleme stratejileri ile Obsesif-Kompulsif Bozukluk (OKB) belirtileri arasındaki ilişkiyi, özellikle ilişki merkezli ve partner odaklı obsesif-kompulsif belirtilerin kapsamında incelemeyi amaçlamıştır. İlişki merkezli ve partner odaklı obsesif-kompulsif belirtilerin, romantik ilişkilerle ilgili obsesif kuşkular ve zorlantılarla karakterize edilen bir OKB alt türü olarak tanımlanmaktadır. Bu belirtiler iki temel boyutta ele alınmaktadır: ilişkinin kendisine yönelik obsesif sorgulamalar içeren romantik ilişki temalı semptomlar ve partnerin özelliklerine ya da algılanan kusurlarına odaklanan partner odaklı semptomlar. Bu doğrultuda çalışma, Gross'un süreç modeli ve Hofmann'ın kişilerarası duygu düzenleme modelinden yola çıkarak, birey içi stratejiler (bilişsel yeniden değerlendirme, bastırma) ve kişilerarası stratejilerin (yatıştırma, sosyal modelleme, bakış açısı alma ve olumlu duyguyu artırma) ilişki merkezli ve partner odaklı obsesif-kompulsif belirtiler ve OKB belirtileriyle ilişkisini incelemiştir. Toplam 752 katılımcı obsesif-kompulsif belirtileri ve duygu düzenleme stratejilerini değerlendiren öz bildirim ölçümlerini tamamlamıştır. Veri toplama araçları arasında Demografik Bilgi Formu, İlişki Odaklı Obsesif-Kompulsif Belirtiler Envanteri (ROCI), Partnere Yönelik Obsesif-Kompulsif Belirtiler Envanteri (PROCSI), Obsesif-Kompulsif Belirtiler Envanteri- Gözden Geçirilmiş Form (OCI-R), Kişilerarası Duygu Düzenleme Ölçeği (IERQ) ve Duygu Düzenleme Ölçeği (ERQ) yer almaktadır. Ardından, belirti şiddetine göre grup karşılaştırmaları yapılmış sonrasında ise OKB ile ilişki merkezli ve partner odaklı obsesif-kompulsif semptomların arasında duygu düzenleme stratejilerinin yordayıcı rolünü değerlendirmek için çoklu regresyon analizleri kullanılmıştır. Bulgular, yüksek OKB ve ilişki merkezli ve partner odaklı obsesif-kompulsif semptomları olan bireylerin, düşük belirti seviyelerine sahip olanlara kıyasla anlamlı derecede daha fazla bastırma ve kişilerarası duygu düzenleme stratejileri kullandıklarını göstermiştir. Bastırma, tüm modellerde belirti şiddetinin en güçlü yordayıcısı olarak ortaya çıkarken, bilişsel yeniden değerlendirme sınırlı ölçüde anlamlı bulunmuştur. Kişilerarası stratejiler, özellikle yatıştırma ve sosyal model alma, ilişki merkezli ve partner odaklı obsesif-kompulsif belirtilerinin önemli yordayıcılarıyken bu stratejiler OKB belirtileri üzerinde daha zayıf bir rol oynamıştır. Bu sonuçlar hem uyumsuz birey içi stratejilerinin hem de kişilerarası duygu

düzenleme stratejilerinin ilişki merkezli ve partner odaklı obsesif-kompulsif ile OKB belirtilerinin deneyimlenmesine katkıda bulunduğunu göstermektedir. Bulgular, ilişki merkezli ve partner odaklı obsesif-kompulsif belirtiler için gelecekteki klinik müdahalelerde duygu düzenleme stratejilerini, özellikle de bastırma ve kişilerarası düzenleme eğilimlerini hedeflemenin önemi için ön kanıtlar sunmaktadır. Keşifsel bir araştırma olan bu çalışma, ilişki merkezli ve partner odaklı obsesif-kompulsif belirtilere dair giderek genişleyen alınyazına katkıda bulunmakta ve OKB belirtilerinde kişilerarası ve birey içi duygu düzenlemenin rolünü daha geniş bir şekilde anlamada bir boşluğu doldurmaktadır. Bu bulgulara göre, gelecekteki ampirik çalışmaların OKB ile ilgili zorlukları ele alırken duygu düzenleme stratejilerini dikkate almaları önemli görünmektedir.

**Anahtar Kelimeler:** ROCD, OKB, duygu düzenleme, kişilerarası duygu düzenleme

# ABSTRACT

**SOYSAL, Demet Esra, Exploring Emotion Regulation in OCD: A Focus on Intrapersonal and Interpersonal Strategies Across OCD, Relationship and Partner Focused OCD, Başkent University, Institute of Social Sciences, Master's Degree in Clinical Psychology, 2025.**

This study aimed to investigate the relationship between emotion regulation strategies and Obsessive-Compulsive Disorder (OCD) symptoms, with a specific emphasis on Relationship Obsessive-Compulsive Disorder (ROCD), which refers to a subtype of OCD characterized by intrusive doubts and compulsions related to romantic relationships. ROCD includes two primary symptom dimensions: relationship-centered (RC-OC), involving obsessive doubts about the relationship itself, and partner-focused (PF-OC), involving preoccupations with the partner's characteristics or perceived flaws. Drawing on Gross's process model of emotion regulation and Hofmann's model of interpersonal emotion regulation (IER), the study examined how both intrapersonal strategies (cognitive reappraisal, expressive suppression) and interpersonal strategies (soothing, social modeling, perspective taking, and enhancing positive affect) relate to symptoms of ROCD and OCD. A total of 752 participants completed self-report measures assessing obsessive-compulsive symptoms and emotion regulation strategies. The instruments included the Demographic Information Form, the Relationship Obsessive-Compulsive Inventory (ROCI), the Partner-Related Obsessive-Compulsive Symptoms Inventory (PROCSI), the Obsessive–Compulsive Inventory–Revised (OCI-R), the Interpersonal Emotion Regulation Questionnaire (IERQ), and the Emotion Regulation Questionnaire (ERQ). Group comparisons were conducted based on symptom severity, and multiple regression analyses were used to evaluate the predictive role of emotion regulation strategies across OCD and ROCD symptoms. Findings indicated that individuals with high OCD and ROCD symptoms reported significantly greater use of expressive suppression and interpersonal emotion regulation strategies compared to those with lower symptom levels. Suppression emerged as the strongest predictor of symptom severity across all models, while cognitive reappraisal showed limited value. Interpersonal strategies, particularly soothing and social modeling, were significant predictors of ROCD symptoms but played a weaker role in OCD. These results suggest that both maladaptive intrapersonal and context-dependent interpersonal regulation patterns contribute to the experience of ROCD and OCD symptoms. The findings offer preliminary evidence for the importance of targeting emotion regulation strategies, especially

suppression and interpersonal regulation tendencies in future clinical interventions for ROCD. As an exploratory effort, the study contributes to the growing literature on ROCD and fills a gap in understanding the role of interpersonal and intrapersonal emotion regulation in obsessive-compulsive symptoms more broadly. These findings suggest that future empirical work should consider emotional regulation strategies when addressing OCD-related difficulties.

**Keywords**: ROCD, OCD, emotion regulation, interpersonal emotion regulation

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| | |
|---|---|
| ER | Emotion Regulation |
| ERQ | Emotion Regulation Questionnaire |
| IER | Interpersonal Emotion Regulation |
| IERQ | Interpersonal Emotion Regulation Questionnaire |
| MDD | Major Depressive Disorder |
| OCD | Obsessive-Compulsive Disorder |
| OCI-R | Obsessive–Compulsive Inventory-Revised |
| PF-OC | Partner-Focused Obsessive-Compulsive |
| PROCSI | Partner-Related Obsessive-Compulsive Symptoms Inventory |
| RC-OC | Relationship-Centered Obsessive-Compulsive |
| ROCD | Relationship-Centered Obsessive-Compulsive Disorder |
| ROCI | Relationship Obsessive-Compulsive Inventory |
| SAD | Social Anxiety Disorder |

# 1. INTRODUCTION

## 1.1. Emotion

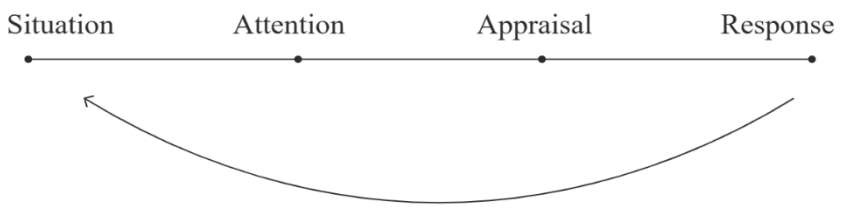
Emotions are fundamental in shaping human experiences, relationships, and behaviors, serving as signals that guide interactions with the surrounding environment. Emotion has been conceptualized in various ways in literature. According to Frijda (1986), emotions represent internal states that motivate individuals to establish, sustain, or modify relationships with their environment. Correspondingly, Carver and Scheier (1990) conceptualize emotions as indicators reflecting one's progress toward reducing discrepancies between personal goals and the present state of reality. The communication of emotions extends far beyond verbal language (Carlson, 2007). Nonverbal channels including facial cues, patterns of eye contact, vocal nuances, gestures, the timing and strength of these responses are essential for accurately conveying and interpreting emotional experiences (Siegel, 1999). Although theories of emotion differ on several points, they commonly agree that emotions emerge from ongoing interactions between individuals and their environment. These interactions typically involve both cognitive evaluations and bodily responses, often displaying consistent patterns over time.

Rather than trying to settle on a strict definition, researchers have approached emotion by exploring the patterns and qualities that most emotional experiences tend to share, offering a more flexible way to understand such a complex concept (Gross, 1998a, 1999, 2013). One influential framework that takes this approach is The Modal Model of Emotion. Emotions emerge through a recurring sequence of interactions between individuals and their environment according to the model (Gross, 1998a, 2013, 2015; Gross & Thompson, 2007). As indicated in Figure 1, this process begins with an emotionally relevant *situation*, which captures *attention*, leads to an *appraisal*, and ultimately generates a coordinated emotional *response* involving subjective experience, physiological changes, and behavioral tendencies. Since this process happens step by step, each part can influence the next, making emotion something that unfolds and changes over time rather than being a fixed reaction (Gross, 2008; Gross & Thompson, 2007). As shown in Figure 1, this emotional response can also influence the original situation, creating a cycle in which emotions and situations continuously affect one another. A clearer sense of this cycle can be seen in a situation between two close friends working on a group project. One of them expresses frustration about having to take on most of the workload. The other, feeling accused, reacts with

irritation, saying they've been doing their part. As the conversation unfolds, the second friend suddenly falls silent and, holding back tears, admits they've been dealing with personal challenges and didn't want to bring it up. This emotional response shifts the tone of the interaction from tension to vulnerability. The first friend's reaction also changes, moving from frustration to empathy. In this moment, the emotional exchange alters the situation itself, setting the stage for a more supportive and understanding interaction.

**Figure 1.1.**

*The modal model of emotion (Gross, 2013)*




Beyond the individual-level functions, emotions play critical interpersonal roles, such as communicating internal states to others, facilitating social problem-solving, and supporting adaptive responses to environmental demands (Keltner & Gross, 1999). Emotions are fundamental for close relationships. Close relationships according to Hazan and Shaver (1994) described as the very context in which powerful emotions take shape. Emotional bonds formed in close relationships often give rise to some of our most intense feelings, particularly during periods of romantic excitement, ongoing connection, or relational breakdown (Bowlby, 1979). It is within these relationships that individuals experience their most varied and intense feelings, ranging from acceptance, security, and joy to jealousy, humiliation, and despair (Fitness & Fletcher, 1990). Moreover, emotions in romantic relationships aren't just felt; how partners express and handle these feelings in response to relational experiences significantly influences the quality and course of the relationship itself (Mikulincer & Shaver, 2005). Numerous studies have examined how emotions fluctuate within romantic relationships and the factors that influence these emotional shifts. For instance, Sprecher (1986) stated that perceived inequity is associated with increased negative emotions and decreased positive emotions. Underbenefiting inequity refers to a situation in which one partner feels they are contributing more to the relationship than they are receiving. It is linked to heightened emotional distress. The study also revealed significant gender-based variations in emotional responses, with men exhibiting a greater

tendency toward anger, whereas feelings of sadness were more likely to reported by women. While fluctuations in emotional experiences are common in romantic relationships, these emotions can become particularly intense and distressing in certain clinical presentations. An example of this is relationship-centered obsessive-compulsive disorder (ROCD), which is marked by intrusive and undesirable thoughts and uncertainties regarding an individual's romantic partner or the relationship itself. Individuals with ROCD report feelings of anxiety, guilt, shame, and even disgust in response to these intrusions (Doron et al., 2012a). These emotional reactions are not only distressing but also deeply tied to the individual's sense of self and relational security. For example, intrusive doubts about one's feelings or a partner's qualities can trigger cycles of fear, rejection sensitivity, and emotional turmoil, particularly in those with heightened relational vulnerabilities (Doron et al., 2014, 2016). These kinds of intense emotional experiences are not unique to ROCD. In fact, similar affective patterns are commonly observed across obsessive-compulsive disorder (OCD) more broadly. Individuals with OCD frequently report overwhelming anxiety, fear, or guilt in response to intrusive thoughts that are perceived as threatening or unacceptable (Abramowitz et al., 2009). Another emotion commonly implicated in OCD is disgust, which is generally associated with the urge to distance oneself from stimuli perceived as contaminating or repulsive (Rozin & Fallon, 1987).

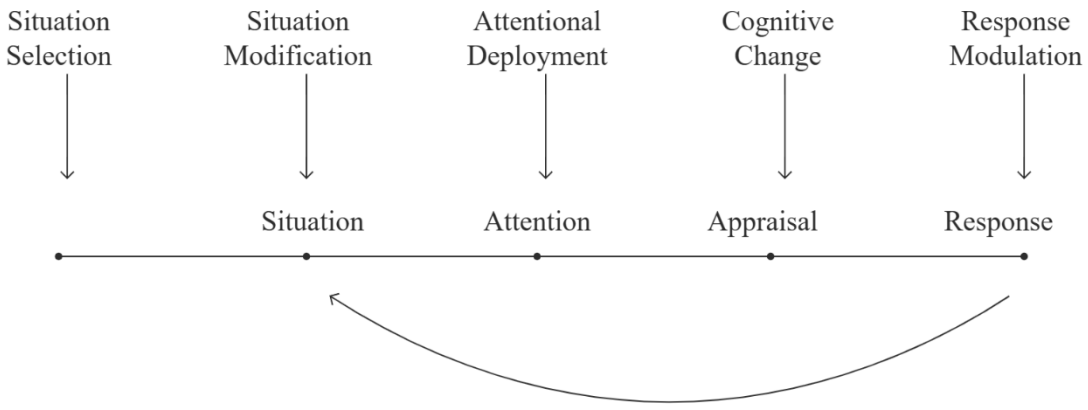
These emotional experiences can often involve intense feelings that are challenging to manage, whether experienced individually or within relational contexts, including clinical conditions such as ROCD and OCD. Given how significantly these emotions shape personal and relational well-being, understanding the ways individuals respond to and manage such emotions has become an important focus of research. Recognizing the emotional intensity involved in relationship dynamics, researchers have increasingly focused on how individuals respond to and manage these emotions. Specifically, the strategies individuals employ to regulate their emotions have been shown to play a significant role in shaping key relational outcomes, including satisfaction, marital quality, and the degree of emotional closeness experienced between partners. Successfully dealing with these emotional situations frequently necessitates that individuals handle or modify their emotional reactions, emphasizing the significance of emotion regulation in the realm of intimate relationships (Gross, 2014). Considering the intensity and complexity of emotions that emerge in romantic dynamics, understanding how people regulate these emotions, both individually and in interaction with their partners, has become a growing area of interest in the literature on emotional and relational well-being.

## 1.2. Emotion Regulation

Emotion regulation (ER) is a fundamental psychological mechanism, involves the ways in which individuals observe, assess, and adjust their emotional responses to internal or external stimuli (Aldao et al., 2010; Gross, 1998a). ER is a constant part of daily life, involving any cognitive or behavioral effort aimed at shaping our emotional experiences to handle better social expectations, responsibilities, or unexpected challenges we encounter in everyday situations. Gross's (1998b) Process Model of Emotion Regulation is among the most well-known frameworks in psychological research (Figure 2). The model highlights how different ER strategies are positioned within the timeline of an emotional experience, describing how individuals regulate emotions at various stages. According to this framework, ER unfolds through five sequential stages: situation selection, situation modification, attentional deployment, cognitive change, and response modulation. Each represents different points at which individuals may intervene to manage their emotional responses (McMahon & Naragon-Gainey, 2019).

**Figure 1.2.**

*The process model of emotion regulation (Gross, 2013)*




Individuals purposefully decide which environments or interactions to enter or avoid based on the emotions they expect to experience, such as behavioral avoidance in the *situation selection* stage, (Aspinwall & Taylor, 1997). Examples of this stage include deciding not to attend a social gathering because you anticipate encountering someone you find difficult to interact with or avoiding watching the news because it often contains upsetting content. The next stage is *situation modification* (Gross, 1998b), which involves

actively altering a situation to reduce its emotional impact. Situations that could potentially trigger emotions do not necessarily cause emotional reactions. Individuals can actively change these situations to reduce their emotional impact. For example, if a movie a person watches includes distressing scenes, you might choose a different film to watch. At the *attentional deployment* stage, individuals attempt to influence their emotional reactions by choosing where to place their focus within a given situation, either by concentrating on or diverting attention from specific elements (Ferri et al., 2016). Someone waiting in a long, frustrating grocery store line might read the nutrition label on a cereal box to shift their focus and manage their emotional state more effectively. Shifting attention away from emotionally charged stimuli has been shown to be an effective way to regulate emotions across distinct stages of life, even infancy (Rothbart et al., 1992). Supporting this, Mangelsdorf and colleagues (1995) examined how infants aged 6 months to 18 months regulate their emotions during interactions with unfamiliar adults. Their findings revealed that younger infants primarily relied on gaze aversion as a method to manage their emotional responses. They suggest that gaze aversion may work as a protective mechanism for more fearful infants, helping them to regulate their emotions in possibly stressful circumstances. Modifying one's assessment of a situation in order to change one's emotional reaction is the fourth stage of ER, known as *cognitive change*. Denial, isolation, cognitive reframing, intellectualization, and reappraisal are all considered forms of cognitive change, as they involve adjusting the approach a situation is mentally interpreted to influence its emotional impact (Gross, 1998b). For example, someone who did not get a job they wanted might think, "This opens up the chance for an even better opportunity to come along." The final phase, *response modulation*, occurs once the emotional response has already started (Gross, 2002; Sheppes & Gross, 2012). It involves directly changing emotional responses at the physiological, experiential, or behavioral degree. A range of strategies have been studied at this stage, including exercise, relaxation techniques, altering facial expressions, listening to music, consuming caffeinated or alcoholic beverages, engaging in social sharing, and suppression (Colombo et al., 2021; Gross, 1998a; Livingstone & Srivastava, 2012; Quoidbach et al., 2015). For instance, after receiving good news, someone might call a close friend to share the moment, this act can amplify their positive emotions and strengthen the experience.

Following his initial definition of the ER phases, response-focused and antecedent-focused strategies defined by Gross (1998). Changing one's thoughts or perceptions before an emotional reaction is fully developed is known as an antecedent-focused strategy (Gross & John, 2003). A prominent example is cognitive reappraisal, which entails changing one’s

interpretation of a situation to shape the resulting emotional experience (Gross, 1998b). In contrast, response-focused strategies occur after the emotional response has already emerged and focus primarily on managing or inhibiting emotional expression. Suppression is a commonly studied example of this type of strategy, involving holding back emotional expressions after the emotion has started (Gross & Levenson, 1993). Individuals engage in these diverse strategies not only to manage the intensity and nature of their emotions but also to actively influence or alter situations that provoke emotional responses, thus achieving greater control over their emotional functioning. Research suggests that these strategies differ significantly in their effects on mental health (Gross & John, 2003; Troy et al., 2013). Cognitive reappraisal is typically linked to favorable psychological functioning, whereas reliance on expressive suppression has been associated with elevated indicators of depressive and anxiety-related disturbances (Aldao et al., 2010, 2014). Hence, ER strategies have generally been argued to fall into two categories: adaptive and maladaptive, depending on their immediate effects on emotions, thoughts, and behaviors, as well as their associations with psychopathology (Gross, 2015; Gross & John, 2003).

