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Adaptation of Relationship Assessment Scale to Turkish Culture: Study of Validity and Reliability

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ABSTRACT

The aim of this research was to examine validity and reliability of Turkish version of Relationship Assessment Scale and its Turkish adaptation. Data for this research collected from 336 married couples. For structure validity of the scale, confirmatory factor analysis was done. The reliability of the scale was examined with internal consistency method. Confirmatory factor analysis provided a good fit to the data ($\chi^2 = 52.87$, $df = 13$, $p = 0.00$, $RMSEA = .069$, $GFI = .95$, $CFI = .97$, $IFI = .97$, $NFI = .95$, and $SRMR = .04$). The internal consistency coefficient was found .87. In the result of the item analysis, corrected item-total correlations ranged from a low of .52 to a high of .74, and were statistically significant at the $p < 0.001$ level. These results demonstrated that this scale is a valid and reliable instrument.

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Keywords:

Relationship assessment, exploratory factor analysis, confirmatory factor analysis

1. Introduction

Relationship satisfaction, a response to feeling of experience Caruna, Money, and Berthon, (2000), is more important because it has been shown to have a great impact on people well-being. According to Guerrero, Anderson, & Afifi, (2011), relationship satisfaction, defined as an interpersonal evaluation of the positivity of feelings for one's partner and attraction to the relationship (Rusbult & Buunk, 1993), is associated with better mental and physical health. It may be thought as important that people have satisfaction in established relationships with other individuals around them to survive in a healthy way biologically and psychologically aspects. According to interdependence theory, individuals prefer to maximize their rewards and minimize their costs in a relationship. When rewards outweigh the costs, the outcome is positive; on the contrary, when costs outweigh the rewards, the outcome is negative. But relationship has a positive or negative outcome is not always enough to satisfy people, because people often have prior expectations of what they believe the relationship should be like. This expectation is based on the person's previous relationship experiences and personal observations of other people's relationships (Guerrero, Anderson, & Afifi, 2011).

The effective measure of relationship satisfaction is a difficult process requiring much effort and energy, because there is not a complete agreement on definition and psychometric aspects about relationship satisfaction (Bradbury, Fincham, & Beach, 2000; Jones, Adams, Monroe, & Berry, 1995; Patrick, Sells, Giordano, & Tollerud, 2007). When it is examined in literature studies, which they are about relationships assessment and relationship satisfaction, it is seen that researches aren't restricted to relationship assessment with married people or individuals who are linked to romantic relationship. Relationship quality or satisfaction covers a wide literature and many scales have been developed about this subject.

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The most of the relationship assessment scale are based on self-report measures scale. These scales provide great benefits and conveniences for researchers in terms of measuring a range of variables and implementation. In addition, these tools have a large role in our understanding of marital satisfaction and interpersonal relationships. The most popular ones of those scales are Marital Assessment Test developed by Locke & Wallace (1959) and Dyadic Adjustment Scale by Spanier (1976). They are used widely in evaluating the marital quality and satisfaction. Furthermore, there are scales like Quality Marriage Index (Norton, 1983) and Kansas Marital Satisfaction Scale (Schumm, Anderson, Benigas, McCutchen, Griffin, Morris, & Race (1985) that used in studies focused on only measuring marital satisfaction. But consisting of many items and difficulties in universal usage cause difficulty in using them. It is reported that these scales are not appropriate measurement tools to measure relationship satisfaction of unmarried individuals (Renshaw *et al.*, 2011). Due to the fact that we can see the same difficulties in Turkish society as experiencing in other cultures, the Relationship Assessment Scale, which was developed by Renshaw *et al.*, (2011), was adapted to Turkish.

The validity of the Relationship Assessment Scale are analyzed by Renshaw *et al.* (2011), found a single factor explaining 50% of the total variance in the result of the exploratory factor analysis. Although this scale was originally created to assess romantic relationships, Renshaw *et al.* (2011) created a generic version that they found to be sufficiently reliable: Cronbach's $\alpha = .89$ for parents, $.87$ for friends, and $.90$ for romantic partners. This scale is 5 Likert-type, single-factor and a measuring instrument which it consists seven items. The scale is based on a measurement tool. Furthermore, it provides information about the individual himself (self report), based on a measurement tool.

2. Method

2.1. Participants

Study groups of this research consist of married couples living in different parts of Istanbul. Within 336 married couples, 105 of them (31%) are men, 231 of them (69%) are women; 136 of them (42%) are teachers, 15 of them (5%) are persons in maritime lines, 14 of them (4%) are doctors and nurses, 171 of them (52%) are housewives and other individuals work in different occupation fields.