Judah and colleagues (2022) explored how ER strategies, specifically cognitive reappraisal and expressive suppression, relate to the comorbidity between social anxiety disorder (SAD) and major depressive disorder (MDD), as these conditions frequently cooccur. Using a large sample of emerging adults, they examined how these strategies may contribute to the link between social anxiety and depressive symptoms. The authors concluded that the interaction between cognitive reappraisal and expressive suppression significantly predicts the relationship between SAD and MDD, indicating that both strategies may serve as protective factors against comorbidity, with the combination of high cognitive reappraisal and low expressive suppression being particularly beneficial. As opposed to this idea, Brockman and colleagues (2016) investigated how daily use of mindfulness, cognitive reappraisal, and emotion suppression relates to daily positive and negative affect, using daily diary methodology. Participants completed an online survey every night for 21 days. Each day, participants rated their positive and negative emotions based on a set of adjectives. Positive affect was captured with words like "*enthusiastic*, *happy*, *satisfied*, and *excited*" while negative affect included adjectives like "*embarrassed*, *disappointed*, *anxious*, and *sad*". They concluded that daily mindfulness practice is generally associated with reduced negative affect and enhanced positive affect. However, the effectiveness of cognitive reappraisal appears to vary across individuals, with some younger participants reporting

heightened negative affect. Additionally, the use of emotion suppression was consistently linked to poorer emotional well-being.

This distinction between adaptive and maladaptive ER strategies extends beyond individual psychopathology and has been explored in the context of relational dynamics, particularly in how couples navigate emotional interactions. For example, Richards and colleagues (2003) examined cognitive reappraisal and expressive suppression to understand their impact on memory during emotionally charged conversations between romantic partners. Participants completed a questionnaire about their relationship conflicts a week before the experiment session. Once the initial procedures were completed, couples took part in one of three experimentally defined groups, determined through random allocation: a control group with no guidance, a group instructed to inhibit outward emotional expressions, or a group encouraged to reinterpret the situation cognitively. In the suppression and reappraisal groups, only one partner received regulation instructions, while the other partner remained uninstructed to keep the interaction natural. Those in the suppression condition were asked to hold back their emotional expressions so their partner wouldn't notice any feelings, while participants in the reappraisal condition were encouraged to focus on the positive aspects of their relationship before the conversation. Participants later completed an emotion assessment, and a task designed to evaluate their memory of the conversation content. Participants who engaged in cognitive reappraisal, which involved focusing on the positive aspects of their relationship, established a higher recall of conversation content compared to those who used expressive suppression, who were instructed to inhibit their emotional expressions. Additionally, Girme and colleagues (2020) explored how expressive suppression in romantic relationships affects both partners, focusing on whether these effects depend on attachment anxiety. Across three dyadic studies, they found that for individual low in attachment anxiety, moderate to high levels of suppression were linked to poorer relationship outcomes for both parties of the partners. In comparison, among individuals with elevated attachment anxiety who are generally more emotionally expressive, engaging in suppression appeared to have a less negative impact on their partners, as it may have helped to lower the emotional intensity usually present in such interactions. Furthermore, meta-analytic findings indicate that relying on expressive suppression during interpersonal encounters tends to undermine first impressions, reduce the sense of social support, and lower satisfaction in both social and romantic relationships (Chervonsky & Hunt, 2017).

While many studies have mainly focused on ER as an internal, individual process (Campos et al., 2011; Hofman et al., 2016), it is important to recognize that ER operates not

only within the individual but also between people. As Thompson (1994) highlights, ER encompasses both intrapersonal and interpersonal processes. According to Zaki and Williams (2013), individuals often require external support while managing their emotions. When it comes to interpersonal emotion regulation (IER), strategies are divided into two categories, intrinsic or extrinsic, depending on whose emotions are regulated. These two regulatory processes reflect how individuals either manage their emotions internally or seek assistance from others. Intrinsic regulation refers to situations where people turn to others for support in managing their emotional states while extrinsic regulation involves actively trying to influence or manage someone else's emotions (Zaki & Williams, 2013).

### 1.2.1. Interpersonal emotion regulation

IER refers to individuals attempt towards managing the emotions of others or seeking support from others to regulate their own emotions. IER has been conceptualized by Zaki and Williams (2013). They theorized two main domains: intrinsic/extrinsic and response independent/response dependent. *Intrinsic IER* involves situations where individuals intentionally seek out social interactions to manage their own emotional experiences. For instance, someone feeling sad might reach out to a close friend to lift their mood or feel comforted. In contrast, *extrinsic IER* indicates instances where a person actively tries to influence the emotional state of another individuals. Such as, reassuring a partner who's worried about an upcoming presentation, or encouraging a friend who feels discouraged about their performance. These interpersonal strategies can further be categorized based on whether they rely on the other person's response. In *response-dependent* IER, whether the strategy works or not is largely shaped by the nature of the other person's reaction. For example, someone may feel relief after expressing their emotions to a friend, depending on whether the friend responds with understanding or support. In contrast, *response-independent IER* takes place within a social interaction but does not require a specific reaction from the other person. Simply articulating emotions or reflecting on them out loud in the presence of someone else can help regulate emotional experience, even if no feedback is given (Zaki & Williams, 2013).

Their classification of regulation expands on traditional, intrapersonal models of ER such as Gross's Process Model by focusing on how people regulate not just their own emotions but also the emotions of others in social contexts. They proposed that ER is not only an individual process but often involves interactions with others, particularly in close relationships. Interpersonal affect regulation is defined as the attempt to influence other's

emotions or mood states. Niven and colleagues (2009) present a theoretical classification of controlled interpersonal affect regulation strategies using a total of 378 distinct strategies through numerous studies, categorizing them into two primary groups: those aimed at improving affect and those aimed at worsening affect. Growing evidence suggests that IER processes depending on contextual factors, goals, and individual differences can function in adaptive or maladaptive ways, just like their intrapersonal counterparts. One example is, supportive strategies such as empathic validation or emotion-focused reappraisal may foster interpersonal closeness and emotional relief in some situations but may backfire or be misinterpreted in others (Dixon-Gordon et al., 2015). Niven and colleagues (2012) introduced the concept of interpersonal spin, which refers to how much a person changes their IER strategies depending on the relationship context (e.g., romantic, familial, or work). Their findings show that individuals with high interpersonal spin reported lower positive mood, higher emotional exhaustion, and weaker relationship closeness. In other words, frequently switching between strategies, such as using helpful, supportive behaviors in one relationship and emotionally distancing or hurtful behaviors in another, may reflect a lack of coherence rather than flexibility. These inconsistent patterns were also linked with lower empathic concern, reduced perspective-taking, and higher levels of anxious attachment, suggesting that certain personality traits might make some people more prone to this type of emotional instability. These results highlight that effective interpersonal regulation is not only about using adaptive strategies, but also about using them in a consistent and attuned way that supports emotional safety in relationships.

Liu and colleagues (2023) investigated the neural mechanisms underlying IER through the same strategies, reappraisal, and suppression. The study involved thirty-five same-sex female friend pairs, with one individual in each dyad taking on the role of emotion regulator and the other as the recipient of regulation. The study outlines three stages of IER. First, *emotion sharing*, where the target expresses their emotions to the regulator; second, *ER*, where the regulator applies either reappraisal or suppression to help reduce the target's negative emotions; and finally, *feedback delivery*, where the target shares their emotional response and perceptions of the regulator's support. Findings revealed that cognitive reappraisal led to broader neural connections across different brain regions, especially in the prefrontal and temporal areas during emotion sharing, whereas during the regulation phase in the prefrontal cortex suppression showed stronger synchronization. The findings suggest that cognitive reappraisal supports the management of negative emotions. Additionally, reappraisal assists the enhancement of positive emotional experiences, benefiting overall

well-being. This study emphasizes that the choice of strategy in IER is crucial, not just for reducing distress, but also for shaping how emotionally connected people feel to each other.

Building on this concept, Hofmann and colleagues (2016) developed a self-report instrument to systematically examine the ways in which individuals engage others in the regulation of their emotional states. They introduced four main factors. *Soothing* focuses on comforting or calming someone during emotional distress, while *enhancing positive affect* involves boosting positive emotions through uplifting activities or conversations. *Social modeling* allows individuals to learn emotional responses by observing others, particularly in how they manage emotions. Lastly, *perspective-taking* involves understanding another person's emotional state and offering support. Together, these strategies help individuals navigate emotional exchanges in close relationships, influencing both emotional well-being and relational dynamics (Lemay et al., 2024). Providing IER serves as a form of social support within couples, helping to enhance relationship satisfaction and encourage more positive perceptions between partners (Ruan et al., 2024).

While the four-factor model of IER developed by Hofmann and colleagues (2016) has received growing empirical attention, recent research has also started to investigate the contextual factors that determine whether these strategies operate in adaptive or maladaptive ways. Using this same framework, Ray-Yol and colleagues (2020) examined how each IER dimension interacts with maladaptive intrapersonal ER strategies to predict psychological distress. Their results suggest that soothing may function as an adaptive strategy, but only when individuals do not heavily rely on maladaptive cognitive strategies such as rumination or catastrophizing. In contrast, for individuals with high levels of maladaptive intrapersonal regulation, soothing was no longer associated with reduced depression symptoms. These findings emphasize the importance of considering the broader emotional regulation context in which IER strategies are used. The same IER strategy may have different effects depending on how it aligns with an individual's habitual coping patterns. These dynamics highlight that the effectiveness of IER is not just about the strategy itself, but also about how it fits within the individual's overall ER profile. Similarly, Zhu and colleagues (2025) aimed to explore how cognitive reframing, considered a strategy activated before the emotional response arises, and suppression of emotional expression, identified as a strategy applied after an emotional response has begun, differentially influence the success of IER in handling a pair of primary negative emotions, namely sadness and anger. The findings indicate that cognitive reappraisal outperforms expressive suppression in supporting effective IER, particularly by alleviating sadness and fostering closer connections between friends.

IER has also been suggested to contribute to the quality of romantic relationships, as behaviors such as intimate touching and joking behavior for regulating a spouse's emotions have been associated with greater intimacy for partners altogether (Debrot et al., 2013; Horn et al., 2019). Ruan and colleagues (2024) demonstrated that perceived effectiveness of both self- and partner-directed IER strategies is positively associated with greater satisfaction in romantic relationships. In a more recent study, Ruan and colleagues (2024) further examined how IER unfolds in daily romantic interactions, using a two-week diary design with couples. They identified specific strategies partners use to regulate each other's emotions, such as distraction, situation modification, and cognitive reappraisal. They found that most were perceived as effective by both the regulator and the target, except for suppression. Moreover, savoring (deliberately focusing on or amplifying positive emotions: e.g., "That was such a great moment, let's enjoy it a bit more!") emerged as the most effective and frequently used strategy for enhancing positive emotions, while suppression and dampening (downplaying or minimizing positive emotions: e.g., "It wasn't that big of a deal," even when something good happened) were least effective. On days when IER was experienced as effective, individuals reported greater relationship satisfaction, particularly in relation to positive emotions. These findings suggest that the everyday success of IER efforts may not only ease emotional distress but also foster closer, more satisfying romantic relationships.

### 1.2.2. IER and psychopathologies

Studies examining various theoretical frameworks of ER suggest that the use of maladaptive intrapersonal ER and IER strategies, along with difficulties in ER, represent central aspects of many psychological disorders (Berking et al., 2008; Dixon-Gordon et al., 2018; Garnefski et al., 2004). Although research on ER has traditionally focused on intrapersonal processes, an increasing number of studies suggest that interpersonal contexts play a significant role in experience and ER. Particularly within the scope of psychological disorders. Supporting the contextual perspective of IER, Liu and colleagues (2024) investigated IER in adults diagnosed with current and previously resolved MDD. Their findings indicate that individuals with decreased MDD engaged in IER most frequently, and they perceived receiving highly adaptive interpersonal strategies, such as affection and encouragement. In contrast, individuals experiencing current episodes of MDD displayed a more mixed pattern; although they frequently received supportive strategies like encouragement to share their feelings, they were also more likely to receive maladaptive responses such as blaming from others. Importantly, the effectiveness of interpersonal

strategies varied across groups: individuals with current MDD benefitted significantly more from affectionate interactions compared to controls or remitted individuals, highlighting a potentially heightened sensitivity or reliance on interpersonal validation during active depressive episodes. These findings emphasize that IER strategies can differ not only in their effectiveness but also in their frequency and relational context depending on the specific psychopathological state (Liu et al., 2024).

For mood and anxiety disorders, an IER model proposed by Hofmann (2014). He argued that many regulatory processes are unfold within social relationships rather than in isolation. In this model, individuals may seek emotional relief by involving others, either by asking for support, reassurance, or presence (intrinsic IER), or by attempting to regulate others' emotions (extrinsic IER). These interpersonal strategies are commonly considered helpful. However, they can also contribute to the maintenance of symptoms depending on their use. For example, excessive reassurance-seeking or emotional dependence behaviors offer short-term comfort but reinforce anxious or obsessive thinking patterns in the long term (Hofmann, 2014). These dynamics suggest that IER strategies' impact depends on the broader emotional and relational context in which they occur thus, they are not inherently adaptive or maladaptive (Hofmann, 2014). As discussed earlier, one condition in which these emotional factors play a particularly important role is OCD. OCD is characterized by intense emotional distress, frequently connected to intrusive thoughts and repetitive behaviors (Abramowitz et al., 2009). Exploring these emotional dimensions in OCD can provide clearer insights into how the disorder develops and persists. Despite the growing interest in IER and its relevance to psychological disorders, studies explicitly examining the link between IER strategies and psychopathology remain limited. This scarcity of research highlights the need for further investigation into how interpersonal processes contribute to, or mitigate, psychological symptoms across various psychological disorders. Emotional and interpersonal factors can influence psychological disorders in complex ways. Understanding these dynamics in specific disorders helps us better grasp how emotional experiences relate to psychological symptoms.

### 1.2.3. Emotion regulation and psychopathologies

ER has been identified as a fundamental factor for maintaining mental health, yet it is frequently overlooked or not fully recognized for its importance (Gross & Muñoz, 1995). ER is profoundly tied to both the emergence and the persistence of various psychological disorders (Berenbaum et al., 2003; Gross & John, 2003; Mennin & Farach, 2007). Research

in this field has covered a wide spectrum of psychopathologies, with studies highlighting the role of ER in mood disorders (Judah et al., 2022; Picó-Pérez et al., 2017), anxiety disorders (Campbell-Sills et al., 2014; Eres et al., 2021), eating disorders (Aldao et al., 2010; Walenda et al., 2021), and OCD (See et al., 2022; Stern et al., 2014; Yap et al., 2018). Building on this, transdiagnostic frameworks have proposed that difficulties in ER contribute to both the onset and maintenance of psychopathology across diagnostic categories (Bullis et al., 2019).

Aldao and colleagues (2010) conducted a meta-analysis examining six dispositional ER strategies (acceptance, avoidance, problem solving, reappraisal, rumination, and suppression) and their associations with depression, anxiety, eating, and substance-related disorders. The results revealed that maladaptive strategies such as rumination, avoidance, and suppression were more robustly associated with psychopathology than adaptive strategies like reappraisal and acceptance. Notably, rumination showed the strongest overall effect, drawing attention to its transdiagnostic significance within internalizing disorders. These findings suggest that while certain ER strategies may buffer against the development of clinical symptoms, others may serve as risk factors, amplifying emotional distress and impairing adaptive functioning. Aldao and colleagues (2010) highlighted that certain ER strategies play a role in the development and persistence of various psychological disorders. In particular, maladaptive ER strategies such as expressive suppression and the lack of emotional clarity and awareness have been consistently linked to both the emergence and maintenance of mental health difficulties (Gross, 2015). For instance, individuals with SAD report significantly higher levels of emotional dysregulation and loneliness compared to non-clinical populations, suggesting that ER deficits may not only exacerbate symptom severity but also hinder interpersonal functioning (Eres et al., 2021). On the other hand, some strategies serve a protective function, helping to prevent the onset of mental health issues. In other words, while maladaptive strategies, like suppression, can contribute to the worsening of symptoms, adaptive strategies, such as cognitive reappraisal, may act as a buffer, reducing the likelihood of developing psychopathology.

These patterns are further supported by recent findings from an ecological momentary assessment study, which provides a better understanding of ER difficulties in OCD. Bischof and colleagues (2024) tracked moment-to-moment affect and regulation attempts over six days, revealing that individuals with OCD not only experienced more negative and less positive affect compared to healthy controls, but also relied more heavily on avoidance-oriented strategies, such as suppression and distraction. Crucially, they also reported lower perceived effectiveness in their regulation efforts, even after controlling depressive

symptoms and momentary OCD symptom presence. Converging evidence also comes from an experimental study by Çapar Taşkesen and İnözü (2024), which revealed that individuals with elevated OCD symptoms tended to rely more on suppression and showed reduced use of cognitive reappraisal in response to emotionally provocative scenarios. The study further demonstrated that specific difficulties in regulating impulses and selecting effective regulatory responses were significant predictors of symptom severity. Several studies have examined general ER processes in OCD. Furthermore, Goldberg and colleagues (2016) investigated the "health" and "ill-health" paths linking cognitive reappraisal and expressive suppression to obsessive–compulsive symptoms, demonstrating that greater reliance on expressive suppression correlates with increased negative affect and cognitive rigidity, while cognitive reappraisal shows a more beneficial profile.

These results provide additional support for the idea that impairments in ER are not merely correlates of OCD, but may play a central role in its persistence, and thus represent important targets for intervention.

### 1.3. Obsessive-Compulsive Disorder

OCD is a long-term psychological condition marked by ongoing, unwanted thoughts and urges, which are defined as obsessions, as well as repeated actions or mental rituals called compulsions that individuals engage in to alleviate emotional discomfort (American Psychological Association, 2023). In DSM-5 (American Psychiatric Association, 2013), OCD is no longer categorized under anxiety disorders, where it was previously included (American Psychiatric Association, 2000). Instead, it was included under a newly defined category, Obsessive-Compulsive and Related Disorders alongside conditions that share overlapping features as repetitive behaviors. For a diagnosis of OCD, the presence of obsessions and/or compulsions must cause significant distress or interfere with daily functioning typically by taking up a substantial amount of time, often more than an hour a day. Moreover, the symptoms are required to be independent of any medical illness or substance use and must not align more closely with the criteria of another psychiatric condition (American Psychiatric Association, 2013).

Obsessions typically involve distressing, unwanted thoughts, images, or urges that repeatedly invade the mind, for example fears of contamination, harming others, or doubts about safety. Compulsions are the actions or rituals, both physical and mental, that individuals engage in to neutralize the anxiety caused by these obsessions (Pinto et al., 2006). Compulsions, while providing temporary relief from anxiety, reinforce the cycle of

obsessions and compulsions and contribute to the persistence of OCD symptoms over time by preventing the disconfirmation of underlying maladaptive core beliefs (Clark & Beck, 2010; Salkovskis et al., 1995). Experiences such as obsessive thoughts, intrusive urges or images, and compulsive behaviors are not exclusive to clinical OCD populations but are common to varying degrees in the general population as well (Abramowitz et al., 2010; Rachman & De Silva, 1978). According to the cognitive model, what distinguishes individuals with OCD is not the presence of intrusive thoughts, since these are common in the general population, but the way these thoughts are interpreted (Salkovskis, 1985; Salkovskis et al., 1996). Certain belief systems, such as viewing thoughts as highly meaningful or dangerous, can lead people to perceive these intrusions as threatening, which in turn triggers compulsive responses. Over time, these interpretations and behaviors become part of a cycle that maintains the disorder (Frost & Steketee, 2002).

OCD is a heterogeneous disorder, meaning that individuals can present with a wide variety of symptom themes, clinical characteristics, and levels of insight. Obsessive-compulsive symptoms commonly manifest across various domains, such as concerns with contamination and cleanliness, preoccupations with symmetry and precise arrangement, intrusive and socially unacceptable thoughts, and fears of inflicting harm (Mataix-Cols et al., 2005). These dimensions often differ not only in content but also in age of onset, comorbidity patterns, and treatment response (Taylor, 2011). A notable pattern in early-onset OCD includes a stronger emphasis on symptoms related to symmetry, as well as an elevated occurrence of tic-related comorbidities (Leckman et al., 2003), whereas individuals with later-onset OCD may be more likely to experience contamination-related symptoms. Moreover, the extent to which individuals with OCD recognize the irrationality of their obsessions can vary significantly; some may clearly acknowledge their fears as unreasonable, whereas others demonstrate limited insight. Limited insight is associated with less favorable prognosis and reduced responsiveness to treatment (Catapano et al., 2010). These distinctions underscore the need to account for specific symptom patterns and the underlying processes involved in the assessment and treatment of OCD.

In addition to individual symptom profiles and cognitive interpretations, growing attention has been given to the social and relational contexts in which OCD symptoms occur. Although OCD is most often conceptualized as an individualistic disorder, there is growing research that its effects often extend beyond the person experiencing the symptoms. The relational environment in which OCD develops and is maintained plays a crucial role in understanding and treating the disorder (Boeding et al., 2013). One key aspect of this

interpersonal dynamic is known as accommodation, referring to the ways in which close others attempt to reduce the distress or functional impairment caused by OCD symptoms. These accommodating responses, which frequently involve romantic partners or family members, are commonly referred to in the literature as family accommodation (Boeding et al., 2013). Partners or families who accommodate obsessive-compulsive symptoms typically do so with the intention of easing the individual's distress or helping them spend less time on compulsive behaviors (Calvocoressi et al., 1999). However, studies have found that accommodating behaviors from family members are linked to more severe OCD symptoms, strained interpersonal dynamics, and less favorable treatment outcomes in both adult and child populations (Boeding et al., 2013).

### 1.3.1. Romantic relationship and partner-oriented obsessive-compulsive disorder

OCD includes a broad spectrum of clinical symptoms and obsessional themes (Doron et al., 2013; Trak & İnözü, 2019). In recent years, growing attention has been directed toward understanding OCD within the context of romantic relationships, giving rise to a specific subtype known as Relationship Obsessive-Compulsive Disorder (ROCD) (Brandes et al., 2020; Doron et al., 2016). This line of research highlights that relationship-related obsessions and compulsions are significantly linked to dissatisfaction within the relationship (Doron et al., 2012a), which can ultimately undermine emotional intimacy and partnership stability. ROCD is typically presented in two primary symptom dimensions. The first is RC-OC symptoms where obsessions center on the relationship itself. These often involve persistent doubts about the "rightness" of the relationship. The second is PF-OC symptoms, where the focus is on the partner. Within this symptom dimension, individuals experience intrusive concerns about their partner’s suitability or specific personal traits (Doron et al., 2014). Doron and colleagues emphasize that these two symptom dimensions are not mutually exclusive and often reinforce one another over time. Each domain of ROCD poses unique challenges, complicating emotional regulation and intensifying distress within romantic partnerships, often leading to cycles of compulsive reassurance-seeking or avoidance behaviors.

Doron and colleagues (2014) have explored how maladaptive appraisals, for example overestimating threats and holding perfectionistic standards contribute to ROCD symptoms. They suggest that individuals often engage in catastrophic interpretations of intrusive thoughts related to their romantic relationships. These maladaptive appraisals are frequently driven by distorted beliefs, such as the overestimation of threat or harm. For example, if a

partner fails to call for several hours, an individual whose ROCD symptoms are primarily relationship-focused may interpret this as a sign that their partner no longer loves them. In contrast, those experiencing more PF-OC symptoms might view their partner's emotional distress as evidence that they are fundamentally incapable of managing their own emotions or responsibilities. (Doron et al., 2012b).

Furthermore, the emergence and persistence of ROCD symptoms seem to be significantly influenced by perfectionistic ideals (Melli et al., 2018). In the context of partner- PF-OC symptoms, individuals may obsessively scrutinize their partner's traits, behaviors, or emotional reactions based on rigid internal ideals. For example, one might think, "Her appearance isn't perfect, so something must be wrong with the relationship." In contrast, RC-OC symptoms often involve perfectionistic expectations directed at the overall experience of being in a romantic relationship, such as believing, "If he doesn't make me feel the way I imagined a partner should, then he must not be the one" (Doron & Derby, 2017). Another key cognitive factor in ROCD is intolerance of uncertainty, particularly regarding the "rightness" of the relationship or the partner (Doron et al., 2012a, 2012b, 2016). Individuals with ROCD often struggle with the uncertainty that is inherent in romantic relationships, feeling distressed by the inability to be completely certain about their feelings or the suitability of their partner (Doron et al., 2016). This uncertainty is compounded by the general vagueness of emotions like love, making it difficult for individuals with ROCD to trust their own emotional experiences. One theoretical perspective suggests that individuals with OCD may also have difficulty accurately recognizing or interpreting their internal emotional states, a concept referred to as alexithymia, which could further contribute to their obsessive doubts (Summerfeldt, 2004).

A recent systematic review conducted by Mısırlı and Karadayı Kaynak (2023b) aimed to clarify how RC-OC and PF-OC symptoms interact with individual and relational variables. Their review highlighted that obsessive-compulsive symptoms in romantic relationships, including RC-OC and PF-OC types, were consistently linked with a variety of individual variables like depression, anxiety, obsessive beliefs, perfectionism, and early maladaptive schemas. Additionally, relational factors including attachment styles, parental attitudes, relationship satisfaction, jealousy, and self-worth tied to relationship dynamics emerged as significant correlations of these symptoms. Importantly, these findings reinforce the conceptualization of RC-OC and PF-OC symptoms as distinct yet interrelated dimensions of ROCD, both associated with similar psychopathological and interpersonal vulnerabilities.

Adding to this growing body of work, Maadi Esfahan and colleagues (2024) used a network analysis approach to explore the structure of both RC-OC and PF-OC symptoms. Using the Relationship Obsessive-Compulsive Inventory (Doron et al., 2012b) and Partner-Related Obsessive-Compulsive Symptoms Inventory (Doron et al., 2012a), their study identified key symptom nodes that appear to play a significant role in the cognitive structure of ROCD. The study identified central symptom themes such as doubts about one's affection for the partner and concerns about the partner's intelligence. In addition, neuroticism and negative affect (a maladaptive trait involving a tendency toward persistent negative emotions such as anxiety and emotional instability) were found to be closely linked to ROCD symptoms, suggesting that these personality traits might influence how RC-OC symptoms arise and are sustained over time.

Beyond individual factors, recent research has begun to examine how dyadic relationship dynamics contribute to the development and maintenance of ROCD symptoms. Ahuvia and colleagues (2025) identified two key interpersonal pathways that may reinforce the ROCD cycle: cognitive reinforcement and dyadic avoidance. Cognitive distortions are common in ROCD. Increased responsibility, overvaluation of thoughts, and perfectionistic relationship standards can be unintentionally validated by partners, deepening the individual's compulsive behaviors. Additionally, avoidance patterns such as partner accommodation or demand-withdrawal interactions may provide short-term relief but maintain or intensify symptoms over time. Together, these findings point to the multifaceted nature of ROCD, shaped by individual vulnerabilities, maladaptive cognitive patterns, and relational dynamics. Despite its increasing recognition, ROCD remains underrepresented in the broader OCD literature, and its overlap and distinctions with more general obsessive-compulsive symptoms warrant further examination.

### 1.3.2. OCD and ROCD

ROCD shares several cognitive processes common to OCD, particularly a heightened sensitivity to internal experiences (Doron et al., 2013). Individuals experiencing these disorders often excessively monitor their internal states such as love or happiness, continually evaluating their feelings as indicators of certainty or correctness (Liberman & Dar, 2009). However, the relational context of ROCD introduces cognitive elements that distinguish it from other OCD manifestations (Doron & Derby, 2017). Despite overlapping with OCD in terms of intrusive thoughts and ritualistic behaviors, ROCD has key differences in how these symptoms manifest (Doron et al., 2014). In traditional OCD, obsessions often

center around themes like contamination, harm, or symmetry, with compulsions designed to neutralize the anxiety that arises from these intrusive thoughts (Abramowitz & Jacoby, 2008). These themes are usually disconnected from the individual's close relationships and are generally viewed as irrational by the person experiencing them. In contrast, ROCD focuses specifically on intimate relationships. Individuals with ROCD experience obsessions about their romantic partner or the relationship itself, for example doubts about their partner's love or the "rightness" of the relationship (Doron & Derby, 2017). These obsessions can drive compulsive behaviors such as constant reassurance seeking from the partner, repeated analysis of the relationship, or frequent mental checks of their feelings (Doron et al., 2012a, 2012b). Importantly, ROCD has been found to be conceptually and empirically distinct from other OCD themes, with unique correlates such as attachment insecurities, self-worth contingencies, and relationship-related dysfunctional beliefs (Doron et al., 2014). The highly relational nature of these obsessions makes ROCD different from other dimensions of OCD, as the source of distress is directly tied to the partner or relationship, rather than to external triggers like contamination or danger. ROCD has been recognized as a distinct symptom dimension within the broader OCD spectrum (Doron et al., 2012a; Fernandez et al., 2021; Melli et al., 2018a).

### 1.3.3. ROCD and emotion regulation

Although considerable attention has been given to the cognitive and relational features of ROCD, much less is known about the emotional processes that contribute to its onset and maintenance. Given the intense emotional distress reported by individuals with ROCD, including anxiety, guilt, shame, and confusion (Doron et al., 2012a), ER is likely to play a significant role in how these symptoms unfold. Despite this, studies explicitly examining the role of ER in ROCD remain scarce. As ROCD involves ongoing efforts to manage emotionally charged thoughts and relational uncertainty, investigating how individuals attempt to regulate their emotions, both individually and interpersonally, may offer valuable insight into the underlying mechanisms of the disorder.

One recent study has begun to address this gap. Naji Meydani and colleagues (2022) investigated the mediating role of ER difficulties and experiential avoidance in the relationship between attachment styles and ROCD symptoms. Their findings indicated that individuals with insecure attachment styles often struggle to regulate emotions effectively and tend to engage in experiential avoidance, both of which were linked to increased severity of ROCD symptoms. These results support the notion that emotional dysregulation may be

a key vulnerability factor in ROCD. Similarly, Mısırlı and Karadayı Kaynak (2023a) explored the associations between difficulties in ER, RC-OC symptoms, and psychological well-being among young adults in romantic relationships. Their findings revealed that higher levels of ROCD symptoms were significantly associated with greater difficulties in ER, and both were negatively related to psychological well-being. These results suggest that difficulties in managing emotional responses may be one mechanism through which ROCD symptoms contribute to broader psychological distress. Evans (2023) has provided an in-depth overview of ROCD symptomatology and noted that individuals with ROCD typically exhibit cognitive–emotional patterns that are interpersonally oriented, such as the need for reassurance and excessive monitoring of relationship quality.

Together, these findings emphasize the relevance of ER in understanding the development and persistence of ROCD. Although the available research remains limited, these studies highlight the importance of further exploring both the intrapersonal ER and IER strategies that individuals with ROCD employ to cope with their emotional experiences. Moreover, these reviews suggest that ROCD sufferers may employ interpersonal strategies. Although empirical literature lacks direct experimental comparisons between ROCD and general OCD in this regard.

### 1.4. The Aim of the Study

This study serves as an exploratory investigation into how both IER and intrapersonal ER strategies relate to obsessive-compulsive symptoms, particularly focusing on both general OCD symptoms and ROCD symptoms such as RC-OC and PF-OC. Given the limited research in this area, particularly regarding the role of interpersonal and intrapersonal ER strategies, this study aims to offer preliminary insights. By examining how both IER and intrapersonal ER strategies relate to ROCD, this study seeks to identify whether these strategies function similarly in relationship-focused OCD as they do in other forms of OCD.

Although interest in ROCD has grown in recent years, there remains a significant gap in understanding how ER strategies shape the severity and persistence of OCD and ROCD symptoms. While Gross's work (2014) and other research (Aldao & Nolen-Hoeksema., 2010; Campbell-Sills et al., 2014; Lewis et al., 2010) have established the role of ER difficulties across a range of psychopathologies, including anxiety disorders, eating disorders, and mood disorders, the specific role of ER in ROCD is still underexplored. a substantial body of research has examined the connection between OCD and ER (See et al., 2022; Stern et al., 2014; Yap et al., 2018), the specific link between IER and OCD, and more

specifically ROCD, has received little empirical attention. The overall picture emerging from the aforementioned studies is that while theoretical models and clinical observations point to a potential differential use of ER strategies between individuals with high ROCD symptoms and those with high OCD symptoms, there is a dearth of direct empirical comparisons specifically quantifying the IER and intrapersonal dimensions.

Building on this rationale, the current study first explores group differences in ER strategies, comparing individuals with predominantly RC-OC and PF-PC symptoms with more general OCD symptoms. These comparisons aim to determine whether distinct ER profiles are specifically associated with RC-OC and PF-OC symptoms, thereby offering further insight into ROCD as a potentially unique clinical manifestation within the broader OCD spectrum. Following the group comparisons, the study further examines how both IER and intrapersonal ER strategies predict the severity of ROCD and OCD symptoms. Considering the relational nature of ROCD, particular attention is given to the predictive value of IER strategies, examining whether they hold greater explanatory power for ROCD symptom severity compared to intrapersonal strategies. Taking together, this study investigates the contribution of IER and intrapersonal ER strategies to OCD, RC-OC and PF-OC symptoms, examining the predictive value of these strategies for symptom severity and group differences.

### 1.4.1. Research Questions and Hypothesis

Question 1: Are there significant differences in the levels of RC-OC and PF-OC symptoms based on demographic variables?

**H1a.** Longer relationship duration is expected to be associated with lower levels of RC-OC and PF-OC symptoms.

**H1b.** Participants who are currently in a romantic relationship are expected to report higher levels of RC-OC and PF-OC symptoms than those who are not.

Question 2: Do individuals with high ROCD symptoms differ from those with high OCD symptoms in their use of IER and intrapersonal ER strategies?

**H2a**: Participants with high RC-OC symptoms are expected to differ from those with high OCD symptoms in their use of IER and intrapersonal ER strategies

**H2b**: Participants with high PF-OC symptoms are expected to differ from those with high OCD symptoms in their use of IER and intrapersonal ER strategies.

Question 3: Do individuals with high and low levels of OCD symptoms differ in their use of IER and intrapersonal ER strategies?

**H3a**: Participants with high OCD symptoms are expected to show greater use of expressive suppression than those with low OCD symptoms.

**H3b**: Participants with high OCD symptoms are expected to show greater use of IER than those with low OCD symptoms.

Question 4: Do individuals with high and low levels of ROCD symptoms differ in their use of IER and intrapersonal ER strategies?

**H4a**: Participants with high RC-OC symptoms are expected to show greater use of expressive suppression than those with low RC-OC symptoms.

**H4b**: Participants with high RC-OC symptoms are expected to show greater use of IER than those with low RC-OC symptoms.

**H4c**: Participants with high PF-OC symptoms are expected to show greater use of expressive suppression than those with low PF-OC symptoms.

**H4d**: Participants with high PF-OC symptoms are expected to show greater use of IER than those with low PF-OC symptoms.

Question 5: To what extent do IER and intrapersonal ER strategies predict ROCD and OCD symptoms?

**H5a:** IER strategies are expected to positively predict RC-OC symptoms.

**H5b:** IER strategies are expected to positively predict PF-OC symptoms.

**H5c:** IER strategies are expected to positively predict OCD symptoms.

**H5d:** Expressive suppression is expected to be a stronger predictor of RC-OC symptoms than cognitive reappraisal.

**H5e:** Expressive suppression is expected to be a stronger predictor of PF-OC symptoms than cognitive reappraisal.

**H5f:** Expressive suppression is expected to be a stronger predictor of general OCD symptoms than cognitive reappraisal.

# 2. METHOD

## 2.1. Participants

The study's sample comprises Turkish-speaking people aged 18 to 65, and convenience sampling is used to gather data. Additionally, individuals with no prior romantic relationship experience were excluded to ensure that the ROCD measures would be applicable and meaningful. In total, 865 participants fully completed the survey measures. As part of the data cleaning process, 50 participants were excluded for reporting no history of romantic relationships, and 55 were removed due to incorrect responses on the attention check item. In addition, 8 participants were identified as univariate outliers based on subscale z-scores exceeding +3.29 and -3.29, were excluded from the dataset. The final sample included 752 participants whose data was used in the analyses. Participants ranged in age from 18 to 65 years ($M$ = 25.75, $SD$ = 7.44). Details regarding the distribution of participants across other demographic variables are provided in Table 2.1.

**Table 2.1.**

**Demographic Characteristics of the Sample**

| *Variable* | *N* | *%* |
|---|---|---|
| Gender | | |
| Woman | 559 | 74.3 |
| Man | 188 | 25 |
| Non-binary | 1 | .1 |
| Did not specify | 4 | .5 |
| Education | | |
| Primary school | 2 | .3 |
| Middle school | 1 | .1 |
| High school | 380 | 50.5 |
| Associate degree | 42 | 5.6 |
| Undergraduate degree | 273 | 36.3 |
| Graduate degree | 54 | 7.2 |
| Relationship Status | | |
| Currently in a relationship | 470 | 62.5 |
| Single (previous relationship experience) | 282 | 37.5 |
| Relationship Type | | |
| Married | 93 | 19.8 |
| Engaged / Promised | 18 | 3.8 |
| In a relationship | 359 | 76.4 |
| Living Situation with Partner | | |
| Living together (same residence) | 114 | 24.3 |
| Living apart in the same city | 272 | 57.9 |
| Living in different cities | 84 | 17.9 |

## 2.2. Instruments

### 2.2.1. Demographic Information Form

To collect details regarding participants' age, gender, current relationship situation, type of relationship, and relationship duration, a demographic information form was created (Appendix 1).

### 2.2.2. Relationship Obsessive-Compulsive Inventory (ROCI)

To assess the level of obsessive-compulsive symptoms related to romantic relationships, the Turkish adaptation (Trak & İnözü, 2017) of the Relationship Obsessive-Compulsive Inventory (Doron et al., 2012b) was used. It is a self-report measure consisting

of 14 items, two of which are control items, and three sub-dimensions: feelings toward one's partner, the partner's feelings toward oneself, and the rightness of the relationship. Participants indicate their responses on a 5-point Likert-type scale (0 = not at all, 4 = very much). Higher scores indicate greater obsessive-compulsive symptoms related to romantic relationships.

In a study conducted with a non-clinical adult sample, the ROCI demonstrated excellent internal consistency, with a Cronbach's alpha of .93 for the total scale. Subscale reliability coefficients were .87 for "partner's feelings toward oneself," .84 for "feelings toward one's partner," and .79 for "rightness of the relationship" (Doron et al., 2012a). Overall, the ROCI has been found to be a psychometrically sound instrument with satisfactory levels of reliability and validity. The internal consistency coefficients reported by Trak and İnözü (2017) were .89 for the full scale, .78 for the "rightness of the relationship" subscale, .82 for "partner's feelings toward oneself," and .72 for "feelings toward one's partner." In the current study, the internal consistency of the ROCI total score in the present sample was .91. The "feelings toward one's partner," "partner's feelings toward oneself," and "rightness of the relationship" subscales showed good reliability, with Cronbach's alpha values of .83, .81, and .86, respectively (Appendix 2).