2.2. Measure

2.2.1. Relationship Assessment Scale (RAS). This is a 7-item scale (Hendrick, 1988) used to assess subjective satisfaction with a given relationship. Answers are rated on a 5-point Likert scale, ranging from 1 (not well), to 5 (very well). The respondent's average score is obtained after reverse scoring items 4 and 7. Although this scale was originally created to assess romantic relationships, Renshaw *et al.* (2011) created a generic version that they found to be sufficiently reliable: Cronbach's $\alpha = .89$ for parents, $.87$ for friends, and $.90$ for romantic partners. High scores of individuals have established relationships with other individuals and have a high level of satisfaction. The possible scores gained from this scale range from 7 to 35.

2.3. Procedure

A communication established through e-mail with Renshaw *et al.* (2011) who studied on psychometric aspects of Relationship Assessment Scale and necessary permission is granted. In the process of translation of Relationship Assessment Scale in Turkish, at first, 4 expert translators translated them into first Turkish, then into English again to examine their consistency. Necessary corrections are made by 8 experts in psychological counselling and guidance field by getting their opinion. Scale's Turkish form reexamined and reduced by three experts in Turkish language and literature in meaning and grammar. At next step, pilot Turkish form is applied on 54 married couples and they are asked to determine unclear statements. In the end, those unclear statements have been expressed comprehensibly.

In scale development studies, to express the validity of the scale, structure validity, content validity, and compliance validity are used. For content validity of the scale, experts are consulted, for structure validity, explanatory and confirmatory factor analysis are used., Cronbach Alpha and Split-half test were used to determine the reliability of the scale, and t-test and corrected item correlation were used for item analysis.

3. Results

3.1. Structure Validity

3.1.1. Explanatory Factor Analysis. It was made to examine the structure validity of the Relationship Assessment Scale, firstly, it was looked whether there was meaningful correlations in imported quantity or not by examining correlation matrix among all items. It is stated that Barlett test should be meaningful and KMO is higher than .60 to determine that whether datas are suitable for explanatory factor analysis that is determine the structure validity of scale (Büyüköztürk, 2010). In this analysis, that is made for that purpose, KMO example suitable coefficient is .86, Barlett Sphericity test χ^2 value is 1010,00 ($p < .001$), and answer for the scale are factorable. At first analyze; there was one factor that explained %56.45 of total variance and factor eigenvalue was over 3,95. Item factor loading that belongs to each factor are in Table 1. Also, factor loading of the scale differ from .63 to .82. In addition, in the analyze that was made to determine compliance validity of Relationship Assessment Scale is found .26 with Marital Life Satisfaction Scale.

Table 1. The Items of Relationship Assessment Scale, Factor Loadings, Eigenvalue, Percentages of Explained Variance, Corrected item-total Correlation, Cronbach's Alpha, Split-half, and T-test Results

Items	Factor Loadings	Corrected Item- Total Correlation	T-test
1	.76	.65	18,13***
2	.80	.70	17,54***
3	.80	.70	18,88***
4	.63	.52	16,04***
5	.82	.73	17,93***
6	.73	.62	13,46***
7	.67	.56	11,98***
Eigenvalue	3,95		
Variance (%)	56.45		
Cronbach's Alpha	.86		
Split-half	.81		