### 2.2.3. Partner-Related Obsessive-Compulsive Symptoms Inventory (PROCSI)

This self-report scale developed by Doron and colleagues (2012a) assesses the level of partner-related obsessive-compulsive symptoms. It consists of 28 items, 4 of which are control items, and 6 subscales (appearance, morality, sociability, intelligence, emotional stability, and general competence). The scale is graded on a 5-point Likert scale that ranges from 0 (not at all) to 4 (very much). Higher scores indicate an increased level of partner-related obsessive-compulsive symptoms. The PROCSI has demonstrated excellent internal consistency in studies with adult populations, with a Cronbach's alpha of .95 for the full scale. The subscales, which assess morality, sociability, appearance, professional competence, intelligence, and emotional stability, showed strong internal reliability, with alpha values ranging from .83 to .89.

Trak and İnözü (2017) carried out the scale's validity and reliability study, confirming that its six-factor structure was applicable to the Turkish sample as well. Cronbach's Alpha coefficients for the internal consistency of the PROCSI were .94 for the whole scale. It has been shown that it can be used as a valid and reliable instrument. In the current study, the

total score of PROCSI showed excellent internal consistency with Cronbach's alpha value of .91 (Appendix 3).

### 2.2.4. Obsessive–Compulsive Inventory-Revised (OCI-R)

The OCI-R was developed by Foa and colleagues (2002) to assess the level of obsessive-compulsive symptoms and general obsessive-compulsive symptom severity. It has 18 items and 6 subscales (washing, checking, ordering, obsessing, hoarding, mental neutralization). Participants rate the degree to which they are bothered by OCD symptoms in the past month on a 5-point Likert-type scale ranging from 0 (not at all) to 4 (extremely). High scores obtained from the scale indicate an increase in the level of obsessive-compulsive symptoms. In previous studies with adult samples, the internal consistency of the total scale was found to be adequate to high, with Cronbach's alpha values of .81 in clinical samples and .89 in non-clinical samples. For the subscales, alpha values ranged from .82 to .90 in the OCD group and from .34 to .89 in the control group. The findings from validation studies suggest that the scale has satisfactory psychometric properties and can be used both in clinical and non-clinical populations.

The Turkish version of the OCI-R was adapted by Yorulmaz and colleagues (2015). The internal consistency coefficients of this scale were found to be .90 for the whole scale and between .64 and .84 for the sub-dimensions, and it has been shown that it can be used as a valid and reliable instrument in the Turkish sample. In the current study, the total OCI-R score demonstrated high internal consistency, with Cronbach's alpha of .89 (Appendix 4).

### 2.2.5. Interpersonal Emotion Regulation Questionnaire (IERQ)

The Interpersonal Emotion Regulation Questionnaire (Hofmann et al., 2016) was employed to evaluate the extent to which individuals involve others in the regulation of their emotional states. The scale consists of 20 items and includes four sub-dimensions: enhancing positive affect, soothing, social modeling, and perspective taking. Items are rated on a 5-point Likert-type scale ranging from 1 (not true for me at all) to 5 (extremely true for me). In the original validation study, internal consistency coefficients were reported as .87 for Enhancing Positive Affect, .85 for Perspective-Taking, .89 for Soothing, and .91 for Social Modeling. The Turkish adaptation of the scale was conducted by Koç and colleagues (2019), with Cronbach's alpha values of .81, .87, .77, and .90 for the respective subscales. In the present study, the total IERQ score demonstrated excellent internal consistency ($\alpha$ = .91).

Subscale reliabilities were also satisfactory: .84 for Enhancing Positive Affect, .75 for Perspective-Taking, .84 for Soothing, and .90 for Social Modeling (Appendix 5).

#### 2.2.6. Emotion Regulation Questionnaire (ERQ)

The Emotion Regulation Questionnaire (Gross & John, 2003) is a 10-item self-report scale developed to assess two ER strategies: cognitive reappraisal and expressive suppression. Participants rate each item on a 7-point Likert-type scale ranging from 1 (strongly disagree) to 7 (strongly agree). In the original validation study, the internal consistency coefficients were found to be .79 for the cognitive reappraisal subscale and .73 for the expressive suppression subscale. The Turkish adaptation of the scale was initially conducted by Yurtsever (2008). Later, Aka and Gençöz (2014) revised the Likert response format and certain item translations, reporting Cronbach's alpha coefficients of .85 for the reappraisal subscale and .78 for the suppression subscale. In the present study, internal consistency coefficients were .84 for cognitive reappraisal and .74 for expressive suppression (Appendix 6).

### 2.3. Procedure

Ethical clearance was granted by the Başkent University Ethics Committee prior to data collection (E-62310886-605-415773, 06.01.2025), a convenience sampling method employed, furthermore participants reached through social media platforms. Additionally, students from Başkent University were asked to assist in reaching potential participants as part of a course credit incentive. Qualtrics, an online survey software, utilized for data collection. Before beginning, participants received detailed information about the purpose and process of the study, along with their rights (Appendix 7). All participants joined the study willingly and could leave at any stage without obligation or repercussions. Following this procedure, participants first completed the demographic information form. Subsequently the OCD and ROCD instruments were administered in a randomized order. Then, the emotion regulation instruments provided, also presented in a randomized order.

### 2.4. Statistical Analysis

Data was analyzed using IBM SPSS Statistics for Windows, Version 24. Preliminary analyses were conducted to examine missing data, detect outliers, and assess the distribution of the variables. Skewness and kurtosis values were found to be within the acceptable range

of +1.5 and -1.5, suggesting that the data met the assumption of normality. Prior to each analysis, assumptions specific to the statistical tests were evaluated using appropriate methods, including Levene's test for homogeneity of variances, multicollinearity diagnostics, and Box's M test for equality of covariance matrices.

Following data cleaning, descriptive statistics were computed to summarize the characteristics of the sample. Associations among the main variables were analyzed using Pearson's correlation analyses. Multiple linear regression analyses were then performed to investigate the predictive roles of IER and intrapersonal ER strategies on obsessive-compulsive symptoms. Multivariate analyses of variance (MANOVA) were performed to compare groups based on RC-OC and PF-OC symptoms, as well as the general obsessive-compulsive symptoms. Additional MANOVA's were conducted to examine whether ER strategies differed between participants with higher and lower levels of obsessive-compulsive symptoms. For this purpose, participants scoring 1 standard deviation above the mean on the ROCI, PROCSI, and OCI-R were categorized into the high symptom group, while those scoring 1 standard deviation below the mean formed the low symptom group. This classification method was employed to compare individuals with elevated versus low levels of obsessive-compulsive tendencies, in line with previous research examining subclinical OCD traits (e.g. Fullana et al., 2004). To confirm that the symptom-based groupings reflected meaningful differences, independent samples t-tests were conducted to compare high and low groups on their respective ROCI, PROCSI, and OCI-R scores.

In addition to these classifications, non-overlapping groups were created to compare individuals with symptom elevations in either OCD or RC-OC symptoms. Participants whose ROCI scores were at least 1 standard deviation above the mean and whose OCI-R scores fell within or below 1 standard deviation from the mean were classified as belonging to the high RC-OC group (n = 90). In contrast, individuals whose OCI-R scores were at least 1 standard deviation above the mean, and whose ROCI scores were within or below 1 standard deviation of the mean, were classified as the high OCD-only group (n = 84). This approach enabled the comparison of individuals characterized by primarily RC-OC or OCD symptoms, while minimizing overlapping between symptom domains.

Similarly, a second non-overlapping grouping was conducted to compare individuals with high PF-OC symptoms to those with high OCD symptoms. Individuals whose PROCSI scores exceeded 1 standard deviation above the sample mean, while their OCI-R scores fell within or below 1 standard deviation, were classified as belonging to the high PF-OC group (n = 91). In contrast, individuals whose OCI-R scores were at least 1 standard deviation

above the mean, while their PROCSI scores were within or below 1 standard deviation, were classified as part of the high OCD group (n = 92).

# 3. RESULTS

## 3.1. Data Screening and Descriptive Analyses of the Study Variables

Before conducting the main analyses, data screening conducted for missing values, outliers, and assumption violations. Skewness and kurtosis statistics were assessed for all continuous variables to evaluate univariate normality. Following the guideline suggested by Tabachnick and Fidell (2013), values within the range of -1.5 to +1.5 are interpreted as evidence of an approximately normal distribution. The distribution of all variables in the current study fell within this range, indicating that the assumption of normality was satisfied.

Using standardized z-scores and Mahalanobis distance univariate and multivariate outliers were examined. For univariate outliers, cases with z-scores exceeding +3.29 and –3.29 were identified and excluded from the dataset prior to the main analyses. Multivariate outliers were assessed using Mahalanobis distance with a significance threshold of $p < .001$; however, no cases met this criterion, and therefore no exclusions were made based on multivariate outlier detection. Means, standard deviations, skewness, and kurtosis values for the main study variables are presented (see Table 3.1.).

To confirm that the symptom-based groupings reflected meaningful differences, independent samples t-tests were conducted to compare high and low groups on their respective ROCI, PROCSI, and OCI-R scores. An independent samples t-test was conducted to compare ROCI scores between participants in the high and low ROCI groups. Levene's test indicated unequal variances ($F = 153$, $p < .001$), so degrees of freedom were adjusted accordingly. Results indicated that scores were significantly higher for participants in the high ROCI group ($M = 40.6$, $SD = 5.53$) than for those in the low ROCI group ($M = 12.4$, $SD = .49$) on the ROCI scale, [$t(146) = 60.90$, $p < .001$]. An independent samples t-test was also conducted to compare PROCSI scores between participants with high and low PROCSI groups. Levene's test was significant ($F = 145$, $p < .001$), and degrees of freedom were adjusted accordingly. Participants in the high PROCSI group (M = 72.1, SD = 9.53) scored significantly higher than those in the low PROCSI group (M = 28.1, SD = 1.04), [$t(140) = 53.30$, $p < .001$]. Lastly, an independent samples t-test was conducted to compare OCI-R scores between participants in high and low OCI-R groups. Levene's test indicated unequal variances ($F = 47.70$, $p < .001$), accordingly degrees of freedom were adjusted. Results showed that the high OCI-R group ($M = 62.1$, $SD = 6.76$) reported significantly higher scores than the low OCI-R group ($M = 26.7$, $SD = 3.43$), [$t(200) = 54.80$, $p < .001$].

**Table 3.1.**

**Descriptive Statistics**

| Variables | *Mean* | *Min* | *Max* | *SD* | *Skewness* | *Kurtosis* |
|---|---|---|---|---|---|---|
| ROCI | 23.71 | 12 | 57 | 10.19 | .86 | -.07 |
| PROCSI | 44.81 | 24 | 98 | 15.7 | 1.09 | .47 |
| OCI-R | 42.89 | 18 | 84 | 12.39 | .46 | -.11 |
| IERQ | 64.22 | 27 | 100 | 13.71 | -.08 | -.19 |
| Reappraisal | 28.45 | 6 | 42 | 6.79 | -.66 | .37 |
| Supression | 14.63 | 4 | 28 | 5.19 | -.04 | -.75 |

***Note.*** *ROCI: Relationship Obsessive-Compulsive Inventory, PROCSI: Partner-Related Obsessive-Compulsive Symptoms Inventory, OCR-R: Obsessive–Compulsive Inventory-Revised, IERQ: Interpersonal Emotion Regulation Questionnaire, Reappraisal: Emotion Regulation Questionnaire Cognitive Reappraisal Subscale, Supression: Emotion Regulation Questionnaire Expressive Supression Subscale*

## 3.2. Analysis of ROCD and OCD Symptoms by Demographic Variables

To examine the relationship between age and both RC-OC, PF-OC and OCD symptoms, Pearson correlation analyses were conducted (see Table 3.2.). Pearson correlation analyses revealed that age was negatively associated with PROCSI ($r = –.16$, $p < .001$), ROCI ($r = –.19$, $p < .001$), and OCI-R ($r = –.13$, $p < .001$). These findings indicated that younger participants tended to report higher levels of PF-OC, RC-OC, and OCD symptoms.

To explore the relationship between relationship duration and RC-OC, PF-OC, and OCD symptoms, Pearson correlation analyses were conducted (see Table 3.2.). As three participants had missing data for relationship duration, the analysis was conducted on a subsample of 467 participants. The results indicated a significant negative correlation between relationship duration and ROCI ($r = –.19$, $p < .001$) indicating that longer relationship duration was associated with lower levels of RC-OC. Similarly, PROCSI were also negatively correlated with relationship duration ($r = –.14$, $p < .01$). These findings supported H1a and suggested that individuals in longer-term relationships reported lower levels of RC-OC and PF-OC symptoms.

Following the preliminary correlation analyses between the demographic variables and key outcome variables, a multivariate analysis of variance (MANOVA) was conducted to test whether participants' current relationship status (in a relationship and not in a relationship) led to significant differences in RC-OC symptoms, PF-OC symptoms, and OCD symptoms. The assumption of multicollinearity was checked by examining

intercorrelations among the dependent variables, and no correlation exceeded .90, indicating that multicollinearity was not a concern. Homogeneity of covariance matrices was tested using Box's M test, which was significant [$F(6, 2327971.32) = 10.85$, $p < .001$], indicating that this assumption was violated. Therefore, Pillai's Trace was used as a more robust test statistic for interpreting multivariate results. The overall MANOVA model was significant, Pillai's Trace = .18, $F(3, 748) = 53.48$, $p < .001$ indicating a significant multivariate effect of relationship status on the set of dependent variables. Follow-up univariate analyses revealed that participants in a relationship scored significantly higher on both ROCI ($M$ = 23.71, $SD$ = 10.19), $F(1, 750) = 122.25$, $p < .001$, $\eta^2 = .140$, and PROCSI ($M$ = 44.81, $SD$ = 15.70), $F(1, 750) = 130.39$, $p < .001$, $\eta^2 = .148$. However, there was no significant difference in OCI-R ($M$ = 42.89, $SD$ = 12.39) scores between the two groups, $F(1, 750) = 1.89$, $p$ = .169. To adjust for the risk of Type I error due to multiple comparisons, a Bonferroni correction was applied, resulting in a corrected alpha level of .016 (.05/3). The significance of the ROCI and PROCSI findings remained robust under this adjustment. The results remained significant for both ROCI and PROCSI scores, thereby supporting Hypothesis 1b.

**Table 3.2.**

**Correlations Between the Main Study Variables and Demographic Variables**

| Variables | 1. | 2. | 3. | 4. | 5. | 6. | 7. | 8. | 9. | 10. | 11. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **1. Age** | 1 | | | | | | | | | | |
| **2. Relationship Duration** | .82*** | 1 | | | | | | | | | |
| **3. ROCI** | -.19*** | -.19*** | 1 | | | | | | | | |
| **4. PROCSI** | -.16*** | -.14** | .74*** | 1 | | | | | | | |
| **5. OCI-R** | -.13*** | -.10* | .36*** | .32*** | 1 | | | | | | |
| **6. IERQ** | -.04 | -.05 | .27*** | .24*** | .13*** | 1 | | | | | |
| **7. Reappraisal** | .02 | -.01 | -.02 | .01 | -.09* | .13*** | 1 | | | | |
| **8. Supression** | -.03 | .02 | .18*** | .18*** | .24*** | -.13*** | .08* | 1 | | | |
| **9. IERQ-EPA** | -.002 | -.02 | .06 | .04 | -.01 | .60*** | .18*** | -.20*** | 1 | | |
| **10. IERQ-PT** | .03 | .01 | .22*** | .22*** | .16*** | .78*** | .12*** | .02 | .21*** | 1 | |
| **11. IERQ-S** | -.10** | -.10* | .27*** | .23*** | .15*** | .85*** | .05 | -.16*** | .43*** | .54*** | 1 |
| **12. IERQ-SM** | -.02 | -.05 | .27*** | .24*** | .10** | .86*** | .08* | -.06 | .35*** | .65*** | .61*** |

* p < .05, ** p < .01, *** p < .001 ***Note.*** *ROCI: Relationship Obsessive-Compulsive Inventory, PROCSI: Partner-Related Obsessive-Compulsive Symptoms Inventory, OCIR-R: Obsessive–Compulsive Inventory-Revised, IERQ: Interpersonal Emotion Regulation Questionnaire, Reappraisal: Emotion Regulation Questionnaire Cognitive Reappraisal Subscale, Suppression: Emotion Regulation Questionnaire Expressive Suppression Subscale, IERQ-EPA: Interpersonal Emotion Regulation Questionnaire Enhancing Positive Affect Subscale, IERQ-PT: Interpersonal Emotion Regulation Questionnaire Perspective-Taking Subscale, IERQ-S: Interpersonal Emotion Regulation Questionnaire Soothing Subscale, IERQ-SM: Interpersonal Emotion Regulation Questionnaire Social Modeling Subscale*

### 3.3. Correlations Between the Main Study Variables

To examine the relationships between the main study variables RC-OC symptoms, PF-OC symptoms, OCD symptoms, IER, and intrapersonal ER strategies, Pearson correlation analyses were conducted (see Table 3.2.). ROCI were positively and significantly correlated with both PROCSI ($r = .74, p < .001$) and OCI-R ($r = .36, p < .001$). ROCI was also positively correlated with IERQ total score ($r = .27$, $p < .001$), including subscales of perspective-taking ($r = .22$, $p < .001$), social modeling ($r = .27$, $p < .001$), and soothing ($r = .27$, $p < .001$), but not significantly related to enhancing positive affect. ROCI also showed a significant positive correlation with expressive suppression ($r = .18$, $p < .001$). However, cognitive reappraisal did not show a correlation with ROCI.

Likewise, PROCSI showed significant positive correlations with OCI-R ($r = .32$, $p < .001$) and IER total score ($r = .24$, $p < .001$), particularly with the subscales of soothing ($r = .23$, $p < .001$), social modeling ($r = .24$, $p < .001$), and perspective-taking ($r = .22$, $p < .001$). A significant positive correlation was also observed between PROCSI and suppression ($r = .18$, $p < .001$), an intrapersonal regulation strategy. Thereafter, OCI-R were positively correlated with IER total score ($r = .13$, $p < .001$) likewise other subscales such as perspective-taking ($r = .16, p < .001$), soothing ($r = .15, p < .001$), and social modeling ($r = .10, p < .01$). OCI-R also showed significant positive correlation with expressive suppression ($r = .24, p < .001$), while showing a weak negative correlation with cognitive reappraisal ($r = –.09, p = .007$).

The total score of IERQ was positively correlated with cognitive reappraisal ($r = .13$, $p < .001$) and negatively correlated with expressive suppression ($r = –.13, p < .001$). Among the IERQ subscales, enhancing positive affect ($r = .18$, $p < .001$) and perspective-taking ($r = .12, p < .001$) were positively correlated with cognitive reappraisal, whereas soothing ($r = –.16, p < .001$) and enhancing positive affect ($r = –.20, p < .001$) showed negative correlation with expressive suppression.

### 3.4. Differences in Emotion Regulation Strategies Across Obsessive-Compulsive Symptom Groups

To test Hypothesis 2a a one-way multivariate analysis of variance (MANOVA) was conducted to examine whether IER and ER strategies differed between participants with high levels RC-OC symptoms and those with high levels of OCD symptoms. The independent

variable was symptom group, which included two levels: the high RC-OC group (participants who scored high only on the ROCI) ($n$ = 90) and the high OCD group (participants who scored high only on the OCI-R) ($n$ = 84). The dependent variables included two intrapersonal ER strategies (expressive suppression and cognitive reappraisal) and four IER strategies from the IERQ (soothing, social modeling, perspective-taking, and enhancing positive affect). The assumption of homogeneity of covariance matrices was tested using Box's M test. The result was not significant ($p$ = .015) indicating that the covariance matrices of the dependent variables were equal across the two symptom groups. The multivariate test revealed a statistically significant overall effect of group [(*Wilks'* $\lambda$ = .92, $F(6, 167) = 2.508$, $p$ = .024, $\eta p^2$ = .083)]. However, to control Type I error across the six dependent variables, a Bonferroni-adjusted alpha level of .008 (.05/6) was applied. Based on this stricter threshold, only soothing and social modeling showed statistically significant group differences. Participants with high RC-OC symptoms ($M$ = 17.46, $SD$ = 4.56) reported significantly greater use of soothing compared to participants with high OCD symptoms ($M$ = 15.05, $SD$ = 4.70), [$F(1, 172) = 11.761$, $p < .001$, $\eta p^2 = .064$]. Participants with high RC-OC symptoms ($M$ = 18.03, $SD$ = 4.80) also reported significantly greater use of social modeling than those with high OCD symptoms ($M$ = 15.38, $SD$ = 5.49), [$F(1, 172) = 11.55$, $p$ = .001, $\eta p^2$ = .063]. However, no significant group differences were observed for the remaining ER strategies. Specifically, the use of cognitive reappraisal did not significantly differ between participants with high RC-OC symptoms ($M$ = 27.47, $SD$ = 6.51) and those with high OCD symptoms ($M$ = 26.92, $SD$ = 7.78). Similarly, expressive suppression scores did not differ between the two groups RC-OC ($M$ = 15.43, $SD$ = 4.78) and OCD ($M$ = 15.62, $SD$ = 5.20). In terms of IER strategies, no statistically significant differences were found in enhancing positive affect between RC-OC ($M$ = 21.03, $SD$ = 3.59) and OCD ($M$ = 20.12, $SD$ = 3.47), or in perspective-taking between RC-OC ($M$ = 13.66, $SD$ = 4.03) and OCD ($M$ = 12.63, $SD$ = 4.71). Hypothesis 2a was partially supported. While no significant differences were observed for the intrapersonal strategies (suppression, reappraisal) or for two IER strategies (enhancing positive affect, perspective-taking), the RC-OC group reported significantly greater use of soothing and social modeling, both of which are IER strategies.

To test Hypothesis 2b a one-way multivariate analysis of variance (MANOVA) was conducted to examine whether participants who reported high levels of PF-OC symptoms differed from those with high levels of OCD symptoms in their use of IER and ER strategies. The independent variable was symptom group, with two levels: the high PF-OC group (participants who scored high only on the PROCSI) ($n$ = 91) and the high OCD group

(participants who scored high only on the OCI-R) ($n = 92$). The dependent variables included two intrapersonal ER strategies (expressive suppression and cognitive reappraisal) and four IER strategies from the IERQ. The assumption of equality of covariance matrices was met, as indicated by a non-significant result on Box's M test ($p = .023$). To control for Type I error in follow-up univariate tests, a Bonferroni-adjusted alpha level of .008 (.05/6) was applied.

The multivariate test did not reveal a statistically significant overall effect of group, indicating that the combined dependent variables did not differ significantly between participants with high PF-OC symptoms and those with high OCD symptoms [(*Wilks'* $\lambda = .96$, $F(6, 176) = 1.18$, $p = .32$, $\eta p^2 = .039$)]. Based on these results, the hypothesis (2b) that participants with high levels of PF-OC symptoms would differ significantly from those with high OCD symptoms in their use of IER and intrapersonal ER strategies and participants with high PF-OC symptoms would report greater use of IER strategies was not supported by the findings.

To test Hypotheses 3a and 3b, another one-way multivariate analysis of variance (MANOVA) was conducted to examine whether participants with high and low levels of OCD symptoms differed in their use of IER and ER strategies. The independent variable was OCD symptom level, with two groups: high OCD ($n$ =137) and low OCD ($n = 143$) and the six dependent variables were cognitive reappraisal, expressive suppression, enhancing positive affect, perspective-taking, soothing, and social modeling. Box's M test was not significant ($p = .148$), indicating that the assumption of homogeneity of covariance matrices was met. To control Type I error, the significance level was adjusted using the Bonferroni correction and set at .008 ($p = .05/6$). As a result of the analysis, the model testing whether IER and ER scores differed according to OCD symptom group was found to be significant, [(*Wilks'* $\lambda = .82$, $F(6, 273) = 10.35$, $p < .001$, $\eta p^2 = .185$)], indicating that ER and IER strategies differed across OCD symptom levels. Participants with high OCD scores ($M = 16.06$, $SD = 5.34$) reported more frequent use of expressive suppression than those with low scores ($M = 12.64$, $SD = 4.92$), $F(1, 278) = 30.86$, $p < .001$, $\eta p^2 = .100$. Similarly, participants with high OCD scores showed significantly greater use of perspective-taking ($M = 13.50$, $SD = 4.81$) than the low-symptom participants ($M = 11.52$, $SD = 3.98$), $F(1, 278) = 14.02$, $p < .001$, $\eta p^2 = .048$. High OCD group ($M = 16.36$, $SD = 5.07$) showed greater use of soothing than low OCD group ($M = 14.35$, $SD = 4.81$), $F(1, 278) = 11.59$, $p = .001$, $\eta p^2 = .040$. Although social modeling appeared to be used more frequently by the high OCD group ($M = 16.53$, $SD = 5.18$) compared to the low OCD group ($M = 14.94$, $SD = 4.94$), this difference

did not reach statistical significance after adjusting for multiple comparisons, $F(1, 278) = 6.25$, $p = .013$, $\eta p^2 = .022$.

However, no significant differences were observed for cognitive reappraisal use of high OCD group ($M = 28.10$, $SD = 7.68$) and low OCD group ($M = 29.57$, $SD = 6.50$). Similarly high OCD group ($M = 20.20$, $SD = 3.68$) and low OCD group ($M = 20.20$, $SD = 3.60$) had no significant differences for enhancing positive affect use. These findings support Hypothesis 3a (greater use of suppression) and partially support Hypothesis 3b (greater use of IER) among participants with high OCD symptoms.

To test Hypotheses 4a and 4b, a one-way multivariate analysis of variance (MANOVA) was conducted to examine whether participants with high ($n$ =144) and low ($n$ = 116) levels of RC-OC symptoms differed in their use of ER strategies. The independent variable was RC-OC symptom level (high vs. low, based on ROCI scores), and the dependent variables were expressive suppression, cognitive reappraisal (intrapersonal strategies), and four IER strategies (soothing, social modeling, perspective-taking, and enhancing positive affect). Box's M test was not significant ($p = .172$), indicating that the assumption of equality of covariance matrices was met. The results revealed a statistically significant effect of RC-OC group on the combined dependent variables, [($Wilks' \lambda = .775$, $F(6, 253) = 12.23$, $p < .001$, $\eta p^2 = .225$)]. To control for Type I error in follow-up univariate tests, a Bonferroni-adjusted alpha level of .008 (.05/6) was applied. Results revealed that participants with high levels of RC-OC symptoms reported significantly greater use of several ER and IER strategies compared to those with low RC-OC symptoms. Specifically, high RC-OC ($M = 15.90$, $SD = 5.13$) participants reported more frequent use of expressive suppression than low RC-OC participants ($M = 13.85$, $SD = 4.78$), [$F(1, 258) = 11.90$, $p = .001$, $\eta p^2 = .044$]. Similarly, participants with high RC-OC symptoms ($M = 20.72$, $SD = 3.80$) showed greater use of enhancing positive affect strategies compared to low RC-OC participants ($M = 19.33$, $SD = 3.97$), [$F(1, 258) = 8.33$, $p = .004$, $\eta p^2 = .031$]. In addition, individuals in the high RC-OC group ($M = 14.08$, $SD = 4.26$) reported significantly higher levels of perspective-taking than those in the low group ($M = 11.94$, $SD = 3.94$), [$F(1, 258) = 17.17$, $p < .001$, $\eta p^2 = .062$], and greater use of soothing ($M = 17.79$, $SD = 4.72$) relative to the low RC-OC group ($M = 14.37$, $SD = 4.25$), [$F(1, 258) = 36.78$, $p < .001$, $\eta p^2 = .125$]. A similar pattern was observed for social modeling, with high RC-OC participants reporting greater use ($M = 18.09$, $SD = 4.62$) than those with low RC-OC symptoms ($M = 14.69$, $SD = 4.76$), [$F(1, 258) = 30.66$, $p < .001$, $\eta p^2 = .106$]. By contrast, no significant difference was observed between the high RC-OC

($M$ = 28.26, $SD$ = 6.82) and low RC-OC ($M$ = 28.77, $SD$ = 7.08) in their use of cognitive reappraisal.

Lastly, to test Hypotheses 4c and 4d, a one-way multivariate analysis of variance (MANOVA) was conducted to examine whether participants with high and low levels of PF-OC symptoms differed in their use of ER strategies. The independent variable was PF-OC symptom level, high ($n$ = 136) vs. low ($n$ = 83), based on PROCSI scores, and the dependent variables were expressive suppression, cognitive reappraisal (intrapersonal strategies), and four IER strategies (soothing, social modeling, perspective-taking, and enhancing positive affect). Box's M test was not significant, ($p$ = .568), indicating that the assumption of equality of covariance matrices was met. The results revealed a statistically significant effect of PF-OC group on the combined dependent variables, [$Wilks'\ \lambda$ = .867, $F(6, 212) = 5.42$, $p < .001$, $\eta p^2 = .133$)]. To control for Type I error, a Bonferroni-adjusted alpha level of .008 (.05/6) was used.

Analyses showed that participants with high PF-OC symptoms reported significantly greater use of several strategies. Expressive suppression was significantly higher among individuals with high PF-OC symptoms ($M$ = 16.07, $SD$ = 5.24) compared to those with low PF-OC symptoms ($M$ = 13.35, $SD$ = 5.30), $F(1, 217) = 13.74$, $p < .001$, $\eta p^2 = .060$. Similarly, participants high in PF-OC symptoms reported greater use of perspective-taking ($M$ = 14.10, $SD$ = 4.11) than those low in PF-OC ($M$ = 12.12, $SD$ = 4.03), $F(1, 217) = 11.82$, $p < .001$, $\eta p^2 = .052$. Soothing also differed significantly between groups, with the high PF-OC group scoring higher ($M$ = 17.40, $SD$ = 4.73) than the low PF-OC group ($M$ = 15.39, $SD$ = 4.23), $F(1, 217) = 9.43$, $p = .002$, $\eta p^2 = .042$. Lastly, social modeling was significantly more frequent in the high PF-OC group ($M$ = 17.59, $SD$ = 4.60) compared to the low PF-OC group ($M$ = 15.51, $SD$ = 4.68), $F(1, 217) = 9.00$, $p = .003$, $\eta p^2 = .040$. However, no significant group differences were found for cognitive reappraisal for high PF-OC ($M$ = 28.41, $SD$ = 6.35) and low PF-OC ($M$ = 27.20, $SD$ = 7.05), or enhancing positive affect use for high PF-OC ($M$ = 20.34, $SD$ = 3.96) and low PF-OC ($M$ = 20.07, $SD$ = 3.96). These findings supported Hypothesis 4c (greater use of suppression) and partially supported Hypothesis 4d (greater use of IER) among participants with high PF-OC symptoms. Table 3.3. presents a comprehensive summary of all findings from the multivariate analyses examining differences in IER and intrapersonal ER strategies across symptom groups.

**Table 3.3.**

**Summary of MANOVA Results on Interpersonal and Intrapersonal Emotion Regulation Strategies Across Symptom Groups**

| Group Comparison (IV) | Emotion Regulation Strategy (DV) | Direction of Difference |
|---|---|---|
| High RC-OC - High OCD | Suppression | — |
| | Reappraisal | — |
| | Soothing | Greater use in High RC-OC |
| | Social Modeling | Greater use in High RC-OC |
| | Perspective Taking | — |
| | Enhancing Positive Affect | — |
| High PF-OC - High OCD | Suppression | — |
| | Reappraisal | — |
| | Soothing | — |
| | Social Modeling | — |
| | Perspective Taking | — |
| | Enhancing Positive Affect | — |
| High - Low OCD | Suppression | Greater use in High OCD |
| | Reappraisal | — |
| | Soothing | Greater use in High OCD |
| | Social Modeling | Greater use in High OCD |
| | Perspective Taking | Greater use in High OCD |
| | Enhancing Positive Affect | — |
| High - Low RC-OC | Suppression | Greater use in High RC-OC |
| | Reappraisal | — |
| | Soothing | Greater use in High RC-OC |
| | Social Modeling | Greater use in High RC-OC |
| | Perspective Taking | Greater use in High RC-OC |
| | Enhancing Positive Affect | Greater use in High RC-OC |
| High - Low PF-OC | Suppression | Greater use in High PF-OC |
| | Reappraisal | — |
| | Soothing | Greater use in High PF-OC |
| | Social Modeling | Greater use in High PF-OC |
| | Perspective Taking | Greater use in High PF-OC |
| | Enhancing Positive Affect | — |

### 3.5. The Predictive Relationships Between Emotion Regulation Strategies and OCD Symptoms

The multiple linear regression assumptions have been examined before the regression analysis was performed. The data met the assumptions of linearity, independence of errors, normality of residuals, and homoscedasticity. Multicollinearity was also assessed using Tolerance and Variance Inflation Factor (VIF) values. All tolerance values were above .20 and all VIF values were below 2.5, indicating that multicollinearity was not a concern in the model. The Durbin-Watson values ranged from 1.680 to 1.737, indicating no severe autocorrelation in the residuals (Field, 2009). Following confirmation that assumptions were met, a hierarchical multiple regression analysis was conducted to examine whether IER and intrapersonal ER strategies predicted RC-OC symptoms, after controlling for age and relationship status (see Table 3.4.). Based on preliminary correlation analyses, cognitive reappraisal and enhancing positive affect were not included in the model due to nonsignificant correlations with RC-OC symptoms. In the first block, age and relationship status (no partner, in a relationship) were entered as control variables. This model was significant, [$F(2, 749) = 69.53$, $R^2 = .157$, $p < .001$], and explained 15.7% of the variance in RC-OC scores. Specifically, both age ($\beta = -.13$, $p < .001$) and relationship status ($\beta = .35$, $p < .001$) were significant predictors, indicating that younger individuals and those currently in a romantic relationship reported higher RC-OC symptom levels.

In the second block, the predictors included IER strategies of perspective-taking, soothing, and social modeling, along with the intrapersonal strategy of expressive suppression. After controlling for age and relationship status, the final regression model was significant, [$F(6, 745) = 43.95$, $R^2 = .261$ $p < .001$], and explained 26.1% of the variance in RC-OC symptoms. Five predictors were statistically significant: relationship status ($\beta = .32$, $p < .001$), age ($\beta = -.11$, $p < .001$), soothing ($\beta = .18$, $p < .001$), social modeling ($\beta = .12$, $p = .007$), and expressive suppression ($\beta = .19$, $p < .001$). Perspective-taking was not a significant predictor ($\beta = .03$, $p = .496$). These results partially supported Hypothesis 5a, indicating that certain IER strategies: soothing and social modeling significantly predict RC-OC symptoms. However, in line with Hypothesis 5d, expressive suppression emerged as the strongest predictor in the model.

In a subsequent hierarchical multiple regression analysis, the same set of predictors was used to examine whether IER and ER strategies predicted PF-OC symptoms, while controlling age and relationship status. Prior to conducting the hierarchical multiple

regression analysis, assumptions of linearity, normality, homoscedasticity, and absence of multicollinearity were examined and met. Tolerance values ranged from .483 to .959 and VIF values were all below 2.5, indicating no multicollinearity concerns. The Durbin-Watson value was 1.683, indicating no major autocorrelation in the residuals (Field, 2009). In the first block, age and relationship status were entered as control variables. The model was statistically significant, [$F(2, 749) = 70.0$, $R^2 = .158$ $p < .001$], accounting for 15.8% of the variance in PF-OC scores. Both predictors were significant: younger age ($\beta = -.10$, p = .004) and being in a romantic relationship ($\beta = .37$, p < .001).

In the second block, the predictors included the IER strategies of perspective-taking, soothing, and social modeling, along with the intrapersonal strategy of expressive suppression. Cognitive reappraisal and enhancing positive affect were again excluded due to nonsignificant correlations with the dependent variable. The regression model was statistically significant, [$F(6, 745) = 39.44$, $R^2 = .241$ $p < .001$], and explained 24.1% of the variance in PF-OC symptoms. Relationship status ($\beta = .34$, $p < .001$), expressive suppression ($\beta = .17$, $p < .001$), and soothing ($\beta = .13$, $p = .003$) emerged as significant predictors of PF-OC. Perspective-taking ($\beta = .09$, $p = .044$) was a marginally significant predictor, whereas social modeling ($\beta = .08$, $p = .088$) did not reach significance. Age was also a significant negative predictor ($\beta = –.09$, $p = .008$), indicating that younger participants reported more severe PF-OC symptoms. These findings provide partial support for Hypothesis 5b, as only soothing significantly predicting PF-OC among the IER strategies. However, consistent with Hypothesis 5e, expressive suppression had the strongest effect among all predictors, indicating that expressive suppression plays a more dominant role in the prediction of PF-OC symptoms.

To test Hypotheses 5c and 5f, a hierarchical multiple regression analysis was conducted to examine whether IER and intrapersonal ER strategies predicted general OCD symptoms, while controlling for age and relationship status (see Table 3.4.). Prior to analysis, the assumptions of multiple linear regression were checked and met. No issues of multicollinearity were detected; tolerance values ranged from .483 to .977 and all VIF values were below 2.5. The Durbin-Watson value was 1.680, indicating no severe autocorrelation in the residuals. (Field, 2009). In the first block, age and relationship were entered as control variables. The model was statistically significant, [$F(2, 749) = 6.65$, $R^2 = .0174$, $p = .001$], explaining 1.7% of the variance in OCIR scores. Within this model, age was a significant negative predictor ($\beta = -.12$, $p < .001$), indicating that younger individuals reported higher OCD symptoms. Relationship status was not a significant predictor ($\beta = .03$, $p = .405$). In

the second block, the predictors included both IER strategies: perspective-taking, soothing, and social modeling besides intrapersonal strategies: reappraisal and suppression. Based on preliminary correlation analyses, enhancing positive affect was not included in the model due to nonsignificant correlations with OCD symptoms The regression model was statistically significant, [$F(7, 744) = 15.06$, $R^2 = .124$, $p < .001$], and explaining 12.4% of the variance in OCD symptoms. Expressive suppression ($\beta = .26$, $p < .001$), soothing ($\beta = .14$, $p = .002$), perspective-taking ($\beta = .12$, $p = .013$), and reappraisal ($\beta = –.13$, $p < .001$) were all significant predictors. In contrast, social modeling ($\beta = –.04$, $p = .471$) was not a significant predictor of OCD symptoms. Additionally, age remained a significant negative predictor ($\beta = –.11$, $p = .002$), while relationship status was not significant ($\beta = .01$, $p = .853$). These results supported Hypothesis 5c, as two IER strategies: soothing and perspective-taking significantly predicted OCD symptoms. Hypothesis 5f was also supported, as expressive suppression was again the strongest positive predictor and reappraisal negatively predicted OCD symptoms as expected.

**Table 3.4.**

**Regression Analysis of OCD Symptoms Predicted by Emotion Regulation Strategies**

| Predictor | *b* | SE | *t* | *p* | *β* | *F* | $R^2$ |
|---|---|---|---|---|---|---|---|
| **ROCI** | | | | | | | |
| Model 1 | | | | | | 69.5 | .157 |
| Relationship | 7.47 | .72 | 10.41 | < .001 | .35 | | |
| Age | -.18 | .05 | -3.82 | < .001 | -.13 | | |
| Model 2 | | | | | | 43.9 | .261 |
| Relationship | 6.70 | .68 | 9.87 | < .001 | .32 | | |
| Age | -.15 | .04 | -3.45 | < .001 | -.11 | | |
| IERQ-PT | .07 | .11 | .68 | .496 | .03 | | |
| IERQ-S | .38 | .09 | 4.20 | < .001 | .18 | | |
| IERQ-SM | .25 | .09 | 2.70 | .007 | .12 | | |
| Suppression | .38 | .06 | 5.90 | < .001 | .19 | | |
| **PROSCI** | | | | | | | |
| Model 1 | | | | | | 70.0 | .158 |
| Relationship | 11.94 | 1.10 | 10.87 | < .001 | .37 | | |
| Age | -.21 | .07 | -2.90 | .004 | -.10 | | |
| Model 2 | | | | | | 39.4 | .241 |
| Relationship | 10.95 | 1.05 | 10.39 | < .001 | .34 | | |
| Age | -.18 | .07 | -2.65 | .008 | -.09 | | |
| IERQ-PT | .33 | .17 | 2.01 | .044 | .09 | | |
| IERQ-S | .42 | .14 | 3.00 | .003 | .13 | | |
| IERQ-SM | .25 | .14 | 1.71 | .088 | .08 | | |
| Suppression | .52 | .10 | 5.22 | < .001 | .17 | | |

| Predictor | *b* | SE | *t* | *p* | *β* | *F* | $R^2$ |
|---|---|---|---|---|---|---|---|
| **OCI-R** | | | | | | | |
| Model 1 | | | | | | 6.65 | .017 |
| Relationship | .78 | .94 | .83 | .405 | .03 | | |
| Age | -.21 | .06 | -3.37 | < .001 | -.12 | | |
| Model 2 | | | | | | 15.06 | .124 |
| Relationship | .17 | .90 | .19 | .853 | .01 | | |
| Age | -.18 | .06 | -3.06 | .002 | -.11 | | |
| IERQ-PT | .35 | .14 | 2.49 | .013 | .12 | | |
| IERQ-S | .37 | .12 | 3.09 | .002 | .14 | | |
| IERQ-SM | -.09 | .12 | -.72 | .471 | -.04 | | |
| Suppression | .63 | .08 | 7.44 | < .001 | .26 | | |
| Reappraisal | -.24 | .06 | -3.77 | < .001 | -.13 | | |

***Note.*** *ROCI: Relationship Obsessive-Compulsive Inventory, PROCSI: Partner-Related Obsessive-Compulsive Symptoms Inventory, OCIR-R: Obsessive–Compulsive Inventory-Revised, IERQ-PT: Interpersonal Emotion Regulation Questionnaire Perspective Taking Subscale, IERQ-S: Interpersonal Emotion Regulation Questionnaire Soothing Subscale, IERQ-SM: Interpersonal Emotion Regulation Questionnaire Social Modeling Subscale, Suppression: Emotion Regulation Questionnaire Expressive Suppression Subscale, Reappraisal: Emotion Regulation Questionnaire Cognitive Reappraisal Subscale*

# 4. DISCUSSION

This research sought to explore the connection between IER and intrapersonal ER techniques and different subtypes of obsessive-compulsive symptoms, such as RC-OC, PF-OC, and general OCD. Beyond between-group comparisons, the study also explored within-group patterns and predictive associations using MANOVA and hierarchical multiple regression analyses. By focusing on both IER and intrapersonal ER, the study addressed a notable gap in literature. Although previous research has highlighted the relevance of ER in various forms of psychopathology, including OCD, studies rarely differentiate between specific subtypes like ROCD. This study adds to the expanding literature by examining whether different symptom profiles are associated with distinct forms of ER, and whether IER strategies in particular show stronger associations with OCD, RC-OC, or PF-OC symptoms. Previous research has extensively demonstrated the importance of ER processes in various psychological disorders, emphasizing the critical role ER strategies play in symptom development and maintenance. However, literature specifically examining ER strategies within the context of ROCD remains limited. Although existing studies have established connections between ER strategies and general OCD symptoms, these studies typically fail to distinguish between distinct OCD subtypes such as RC-OC and PF-OC, leading to an oversimplified understanding of the disorder's emotional regulatory mechanisms.

In this section, the observed associations between ROCD and OCD symptoms, demographic factors, and core study variables are examined within the context of prior research. Group differences in ER strategies based on RC-OC, PF-OC, and OCD symptoms are also interpreted. Additionally, the predictive roles of IER and intrapersonal ER strategies on each symptom domain were evaluated within the context of relevant conceptual models and research-based evidence. Lastly, limitations of this research, clinical significance of the results, and directions for future investigations have been discussed.

## 4.1. Discussion of ROCD and OCD Symptoms in Relation to Demographic Variables

The present study explored how demographic factors such as age, relationship duration, and relationship status relate to OCD and ROCD symptoms. Pearson correlation analyses revealed that younger participants reported significantly higher levels of OCD symptoms as well as RC-OC and PF-OC symptoms, suggesting that symptom severity tends to decline with age. These results are consistent with epidemiological data showing that the

lifetime prevalence of OCD tends to peak during adolescence and early adulthood, particularly between the ages of 15 and 25 which is a period marked by heightened emotional vulnerability and identity development (Fawcett et al., 2020). Additionally, Butwicka and Gmitrowicz (2010) reported that adolescents exhibited different OCD symptom profiles compared to adults, with religious and sexual obsessions, as well as various compulsions (e.g., listmaking, confessing), being more frequent in younger populations. Their findings propose that OCD symptom clusters may shift developmentally, and that early-onset OCD could represent a more severe or heterogeneous subtype. Similarly, Hunt (2020) highlighted that younger individuals tend to report broader and more diverse OCD symptoms when measured through self-report, possibly reflecting less crystallized symptom patterns and greater emotional vulnerability. Furthermore, developmental research suggests that the period between ages 18 to 25, often described as emerging adulthood, is characterized by intensified exploration of romantic relationships, increased emotional investment, and a growing tendency to reflect on long-term relational compatibility (Arnett, 2000). During this life stage, individuals may begin to search for deeper meaning and security in their intimate relationships, which can, in turn, heighten vulnerability to doubts, uncertainty, and obsessive concerns about one's partner or the relationship itself. This developmental lens may partially explain the elevated RC-OC and PF-OC symptom levels observed in younger individuals in the present sample (Toroslu, 2020). In particular, the preoccupation with the rightness of the relationship or the truly ideal partner may become more salient as individuals navigate decisions related to commitment and future orientation.

The results showed that, in addition to age-related variations, an extended relationship duration was substantially linked with reduced levels of RC-OC and PF-OC symptoms. This finding supports Hypothesis 1a low levels of RC-OC and PF-OC symptoms is expected to be associated with extended relationship duration and supports emerging findings about the ongoing development and commitment within romantic relationships may help buffer individuals against obsessive-compulsive tendencies centered around the relationship (Toroslu & Çırakoğlu, 2023; Trak, 2016). In line with these findings, it has been proposed that the maturation of romantic relationships may help reduce obsessive doubts and partner related distress, likely due to increased emotional security and relational stability over time (Tinella et al., 2023). It has been suggested that longer relationships promote greater stability, emotional security, and communication patterns (Berscheid & Reis, 1998; Hadden et al., 2014). In this context, relationship duration might serve as a protective role by facilitating relational trust and reducing the perceived need for constant reassurance or cognitive

checking behaviors which are the mechanisms commonly observed in individuals experiencing ROCD symptoms.

Further supporting this interpretation, the study's MANOVA results showed that participants currently in a intimate-relationship reported significantly higher levels of both RC-OC and PF-OC symptoms compared to those who were not, in line with the study Hypothesis 1b anticipates that participants presently involved in a romantic partnership will exhibit greater severity in RC-OC as well as PF-OC symptomatology compared to individuals who are single. Interestingly, however, this pattern was specific to ROCD symptom dimensions, as no significant difference emerged in OCD symptoms between these two groups. It is possible that this pattern stems from the presence of a current partner and provides a concrete relational context in which ROCD symptoms can be activated. For example, triggering doubts about one's partner's qualities or fears about the rightness of the relationship. In contrast, individuals who are not currently in a relationship may not experience the same intensity or frequency of relational intrusions simply because there is no active partner to focus on or evaluate.

This interpretation aligns with Doron and colleagues (2016) cognitive-behavioral conceptualization of ROCD, which emphasizes that obsessive concerns often revolve around rigid beliefs about the necessity of being in the "right" relationship. These beliefs are more easily activated when a relationship is ongoing, as daily interactions may serve as cues for doubt, emotional conflict, or evaluative rumination. Notably, the current findings also emphasize that ROCD symptoms are not merely a byproduct of general OCD tendencies but rather may manifest distinctly in relational contexts. Suggesting the need for relationship-specific assessment and intervention strategies. That ROCD symptoms were elevated only among those currently in relationships, while general OCD symptoms remained unaffected by relationship status, reinforces this distinction.

All things considered, the results of this investigation show that in the development and intensity of RC-OC and PF-OC, relational dynamics and developmental factors both play a key role. Variables related to age may reflect broader maturational processes, while relational variables such as duration and status shape the immediate activation or suppression of ROCD-related processes. According to these results, the relational context in both the assessment and treatment of OCD-related symptoms plays an important role, particularly for individuals who present with RC-OC concerns.

### 4.2. Discussion of Correlational Analyses Among the Main Study Variables

The correlational analyses among the primary symptom variables provided further support for the conceptual connection between ROCD dimensions and OCD symptoms, while also highlighting the distinct yet interconnected nature of RC-OC and PF-OC tendencies. The strongest correlation was observed between ROCI and PROCSI, indicating that individuals who experience intrusive doubts and compulsions about their relationship are also likely to experience similar symptoms specifically related to their partner. The results align with previous literature highlighting that different dimensions of ROCD often present together rather than in isolation (Doron et al., 2012a, 2016). The moderate correlations observed between these ROCD dimensions and OCD symptoms suggest that although they share fundamental obsessive-compulsive features, relationship-specific concerns represent a distinct yet related area (Doron et al., 2012a).

Both RC-OC and PF-OC symptoms were positively correlated with IER strategies, particularly soothing, taking perspective, and social modeling. Individuals experiencing ROCD related distress may be more likely to rely on others to manage their emotional states, seeking reassurance, validation, or alternative perspectives in response to their intrusive thoughts according to the results. Previous research has suggested that individuals experiencing psychological distress often turn to others for emotional regulation, especially through strategies that involve seeking comfort, guidance, or validation (Gökdağ, 2021; Hofmann et al., 2016). For instance, soothing has been linked to heightened anxiety and distress, especially among people with anxious attachment styles. This may reflect a tendency to seek reassurance and emotional containment from others as a way to manage overwhelming emotional experiences. Interestingly, neither symptom type was significantly related to the enhancing positive affect strategy, which may indicate that the IER strategies used by individuals with elevated ROCD symptoms are oriented more toward regulating distress than cultivating positive relational emotions. These findings also be interpreted in relation to previous findings on attachment tendencies in literature. Attachment anxiety has been associated with increased vulnerability to ROCD (Doron et al., 2014). Gökdağ (2021) found that individuals with high attachment anxiety were more likely to use IER strategies such as soothing and social modeling but not enhancing positive affect. This pattern may suggest that individuals prone to ROCD symptoms primarily use IER strategies to manage distress and reduce perceived relational threats rather than to increase or savor positive emotions.

Moreover, OCD symptoms also showed small but significant positive correlations with overall IER and specific strategies such as taking perspective, soothing, and social modeling. Although there were weaker correlations compared to ones observed with ROCD symptoms, These results imply that people who experience greater OCD symptoms might also use IER strategies to control their distress. This may reflect a more general tendency among individuals with OCD tendencies to seek reassurance or external input when faced with intrusive thoughts or uncertainty. However, the relatively modest strength of these associations may also indicate that IER plays a more prominent role in ROCD, than in broader OCD symptomatology. Moreover, the lack of a significant relationship between OCD symptoms and the use of enhancing positive affect may be explained by previous findings suggesting that individuals with OCD may struggle with or even fear experiencing positive emotions (Stern et al., 2014). Because OCD is often centered around anxiety and threat, strategies that aim to increase positive emotions might feel less relevant or harder to use for individuals with higher OCD symptoms.

Regarding intrapersonal ER strategies, expressive suppression was significantly associated with increased RC-OC, PF-OC, and general OCD symptoms, consistent with literature emphasizing suppression as a maladaptive strategy linked to psychopathology (Aldao et al., 2010; Bischof et al., 2024). Suppression may serve as an immediate but ineffective coping mechanism to reduce distress, reinforce obsessive thoughts and compulsive behaviors in the long term. Conversely, cognitive reappraisal was not significantly correlated with RC-OC or PF-OC and even showed a small negative correlation with general OCD symptoms. One possible explanation is that cognitive reappraisal requires significant cognitive flexibility and emotional insight, which might be challenging for individuals experiencing intense obsessive doubts and anxiety-driven compulsions. Furthermore, the absence of significant correlations between reappraisal and ROCD could suggest that relational obsessions might inherently involve rigid cognitive patterns that make adaptive reframing difficult.

Non-significant correlations such as those between RC-OC and PF-OC symptoms with enhancing positive affect and cognitive reappraisal are also important. The lack of significant association with enhancing positive affect might indicate that individuals with ROCD primarily experience their relationships as sources of anxiety and distress rather than as contexts for positive emotional engagement. This may limit their ability or willingness to pursue positive emotional regulation strategies. Similarly, the non-significant relationship between cognitive reappraisal and ROCD symptoms could suggest that relationship-related

obsessive doubts and worries might be particularly resistant to cognitive restructuring efforts. These findings emphasize the need for tailored interventions addressing emotional regulation deficits specific to relational obsessive-compulsive phenomena.

### 4.3 Discussion of Group Differences in Emotion Regulation Strategies

The current study aimed to explore whether different OCD symptom profiles (RC-OC, PF-OC, and OCD) were associated with distinct patterns of IER and intrapersonal ER strategies. Findings largely supported the hypotheses, highlighting meaningful group differences in IER and ER usage across symptom types. Starting with Hypothesis 2a, significant differences between high RC-OC and high OCD groups emerged only for specific IER strategies, soothing and social modeling. The reliance on these IER strategies among individuals with high RC-OC symptoms aligns with previous literature emphasizing the relational nature of RC-OC, wherein individuals frequently experience intense relational anxieties, driving them to seek comfort, reassurance, and emotional guidance from others (Doron et al., 2014). Additionally, these findings reflect the IER framework, suggesting that relational distress can heighten individuals' reliance on external emotional validation and support (Lemay et al., 2024). Since RC-OC symptoms are directly tied to the romantic relationship itself, it is understandable that individuals experiencing these doubts may look to others for guidance, or comfort. IER strategies such as asking for advice or seeking reassurance may feel especially important when emotional distress is closely linked to one’s relationship dynamics. However, contrary to expectations, no significant differences appeared for enhancing positive affect, taking perspective, or the intrapersonal strategies of suppression and reappraisal. The absence of significant differences in enhancing positive affect, perspective-taking, and cognitive reappraisal between these groups may indicate that the relational anxieties central to RC-OC primarily trigger reassurance-seeking behaviors. This reliance on reassurance might overshadow proactive strategies aimed at fostering positive emotions or cognitive restructuring, highlighting the specific emotional management needs within RC-OC concerns. Enhancing positive affect and perspective-taking strategies involve actively cultivating positive feelings or cognitively reframing one's emotional experiences through interactions with others. Both individuals with RC-OC and those with general OCD symptoms typically experience heightened anxiety, uncertainty, and repetitive negative cognitions (Abramowitz et al., 2009; Doron et al., 2012). These emotional and cognitive burdens might limit their ability or willingness to effectively employ strategies that require cognitive flexibility and positive interpersonal engagement. This finding

suggests that RC-OC doubts primarily activate the need for comfort and external validation rather than proactive positive emotion enhancement or cognitive reframing. Moreover, expressive suppression may operate similarly across OCD subtypes due to shared underlying emotional processing difficulties. This finding may reflect common underlying emotional processing difficulties rather than distinctive relational dynamics.

Contrary to Hypothesis 2b, participants with high PF-OC symptoms did not significantly differ from individuals with high OCD symptoms regarding their use of IER or intrapersonal ER strategies. Although descriptive trends indicating slightly higher IER use among the PF-OC group, these differences were not statistically significant. A possible explanation for this lack of significant differences is that individuals with PF-OC symptoms experience emotional ambivalence regarding interpersonal support, given their distress centers around perceived flaws in their partners. Seeking reassurance from others, particularly their partners, could inadvertently reinforce their doubts or heighten anxiety by potentially confirming these concerns. This internal conflict may hinder individuals from actively seeking external emotional support despite experiencing significant relational distress. Additionally, PF-OC and general OCD share underlying cognitive mechanisms such as maladaptive appraisals and reassurance-seeking behaviors, possibly contributing to the observed similarities in ER strategy use between these groups (Doron et al., 2012b). Since both symptom profiles involve frequent negative appraisals and intrusive thoughts, individuals from both groups may rely similarly on maladaptive strategies like suppression or reassurance-seeking. Therefore, subtle differences in emotional regulation strategies between these groups might be obscured by shared cognitive vulnerabilities, limiting the likelihood of detecting statistically significant differences.

Additionally, supporting Hypothesis 3a, individuals exhibiting elevated OCD symptoms were found to rely more heavily on expressive suppression than those with lower symptom levels. This aligns with previous research emphasizing suppression as a common maladaptive ER strategy frequently employed by individuals experiencing obsessive-compulsive distress to temporarily manage intrusive, anxiety-provoking thoughts (Aldao et al., 2010; Livingstone & Srivastava, 2012; Stern et al., 2014). Expressive suppression, characterized by efforts to inhibit the outward expression of emotions, frequently emerges as a maladaptive regulatory mechanism within OCD. Suppression might temporarily reduce immediate distress triggered by intrusive thoughts but typically exacerbate symptoms over time by reinforcing avoidance behaviors and preventing adaptive emotional processing. Clinically, this indicates suppression may serve as a short-term coping mechanism that

inadvertently maintains obsessive-compulsive cycles by increasing internal tension and emotional buildup (Stern et al., 2014). Supporting this notion, Çapar Taşkesen and İnözü (2024) experimentally demonstrated that individuals with higher OCD symptoms relied significantly more on expressive suppression, which not only increased their momentary distress but also impaired their ability to effectively regulate negative emotions over time. Expressive suppression's dominance among individuals with OCD symptoms highlights its critical role in symptom maintenance. Suppression functions primarily through emotional avoidance, temporarily reducing distress but ultimately reinforcing obsessive-compulsive cycles by blocking adaptive emotional processing and promoting cognitive rigidity (Hayes et al., 1996; Gross & John, 2003). Indeed, consistent with these findings, Çapar Taşkesen (2023) emphasized that difficulties in choosing appropriate ER strategies, particularly the increased reliance on suppression, significantly predicted greater severity of OCD symptoms, suggesting that maladaptive regulation further maintains obsessive-compulsive cycles. Consequently, suppression not only perpetuates distress internally but may also negatively affect interpersonal dynamics and relationship satisfaction (Chervonsky & Hunt, 2017).

Hypothesis 3b, predicting greater use of IER strategies among high OCD participants, was partially supported. Significant differences emerged specifically for soothing and perspective-taking, but not for enhancing positive affect and social modeling. These IER strategies may indicate broader IER challenges frequently observed in OCD, prompting individuals to externalize their emotional regulation through reassurance seeking and social referencing behaviors (Bischof et al., 2024). These findings suggest that individuals with elevated OCD symptoms engage in reassurance seeking and taking perspective as methods to manage distress, possibly reflecting broader difficulties with internally regulating their emotions effectively. One possible reason for this selective use of IER strategies is related to the nature of OCD-related distress. Individuals with OCD may prioritize strategies that immediately relieve anxiety or uncertainty, such as reassurance-seeking (soothing) or attempting to cognitively reframe distress through external input (taking perspective). In contrast, strategies focused on enhancing positive affect or modeling behavior from others may be less appealing or perceived as less effective in addressing their immediate emotional distress. Additionally, individuals with OCD might experience difficulty genuinely feeling or appreciating positive emotions due to their persistent anxiety and repetitive negative thoughts. This difficulty may also help explain why efforts to increase uplifting emotional experiences were not significantly more frequent among individuals with elevated OCD

symptoms. The absence of differences in social modeling could also reflect heightened concerns about uncertainty and the reliability of others' emotional responses. For example, individuals with OCD may perceive modeling emotional responses from others as risky or unreliable, as it may not guarantee emotional safety or reduce uncertainty effectively. Future research studies might delve deeper into the cognitive and motivational bases that shape how individuals with OCD selectively rely on IER.

Fully supporting Hypotheses 4a and 4b, participants with high RC-OC symptoms significantly utilized expressive suppression and all four IER strategies (soothing, social modeling, perspective-taking, and enhancing positive affect) more frequently than those with lower RC-OC symptom levels. These results highlight the strong relational focus of RC-OC symptoms, driving individuals toward IER strategies for emotional management. The intensive use of soothing and social modeling strategies underscores the role of attachment-related anxieties common in RC-OC, where external reassurance and emotional modeling from others become crucial for managing relational uncertainties and distress (Doron et al., 2014; Lemay et al., 2024). The greater reliance on soothing and social modeling among individuals with RC-OC may reflect heightened attachment-related anxieties, driving them to frequently seek external validation and reassurance. This broader reliance on various IER strategies could reflect an overall increased interpersonal sensitivity and heightened relational vigilance observed in individuals experiencing elevated relationship-centered anxiety. From an attachment perspective (Shaver & Mikulincer, 2007), individuals experiencing heightened relational uncertainty may be particularly prone to use IER strategies that provide immediate emotional comfort and reassurance, thereby temporarily alleviating relational distress.

Additionally, intrapersonal ER strategy use, particularly expressive suppression, was also more frequent among individuals with high RC-OC symptoms. This pattern was similarly observed among participants with high OCD symptoms, and high PF-OC symptoms who reported significantly greater use of suppression compared to those with lower symptom levels. The current results align with earlier studies indicating that suppression is frequently employed, though maladaptive, as an ER method by people with obsessive-compulsive tendencies. Suppression has been reliably linked to elevated psychopathological symptoms, especially in disorders related to anxiety, as indicated by Aldao and colleagues (2010). Suppression may serve as a short-term strategy to dampen emotional intensity in individuals with OCD, but it tends to be ineffective in resolving deeper

distress. Instead, it may reinforce avoidance and contribute to the persistence of obsessive-compulsive cycles by preventing the processing of emotional experiences.

Regarding the comparison between high and low PF-OC groups, significant differences were observed for expressive suppression, perspective-taking, soothing, and social modeling, with individuals in the high PF-OC group reporting more frequent use of these strategies. However, cognitive reappraisal and enhancing positive affect did not significantly differ between these groups. A possible explanation for this selective use of strategies could be related to the nature of partner-focused obsessions. Individuals experiencing PF-OC symptoms primarily focus on perceived flaws or inadequacies of their partners, causing them considerable emotional distress and uncertainty. Expressive suppression might serve as an immediate but maladaptive method to manage the negative emotions triggered by these intrusive doubts. Therefore, the frequent use of suppression observed in all of the OCD, RC-OC, and PF-OC groups may reflect a broader difficulty in managing distressing internal states, highlighting the need for interventions that promote more adaptive and flexible emotional coping strategies.

Meanwhile, taking perspective, soothing, and social modeling strategies might be used frequently as interpersonal attempts to manage anxiety indirectly, through external validation or by understanding their situation through others' eyes. In contrast, cognitive reappraisal and enhancing positive affect may require greater cognitive and emotional resources, as well as a positive view of the partner, making these strategies less accessible or appealing to individuals with pronounced partner-related doubts. The persistent negative evaluations of the partner could limit the effectiveness or authenticity of attempts to cognitively reframe situations positively or enhance positive emotional experiences within the relationship, thus explaining the lack of significant differences for these strategies.

Across all comparisons, cognitive reappraisal did not significantly differ. This finding suggests that individuals experiencing OCD and RC-OC and PF-OC symptoms may not rely heavily on this more adaptive intrapersonal strategy. This might be because reappraisal is not a naturally accessible or habitual strategy for many individuals. Unlike suppression or interpersonal reassurance seeking, cognitive reappraisal requires significant cognitive flexibility, emotional insight, and a level of cognitive flexibility that may not be readily available, particularly in the face of intrusive thoughts and uncertainty. As such, it may not be as easily drawn upon in emotionally overwhelming situations, especially for those experiencing obsessive-compulsive symptoms. (Bischof et al., 2024; See et al., 2022; Sheppes & Gross, 2012). Consequently, individuals experiencing OCD and ROCD

symptoms may struggle to engage effectively in cognitive reframing to manage their emotional distress. Previous research has highlighted that individuals with OCD may struggle to identify and accept their emotional experiences (See et al., 2022), and even fear positive emotions (Stern et al., 2014), potentially reducing the likelihood that they engage in reappraisal to manage distress. Instead, their regulation efforts may center more around controlling or avoiding emotional responses, both internally through suppression and externally through IER means. These findings align with prior studies emphasizing how maladaptive strategies, such as suppression, contribute to the onset and persistence of psychological distress (Aldao et al., 2010; Stern et al., 2014). Individuals exhibiting heightened symptoms may engage in suppression to dampen the emotional impact of intrusive thoughts. Additionally, engaging more frequently in IER, such as seeking reassurance or emotional support.

Overall, the findings of this study highlight the complexity and variability in IER and ER strategies across distinct obsessive-compulsive symptom profiles. Maladaptive strategies like expressive suppression emerged consistently, likely contributing to symptom maintenance. However, IER regulation strategies varied significantly based on the relational contexts of the symptoms. The importance of tailoring ER interventions to the unique cognitive and relational dynamics of RC-OC, PF-OC, and general OCD presentations, potentially enhancing therapeutic outcomes and overall emotional well-being highlighted by these differential IER and ER patterns.

### 4.4. Discussion of the Predictive Relationships Between ER Strategies and OCD Symptoms

The predictive roles of IER and intrapersonal ER strategies in relation to RC-OC, PF-OC, and OCD symptoms are further explored by the current study. The findings provided substantial insights into the nuanced roles of these strategies, revealing suppression as a consistently influential predictor across all symptom types.

Regarding Hypothesis 5a, results showed that among the IER strategies, soothing and social modeling significantly predicted RC-OC symptoms. These findings indicate that individuals experiencing RC-OC symptoms tend to heavily rely on external sources for emotional support, reassurance, and validation when confronted with distressing relationship-related thoughts. However, taking perspective did not significantly predict RC-OC symptoms, suggesting that merely understanding another's emotional state without

actively seeking reassurance or guidance may be insufficient to manage intrusive relational doubts. Notably, expressive suppression emerged as the strongest predictor, in line with Hypothesis 5d. This result highlights that individuals with high RC-OC symptoms primarily attempt to cope through emotional inhibition and avoidance, likely due to intense anxiety and relational uncertainty. It is relevant with past findings indicating that suppression is often associated with greater emotional distress and maladaptive outcomes (Aldao et al., 2010; Gross, 2015). Research by Judah and colleagues (2022) also suggests that high suppression, particularly when paired with low reappraisal, may contribute to more severe psychological symptoms. In the current study, the absence of cognitive reappraisal as a significant predictor of ROCD symptoms may further reflect this imbalance, suggesting that individuals with elevated RC-OC symptoms may underutilize adaptive strategies in favor of more avoidant approaches.

Similarly, Hypothesis 5b was partially supported, with soothing significantly predicting PF-OC symptoms, while perspective taking and social modeling showed weaker or marginal predictive effects. Expressive suppression again stood out as the strongest predictor, consistent with Hypothesis 5e. This pattern emphasizes the maladaptive reliance on suppression by individuals with PF-OC obsessions. Suppression in this context likely functions as a coping mechanism to temporarily reduce anxiety stemming from doubts about a partner's perceived flaws or suitability. However, such avoidance-oriented regulation strategies may paradoxically intensify intrusive thoughts over time due to limited emotional processing and cognitive rigidity. These findings align with previous research emphasizing suppression's role in sustaining psychological distress rather than alleviating it effectively (Gross, 2015; Judah et al., 2022).

Testing Hypothesis 5c, the regression analyses revealed soothing and perspective-taking as significant predictors of general OCD symptoms. These strategies likely represent attempts to externally manage obsessive distress through reassurance and emotional validation from others, reflecting broader challenges in intrapersonal emotional regulation typically observed in OCD presentations. Supporting Hypothesis 5f, expressive suppression again emerged as the strongest positive predictor, emphasizing suppression's critical role in maintaining OCD symptomatology. Moreover, cognitive reappraisal negatively predicted OCD symptoms, aligning with the understanding that adaptive strategies like reappraisal can effectively mitigate distress by facilitating emotional clarity and cognitive flexibility. The

significant negative relationship between cognitive reappraisal and OCD symptoms highlights the protective potential of adaptive ER strategies when effectively employed.

Expressive suppression's consistent emergence as the strongest predictor across all models reflects its critical role in obsessive-compulsive psychopathology. Although suppression may help individuals temporarily avoid or control distressing thoughts, the long-term use is associated with interpersonal losses. Meta-analytic research has shown that using suppression in social contexts can undermine social support, worsen romantic relationship satisfaction, and negatively affect first impressions (Chervonsky & Hunt, 2017). In the context of ROCD, where relationship dynamics are already fragile and shaped by doubt and compulsive reassurance-seeking, these consequences may be especially relevant. Suppression has also been linked to poorer relationship outcomes, particularly when individuals have lower levels of attachment anxiety in romantic contexts (Girme et al., 2020). Therefore, the high reliance on suppression among individuals with elevated ROCD or OCD symptoms may contribute not only to internal emotional dysregulation but also to strained interpersonal functioning. Ray-Yol and colleagues (2020) highlighted that IER strategies like soothing may only be adaptive when not accompanied by maladaptive intrapersonal strategies. Given that suppression was a strong predictor in the same models, the combined use of soothing and suppression may reflect a mixed regulation profile that could contribute to the persistence of symptoms. Interestingly, cognitive reappraisal only emerged as a significant, though negative predictor in the OCD model. This suggests that individuals with OCD symptoms may make some use of reappraisal, but this strategy may be less relevant for those whose symptoms are tied to romantic relationships. Prior studies have shown that reappraisal can enhance communication and emotional clarity in couples (Richards et al., 2003), but it may be more difficult to apply when intrusive thoughts directly challenge one's perception of their partner or relationship.

Overall, these findings suggest that individuals with OCD and ROCD symptoms may rely more heavily on maladaptive intrapersonal ER strategies, while underutilizing more adaptive approaches such as reappraisal. This imbalance may not only contribute to symptom severity but also strain relational functioning and emotional well-being over time. Future studies could explore whether the regulation patterns observed here function differently across stages of relationship development, attachment styles, or clinical levels of ROCD severity.

### 4.5. Clinical Implications

ROCD symptoms are tied to interpersonal concerns, often centering on doubts about the self, the partner, or the relationship itself. Given their highly relational content, these symptoms have the potential to interfere not only with internal emotional well-being but also with romantic functioning and interpersonal stability (Doron et al., 2012a, 2012b). Despite their growing recognition in the literature, research on the treatment of ROCD remains limited, and evidence-based clinical guidelines are still under development (Doron et al., 2014). The present study contributes to this emerging field by offering one of the first systematic investigations into how both IER and intrapersonal ER strategies are associated with ROCD, and OCD symptoms.

The findings highlight the importance of considering ER processes in the assessment and treatment of individuals presenting with OCD-related concerns, particularly those focused on relationships. In particular, the consistent role of expressive suppression across all symptom types suggests that emotion avoidance may play a central role in maintaining distress. Suppression has been linked to greater psychological burden, limited access to emotional support, and strained interpersonal functioning (Chervonsky & Hunt, 2017; Gross, 2015). Its strong predictive value in this study suggests that targeting suppression directly, through interventions that foster emotional awareness, acceptance, and expression could be beneficial.

The significant contribution of IER strategies, particularly soothing and social modeling, also points to the interpersonal nature of these symptoms. ROCD may not only disrupt internal thought processes but also influence how individuals seek connection and emotional stability from others. Clinicians may need to assess how clients engage others, when feeling emotionally overwhelmed, and whether these efforts are adaptive or reinforce obsessive cycles. Given that ROCD symptoms often emerge within the context of romantic relationships, dyadic or couple-based interventions may offer valuable space to explore emotional needs, address reassurance-seeking patterns, and improve co-regulation between partners (Lemay et al., 2024; Ruan et al., 2024). In general OCD presentations, the pattern of results suggests that maladaptive intrapersonal strategies remain highly relevant, while more adaptive strategies like reappraisal appear underutilized. Incorporating ER skills training into standard OCD treatment protocols may help strengthen long-term coping and reduce reliance on compulsive behaviors. In sum, this study offers a foundation for understanding how ER manifest across ROCD and OCD symptoms. Integrating both IER

and intrapersonal strategies into the clinical formulation may offer more personalized and context-sensitive interventions, especially in emerging domains such as ROCD where relational and emotional processes are deeply connected.

### 4.6. Limitations and Future Directions

Even if the current study offers insightful information about the role of IER and intrapersonal ER methods in OCD, RC-OC, and PF-OC symptoms, several limitations should be noted. First, the design of the study restricts the capacity to draw conclusions about causality as a cross-sectional and correlational design. using experimental or longitudinal approaches the directionality of these associations would be better examined in future research. Secondly, the sample for the study was taken from a non-clinical population. This could restrict the applicability of the results to clinical groups diagnosed with OCD or ROCD. While elevated symptom scores were used to form high-symptom groups, formal clinical assessments were not conducted. Including clinically diagnosed individuals in future research could help clarify whether similar ER patterns are observed in more severe or treatment-seeking populations. Third, although the study examined key IER and intrapersonal ER strategies, it did not include all potentially relevant variables, such as ER difficulties (Liu et al., 2024), or attachment styles (Bowlby, 1979). These constructs may interact with the strategies studied here or help explain individual differences in regulation tendencies. Expanding the range of ER measures in future studies could offer a more comprehensive understanding of how different strategies contribute to obsessive-compulsive symptomatology. Furthermore, self-report questionnaires were used to gather all of the data, which could be prone to errors in introspective reporting, social desirability, or common method bias. Future research may benefit from incorporating behavioral tasks, clinical interviews, or ecological momentary assessment to assess ER processes more objectively. The unequal distribution of some demographic factors, such gender and relationship status, is another limitation. The manifestation and severity of ROCD symptoms, as well as the application of IER techniques, may have been impacted by this imbalance. To enhance the clarity and generalizability of future findings, studies should aim for more balanced demographic distributions. Finally, although the study included IER strategies, it did not assess the relational context in which these strategies were used. Specifically, it remains unclear who individuals rely on when regulating their emotions, whether they turn to their romantic partner or a close friend and how these interactions are perceived in terms of effectiveness or emotional impact. Future research would benefit from including dyadic

participants, such as both members of a romantic couple, to better understand how IER functions within the relationship itself.

### 4.7. Conclusion

Considering these findings, the present study provides important insights into how ER strategies, both IER and intrapersonal, relate to OCD symptoms, particularly within the context of RC-OC and PF-OC symptoms. By examining not only overall symptom severity but also distinct patterns of ER across symptom-specific groups, the study highlights both shared and unique ER tendencies among individuals with ROCD and OCD.

Expressive suppression emerged consistently as a significant predictor across all symptom dimensions, reinforcing its central role in maintaining obsessive-compulsive psychopathology. The pervasive use of suppression across these symptom groups underscores its maladaptive function as a short-term coping mechanism that paradoxically contributes to increased symptom severity and interpersonal difficulties over time. Furthermore, the study demonstrated that soothing and social modeling have specific relevance to ROCD, highlighting the relational context and the heightened interpersonal dependency characteristic of ROCD.

These findings carry important implications for clinical practice and intervention development. It is suggested that therapeutic approaches should prioritize reducing reliance on suppression while simultaneously fostering adaptive regulation strategies, particularly those enhancing cognitive flexibility and emotional acceptance. Additionally, interventions for ROCD might specifically benefit from addressing interpersonal dynamics, including reducing excessive reassurance-seeking and improving relational communication patterns.

As one of the few studies examining these nuanced relationships comprehensively, this research provides a foundational understanding that can guide future studies. Future investigations may benefit from exploring how these ER strategies interact with developmental stages, attachment styles, and varying clinical severities of ROCD. Such research will improve the efficacy of therapies adapted to the particular difficulties posed by RC-OC, PF-OC, and OCD symptomatology, as well as further refine therapeutic targets.

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# APPENDICES

## APPENDIX 1: Demografik Information Form

1. Cinsiyetiniz

Kadın ( )

Erkek ( )

Diğer (belirtiniz) ……

2. Yaşınız (Lütfen doğum tarihinizi gün/ay/yıl formatında belirtiniz)___

3. Eğitim Durumunuz:

İlkokul mezunu ( )

Ortaokul mezunu ( )

Lise mezunu ( )

Üniversite mezunu ( )

Yüksek Lisans/Doktora mezunu ( )

4. Çalışma durumunuz:

Çalışmıyor ( )

Çalışıyor ( )

Öğrenci ( )

5.Aşağıdakilerden hangisi **mevcut ilişki durumunuzu** en iyi tanımlar?

Şu an bir ilişkim var ( )

Şu an bir ilişkim yok ancak daha önce vardı ( )

Hiç ilişkim olmadı ( )

6. Eğer ilişkiniz var ise aşağıdakilerden hangisi **ilişki durumunuzu** en iyi tanımlar?

Partnerimle birlikte yaşıyoruz. ( )

Partnerimle **aynı** şehirde **ayrı** yaşıyoruz. ( )

Partnerimle ayrı şehirlerde yaşıyoruz (uzun mesafe ilişkisi). ( )

Şu an bir ilişkim yok/Hiç ilişkim olmadı ( )

7. Aşağıdakilerden hangisi **mevcut ilişki türünüzü** en iyi tanımlar?

Evli ( )

Nişanlı/sözlü ( )

Flört/Sevgili ( )

Şu an bir ilişkim yok/Hiç ilişkim olmadı ( )

8. **Şu an bir ilişkiniz var ise;** ilişkiniz ne zaman başladı? (Lütfen gün/ay/yıl formatında belirtiniz) _____

9. **Şu an bir ilişkiniz yok ise;** en son ilişkinizin bitmesi üzerinden ne kadar süre geçti (ay cinsinden belirtiniz) _____

10. Daha önce herhangi bir psikolojik/psikiyatrik tanı (depresyon, kaygı bozukluğu, uyku bozukluğu, vb.) aldınız mı?

Evet ( )

Hayır ( )

*Cevabınız evet ise belirtiniz: _____

## APPENDIX 2: Relationship Obsessive-Compulsive Inventory (ROCI)

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

| Bana hiç uygun değil. 0 | Bana biraz uygun. 1 | Bana orta düzeydeuygun. 2 | Bana oldukça uygun. 3 | Bana çok uygun. 4 |
|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Partnerimi gerçekten sevmediğim fikrini aklımdan çıkaramam. | 0 | 1 | 2 | 3 | 4 |
| 2. | Partnerimle ilgili şüphelerimi aklımdan kolaylıkla çıkarabilirim. | 0 | 1 | 2 | 3 | 4 |
| 3. | İlişkimden sürekli şüphe duyarım. | 0 | 1 | 2 | 3 | 4 |
| 4. | Partnerimin bana olan sevgisiyle ilgili şüphelerimi aklımdan çıkarmakta zorlanırım. | 0 | 1 | 2 | 3 | 4 |
| 5. | İlişkimin doğru olup olmadığını tekrar tekrar kontrol ederim. | 0 | 1 | 2 | 3 | 4 |
| 6. | Sürekli, partnerimin beni gerçekten sevdiğine dair kanıt ararım | 0 | 1 | 2 | 3 | 4 |
| 7. | Partnerimi neden sevdiğimi kendime tekrar tekrar hatırlatmam gerektiğini hissederim. | 0 | 1 | 2 | 3 | 4 |
| 8. | Partnerimin beni sevdiğinden eminim. | 0 | 1 | 2 | 3 | 4 |
| 9. | İlişkimde bir şeylerin "doğru olmadığına" dair düşüncelerden aşırı derecede rahatsız olurum. | 0 | 1 | 2 | 3 | 4 |
| 10. | Partnerime olan sevgimden sürekli şüphe duyarım. | 0 | 1 | 2 | 3 | 4 |
| 11. | Partnerime sürekli beni sevip sevmediğini sorarım. | 0 | 1 | 2 | 3 | 4 |
| 12. | Sık sık ilişkimin "doğru" olduğuna dair onay ararım. | 0 | 1 | 2 | 3 | 4 |
| 13. | Partnerimin aslında benimle birlikte olmak istemediği düşüncesi beni sürekli rahatsız eder. | 0 | 1 | 2 | 3 | 4 |
| 14. | Partnerimi ne kadar sevdiğimi tekrar tekrar kontrol etmem gerektiğini hissederim. | 0 | 1 | 2 | 3 | 4 |

**APPENDIX 3: Partner-Related Obsessive-Compulsive Symptoms Inventory (PROCSI)**

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

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

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Partnerimin sahip olduğu ahlak düzeyinden memnunum. | 0 | 1 | 2 | 3 | 4 |
| 2. | Partnerimin sosyal becerilerini tekrar tekrar gözden geçiririm. | 0 | 1 | 2 | 3 | 4 |
| 3. | Partnerimin yeterince akıllı ve derinlik sahibi biri olup olmadığını sürekli sorgularım. | 0 | 1 | 2 | 3 | 4 |
| 4. | Partnerimin dış görünüşünden memnunum. | 0 | 1 | 2 | 3 | 4 |
| 5. | Partnerimin sosyal becerileri ile ilgili düşünceler beni rahatsız eder. | 0 | 1 | 2 | 3 | 4 |
| 6. | Partnerimin ahlaki düzeyine ilişkin şüpheler beni sürekli rahatsız eder. | 0 | 1 | 2 | 3 | 4 |
| 7. | Partnerimin zihinsel olarak dengesiz olduğu fikrini aklımdan çıkarmakta zorlanırım. | 0 | 1 | 2 | 3 | 4 |
| 8. | Partnerimin yeterince zeki olup olmadığı konusunda çevremdeki insanlardan (arkadaşlarımdan, ailemden vs.) sık sık onay ararım. | 0 | 1 | 2 | 3 | 4 |
| 9. | Partnerimle birlikteyken onun fiziksel kusurlarını görmezden gelmekte zorlanırım. | 0 | 1 | 2 | 3 | 4 |
| 10. | Partnerimin hayatta "bir şey başarma" becerisini sürekli diğer kadın/erkeklerinkiyle karşılaştırırım. | 0 | 1 | 2 | 3 | 4 |
| 11. | Partnerimin zeka seviyesini diğer kadın/erkeklerinkiyle sürekli karşılaştırırım. | 0 | 1 | 2 | 3 | 4 |
| 12. | Partnerimin duygusal tepkilerini diğer kadın/erkeklerle karşılaştırma eğilimimi kontrol etmekte zorlanırım. | 0 | 1 | 2 | 3 | 4 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13. | Partnerimin yeterince zeki olmadığı düşüncesi beni çok rahatsız eder. | 0 | 1 | 2 | 3 | 4 |
| 14. | Partnerimin fiziksel görünüşündeki kusurlarla ilgili düşünceler beni sürekli rahatsız eder. | 0 | 1 | 2 | 3 | 4 |
| 15. | Her gün, partnerimin "iyi ve ahlaklı" bir insan olmadığı düşüncesinden rahatsız olurum. | 0 | 1 | 2 | 3 | 4 |
| 16. | Partnerimin zeka seviyesinden memnunum. | 0 | 1 | 2 | 3 | 4 |
| 17. | Sürekli, partnerimin yeterince ahlaklı olduğuna dair kanıt ararım. | 0 | 1 | 2 | 3 | 4 |
| 18. | Partnerimin sosyal konulardaki beceriksizliğine ilişkin düşünceler beni her gün rahatsız eder. | 0 | 1 | 2 | 3 | 4 |
| 19. | Partnerim aklıma her geldiğinde görünüşündeki kusurları düşünürüm. | 0 | 1 | 2 | 3 | 4 |
| 20. | Partnerimin ahlak düzeyini sürekli incelerim. | 0 | 1 | 2 | 3 | 4 |
| 21. | Sürekli, partnerimin sosyal yetersizliklerini telafi etmeye çalışırım. | 0 | 1 | 2 | 3 | 4 |
| 22. | Partnerimin duygusal olarak dengesiz olduğuna ilişkin şüpheler beni rahatsız eder. | 0 | 1 | 2 | 3 | 4 |
| 23. | Partnerimin sosyal becerilerinden memnunum. | 0 | 1 | 2 | 3 | 4 |
| 24. | Partnerimin tuhaf bir şekilde davranıp davranmadığını sürekli incelerim. | 0 | 1 | 2 | 3 | 4 |
| 25. | Zihnim partnerimin hayatta başarılı olup olmayacağını değerlendirmekle çok meşguldür. | 0 | 1 | 2 | 3 | 4 |
| 26. | Partnerimin fiziksel kusurlarını diğer kadın/erkeklerinkiyle karşılaştırma konusunda kontrol edemediğim bir dürtü hissederim. | 0 | 1 | 2 | 3 | 4 |
| 27. | Partnerimi düşündüğümde, modern dünyada başarılı olabilecek türden biri olup olmadığını merak ederim. | 0 | 1 | 2 | 3 | 4 |
| 28. | Sürekli, partnerimin iş hayatındaki başarısına dair kanıt ararım. | 0 | 1 | 2 | 3 | 4 |

**APPENDIX 4: Obsessive–Compulsive Inventory-Revised**

Aşağıdaki ifadeler, birçok kişinin günlük yaşamlarındaki deneyimlerine işaret etmektedir. Geçtiğimiz ay boyunca, belirtilen durumun sizi ne kadar rahatsız ettiğini ya da sıkıntıya soktuğunu en iyi ifade eden sayıyı işaretleyiniz.

| | | Hiç | Biraz | Orta | Çok | Aşırı derece |
|---|---|---|---|---|---|---|
| 1. | Bir şekilde elime geçmiş olan birçok şeyi biriktiririm. | 0 | 1 | 2 | 3 | 4 |
| 2. | Bir şeyleri gereğinden fazla kontrol ederim. | 0 | 1 | 2 | 3 | 4 |
| 3. | Nesneler düzgün bir şekilde yerleştirilmemişse huzursuz olurum. | 0 | 1 | 2 | 3 | 4 |
| 4. | Bir şeyleri yaparken sayma zorunluluğu hissederim. | 0 | 1 | 2 | 3 | 4 |
| 5. | Yabancıların ya da belirli kişilerin dokunduğunu bildiğim nesnelere dokunmakta zorlanırım. | 0 | 1 | 2 | 3 | 4 |
| 6. | Düşüncelerimi kontrol etmekte zorlanırım. | 0 | 1 | 2 | 3 | 4 |
| 7. | İhtiyacım olmayan şeyleri biriktiririm. | 0 | 1 | 2 | 3 | 4 |
| 8. | Kapı, pencere, çekmece gibi şeyleri tekrar tekrar kontrol ederim. | 0 | 1 | 2 | 3 | 4 |
| 9. | Benim düzenlediğim şeylerin başkası tarafından değiştirilmesinden rahatsız olurum. | 0 | 1 | 2 | 3 | 4 |
| 10. | Belirli numaraları tekrarlama zorunluluğu hissederim. | 0 | 1 | 2 | 3 | 4 |
| 11. | Bazen sadece kirli hissettiğim için kendimi temizlemek ya da yıkamak zorunda kalırım. | 0 | 1 | 2 | 3 | 4 |
| 12. | İsteğim dışında zihnimde beliren olumsuz düşüncelerden huzursuz olurum. | 0 | 1 | 2 | 3 | 4 |
| 13. | Daha sonra ihtiyacım olabileceği korkusuyla bir şeyleri atmaktan kaçınırım. | 0 | 1 | 2 | 3 | 4 |
| 14. | Gazı, çeşmeleri ve ışıkları kapattıktan sonra tekrar tekrar kontrol ederim. | 0 | 1 | 2 | 3 | 4 |
| 15. | Bana göre bazı şeylerin belli bir sıraya göre düzenlenmiş olması gerekir. | 0 | 1 | 2 | 3 | 4 |
| 16. | Ellerimi gereğinden daha sık ve uzun süre yıkarım. | 0 | 1 | 2 | 3 | 4 |
| 17. | Aklıma sıklıkla hoş olmayan düşünceler gelir ve onları zihnimden uzaklaştırmakta zorlanırım. | 0 | 1 | 2 | 3 | 4 |

**APPENDIX 5: Interpersonal Emotion Regulation Questionnaire (IERQ)**

Aşağıda bireylerin başka bireyler aracılığıyla duygularını nasıl düzenlediklerini gösteren ifadeler bulunmaktadır. Bu ölçekte doğru veya yanlış cevap yoktur. Önemli olan verdiğiniz yanıtın sizi ne kadar doğru yansıttığıdır. Lütfen her bir maddeyi dikkatlice okuyun ve her biri için o ifadenin sizin için ne kadar doğru olduğunu **1'den= "Kesinlikle doğru değil"den 5'e= "Tamamen doğru"** kadar uzanan beşli ölçek üzerinde **yalnızca birini** işaretleyerek belirtin.

**1----------2----------3----------4----------5**

| **Kesinlikle doğru değil** | **Çok az doğru** | **Biraz doğru** | **Oldukça doğru** | **Tamamen doğru** |
|---|---|---|---|---|

| | |
|---|---|
| 1. Başka kişilerin duygularıyla nasıl baş ettiğini öğrenmek kendimi daha iyi hissetmemi sağlar. | **1---2---3---4---5** |
| 2. Başka kişilerin bana işlerin göründüğü kadar kötü olmadığını belirtmeleri üzgün/mutsuz ruh halimle baş etmeme yardımcı olur. | **1---2---3---4---5** |
| 3. Mutluluğumu paylaşmak istediğimde başka insanların yanında olmak hoşuma gider. | **1---2---3---4---5** |
| 4. Kendimi kötü hissettiğimde, etrafımda bana şefkat gösteren insanlar olmasını isterim. | **1---2---3---4---5** |
| 5. Endişeli olduğum zamanlarda başka bir kişinin bu işlerle nasıl baş edileceğine dair fikirlerini duymak bana iyi gelir. | **1---2---3---4---5** |
| 6. Sevinçli olduğumda hayatımdaki önemli kişilerle birlikte olmak hoşuma gider. | **1---2---3---4---5** |
| 7. Kendimi kötü hissettiğimde benden daha kötü durumda kişilerin olduğunun hatırlatılması bana iyi gelir. | **1---2---3---4---5** |
| 8. Keyifli olduğumda, başkalarıyla birlikte olmak beni daha da keyiflendirir. | **1---2---3---4---5** |
| 9. Kendimi kötü hissetmek genellikle, bana anlayış gösterecek kişilerle iletişime geçmeme neden olur. | **1---2---3---4---5** |

| | |
|---|---|
| 10. Kendimi kötü hissettiğimde başka kişilerin bana işlerin şimdikinden çok daha kötü sonuçlanmış olabileceğini fark ettirmesi daha iyi hissetmemi sağlar. | **1---2---3---4---5** |
| 11. Hayal kırıklığına uğradığımda başka insanların aynı durumla nasıl başa çıkacaklarını bilmek bana yardımcı olur. | **1---2---3---4---5** |
| 12.Keyifsiz olduğumda rahatlamak için başka insanlara yönelirim. | **1---2---3---4---5** |
| 13. Mutluluk bulaşıcı olduğundan mutlu olduğumda çevremde başka insanlar da olsun isterim. | **1---2---3---4---5** |
| 14. Kızgın olduğumda başkaları bana endişelenmememi söyleyerek beni yatıştırabilir. | **1---2---3---4---5** |
| 15. Üzgün olduğumda başka insanların benzer duygularla nasıl baş etmiş olduklarını duymak bana iyi gelir. | **1---2---3---4---5** |
| 16. Üzgün/mutsuz olduğumda sadece sevildiğimi bilmek için çevremde başka insanlar olsun isterim. | **1---2---3---4---5** |
| 17. Kaygılı olduğumda insanların telaşlanmamamı söylemesi beni sakinleştirir. | **1---2---3---4---5** |
| 18. Sevinçli olduğumda, onları da mutlu etmek için çevremdeki insanlara yönelirim. | **1---2---3---4---5** |
| 19. Üzüldüğümde teselli görmek amacıyla çevremdeki başka insanlara yönelirim. | **1---2---3---4---5** |
| 20. Eğer kötü hissediyorsam, başka insanların benim durumumda ne yapacaklarını bilmeyi isterim. | **1---2---3---4---5** |

**APPENDIX 6: Emotion Regulation Questionnaire (ERQ)**

Lütfen her maddeyi okuduktan sonra, o maddede belirtilen fikre katılma derecenizi 7 (*Tamamen Katılıyorum*) ve 1 (*Hiç Katılmıyorum*) arasında değişen rakamlardan size uygun olanını işaretleyerek belirtiniz. **(1 - Hiç Katılmıyorum, 2 - Katılmıyorum, 3 – Biraz Katılmıyorum, 4- Kararsızım, 5 – Biraz Katılıyorum, 6 – Katılıyorum, 7 Tamamen Katılıyorum)**

| | |
|---|---|
| 1) Olumlu duygularımın fazla olmasını istersem (mutluluk veya eğlence) düşündüğüm şeyi değiştiririm. | 1 2 3 4 5 6 7 |
| 2) Duygularımı kendime saklarım. | 1 2 3 4 5 6 7 |
| 3) Olumsuz duygularımın az olmasını istersem (kötü hissetme veya kızgınlık gibi) düşündüğüm şeyideğiştiririm. | 1 2 3 4 5 6 7 |
| 4) Olumlu duygular hissettiğimde onları ifade etmemeye dikkat ederim. | 1 2 3 4 5 6 7 |
| 5) Stresli bir durumla karşılaştığımda, bu durumu sakin kalmamı sağlayacak şekilde düşünmeyeçalışırım. | 1 2 3 4 5 6 7 |
| 6) Duygularımı, onları ifade etmeyerek kontrol ederim. | 1 2 3 4 5 6 7 |
| 7) Olumlu duygularımın fazla olmasını istediğim zaman durumla ilgili düşünme şeklimi değiştiririm. | 1 2 3 4 5 6 7 |
| 8) İçinde bulunduğum duruma göre düşünme şeklimi değiştirerek duygularımı kontrol ederim. | 1 2 3 4 5 6 7 |
| 9) Olumsuz duygular hissettiğimde onları ifade etmediğimden emin olmak isterim. | 1 2 3 4 5 6 7 |
| 10) Olumsuz duygularımın az olmasını istersem, durumla ilgili düşünme şeklimi değiştiririm. | 1 2 3 4 5 6 7 |

**APPENDIX 7: Informed Consent Form**

Değerli katılımcı,

Bu çalışma, Başkent Üniversitesi Fen-Edebiyat Fakültesi Psikoloji Bölümü öğretim üyesi Doç. Dr. Burçin AKIN SARI danışmanlığında, Klinik Psikoloji Yüksek Lisans programı öğrencisi Demet Esra SOYSAL tarafından yürütülen bir tez çalışmasıdır. Bu çalışmada, bireysel ve kişilerarası duygu düzenleme stratejilerinin, ilişki ve partner odaklı obsesif-kompulsif belirtilerle olan ilişkisinin araştırılması amaçlanmaktadır.

Bu çalışmaya katılım tamamen gönüllülük esasına dayanmaktadır. Katılımcılardan elde edilecek tüm kimlik bilgileri gizli tutulacak ve hiçbir aşamada kimlik bilgileri açıklanmayacaktır. Araştırma bulguları yalnızca bilimsel amaçlarla kullanılacaktır.

Çalışmaya katılım kapsamında, katılımcıların demografik bilgi formu ve çeşitli değerlendirme araçlarını eksiksiz doldurmaları beklenmektedir. Bu süreç yaklaşık olarak 10 dakika sürecektir. Araştırma sonuçlarının güvenilir olabilmesi için, sorulara içten ve eksiksiz yanıt verilmesi büyük önem taşımaktadır. Soruların size tam olarak uymadığı durumlarda, size en yakın gelen yanıtı işaretlemeniz yeterlidir.

Bu çalışmaya katılım herhangi bir risk içermez. Katılımcılar diledikleri zaman çalışmaya katılmayı reddedebilir veya herhangi bir aşamada çalışmadan ayrılabilirler.

Araştırmaya katıldığınız için şimdiden teşekkür ederiz. Bu çalışma hakkında daha fazla bilgi almak için Demet Esra Soysal:  adresine ulaşabilirsiniz.

**Bu araştırmaya tamamen gönüllü olarak katıldığımı, istediğim zaman yarıda bırakabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayınlarda kullanılmasını kabul ediyorum.**

☐ Onaylıyorum ☐Onaylamıyorum

Katılım Tarih:

İmza:

## APPENDIX 8: Ethical Committee Approval

Evrak Tarih ve Sayısı: 06.01.2025-415773

**T.C.**
**BAŞKENT ÜNİVERSİTESİ REKTÖRLÜĞÜ**
**Akademik Değerlendirme Koordinatörlüğü**

Sayı : E-62310886-605-415773
Konu : Demet Esra Soysal'ın Etik Onay Başvurusu

06.01.2025

SOSYAL BİLİMLER ENSTİTÜSÜ MÜDÜRLÜĞÜNE

İlgi : 06.12.2024 tarih ve 405105 sayılı yazınız.

Enstitünüz Klinik Psikoloji (Tezli) Yüksek Lisans Programı öğrencisi Demet Esra Soysal'ın, Doç. Dr. Burçin Akın Sarı danışmanlığında yürüteceği, "Exploring Emotion Regulation in Relationship OCD: A Focus on Interpersonal and Intrapersonal Strategies" başlıklı tez çalışması değerlendirilmiş ve bilgilerinize ekte sunulmuştur.

Prof. Dr. Sadegül AKBABA ALTUN
Kurul Başkanı

Ek: Değerlendirme Formu



Başkent Üniversitesi Bağlıca Kampüsü Fatih Sultan Mahallesi Eskişehir Yolu 18. Km
06790 Etimesgut/ANKARA
Telefon No:0 312 246 67 40 Faks No:0 312 246 66 05
e-Posta:adk@baskent.edu.tr İnternet Adresi:www.baskent.edu.tr
Kep Adresi:baskentuniversitesi@hs02.kep.tr

Bilgi için: Gamze SONBAY
Koordinatör
Telefon No: 246 66 66 / 5138

Evrak Tarih ve Sayısı: 06.01.2025-415773

Sayı : 17162298.600- 295
Konu : Tez Çalışması

23 Aralık 2024

İlgili Makama

Üniversitemiz Sosyal Bilimler Enstitüsü Klinik Psikoloji (Tezli) Yüksek Lisans Programı öğrencisi Demet Esra Soysal'ın, Doç. Dr. Burçin Akın Sarı danışmanlığında yürüteceği, "Exploring Emotion Regulation in Relationship OCD: A Focus on Interpersonal and Intrapersonal Strategies" başlıklı tez çalışması değerlendirilmiş ve yapılmasında bir sakınca olmadığı tespit edilmiştir.

Bilgilerinize saygılarımızla sunarız.

Başkent Üniversitesi Sosyal ve Beşeri Bilimler ve Sanat Alan Araştırma Kurulu

| Ad, Soyad | Değerlendirme | İmza |
|---|---|---|
| Prof. Dr. Gözen Güner Aktaş | Olumlu/Olumsuz | |
| Prof. Dr. Sadegül Akbaba Altun | Olumlu/~~Olumsuz~~ | |
| Prof. Dr. Fatih Çetin | Olumlu/Olumsuz | |
| Prof. Dr. Hasan Tahsin Fendoğlu | Olumlu/Olumsuz | |
| Prof. Dr. Filiz Kalelioğlu | Olumlu/~~Olumsuz~~ | |
| Prof. Dr. Hidayet Hale Künüçen | Olumlu~~/Olumsuz~~ | |
| Prof. Dr. Özcan Yağcı | Olumlu/O~~lumsuz~~ | |