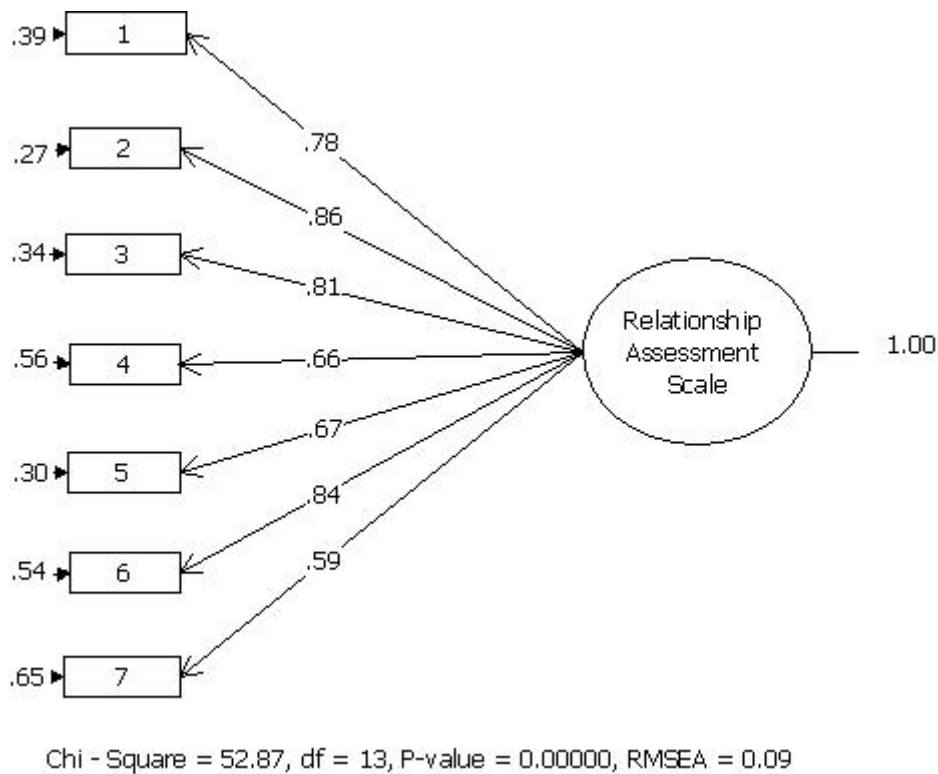
¹n=327 ²n1 = n2 =88 ***p<.001, p<.001

3.1.2. Confirmatory Factor Analyze. CFA was applied to confirm the single-factor Structure, found in original form of scale for structure of Relationship Assessment Scale in CFA. Confirmatory factor analysis provided a good fit to the data ($\chi^2 = 52.87$, $df = 13$, $p = 0.00$, $RMSEA = .069$, $GFI = .95$, $CFI = .97$, $IFI = .97$, $NFI = .95$, and $SRMR = .04$). Factor loadings are shown in Figure 1.

Schermelleh-Engel, Moosbrugger, & Müller (2003) stated that reasonable fit indices of model are ranged between $2 \leq \chi^2/df \leq 3$ for χ^2/df , $0.01 \leq p \leq 0.05$ for p , $0.05 \leq RMSEA \leq 0.08$ for Root Mean Square Error of Approximation, $0.85 \leq AGFI \leq 0.90$ for Adjusted Goodness of Fit Index, and $90 \leq GFI \leq 0.95$ for Goodness of Fit Index, $0.05 \leq SRMR \leq 0.10$ for Standardized Root Mean Square Residual. AGFI values typically range between zero and one with larger values indicating a better fit. A rule of thumb for this index is that .90 is indicative of

good fit relative to the baseline model, while values greater than .85 may be considered as an acceptable fit. Furthermore, Hu and Bentler (1999) gave evidence that .90 might not be a reasonable cutoff for all fit indices under all circumstances. They suggested to raise the rule of thumb minimum standard for the CFI and the NNFI from .90 to .95 to reduce the number of severely misspecified models that are considered acceptable based on the .90 criterion. In this regard, the results indicated that this model has acceptable fit indices.

Figure 1.Path diagram and factor loadings related to Relationship Assessment Scale (RAS)



3.2. Reliability

The reliability of the scale was examined with internal consistency and split-half test methods. Scale's internal consistence reliability coefficient was $\alpha = .87$. If we consider that preassumed reliability is .60 (Büyüköztürk, 2010), it can be used in research, scale's reliability level is enough. Furhermore, scale's split-half test reliability was .82. We can accept that scale is reliable, according to the result of internal consistency, split-half test result. The findings concerning the reliability analyzes are shown in Table 1.

3.2.1. Item Analysis

Corrected item-total correlations and t-test results, which compare lower 27% and upper 27% groups, were formed according to total scores of the test, were used for item analysis. In this study, it was found that corrected item-total correlations differed from .52 to .73, and it was seen that t (df=174) values of lower and upper 27% groups were between 11,98 ($p < .001$) and 18.88 ($p < .001$). We can accept that scale has distinguishing items, according to the corrected item-total correlation and t-test results ($p < .001$). The findings concerning the item analysis are shown in Table 1.

4. Discussion

It is seen that as a result of exploratory factor analysis of Turkish version of Relationship Assessment Scale that explain 56.45% of total variance which a single factor structure is gained that is suitable for original scale's form. If we think that 30% total variance is suitable for scale development and adoption study we see that there is structure validity (Büyüköztürk, 2010). Also, accordance index for Confirmatory Factor Analysis is in accordance in goal level and it is consistent with original form.

Analysis for scale reliability, internal consistence, Split-half test are high and meaningful makes scale reliable. If we think that reliability level is .70 for the scales used in research (Büyüköztürk, 2010; Çokluk, Şekercioğlu, & Büyüköztürk, 2010; Spahi, Yurtkoru, & Çinko, 2008), reliability level is enough. In interpretation of item total correlation .30 and higher items, it differentiate with its own items, we see that item total correlation is in enough level (Büyüköztürk, 2010). In lower upper 27% groups t-test results have meaningful differences. Internal consistence value in the scale are in coherence so reliability for internal consistence is high. Item total correlation and t-test, which lower and upper 27% groups were compared, results showed that the scale has distinguishing items. We can say that Turkish form of Relationship Assessment Scale can be used as valid and reliable as a result of studies.

There can be some offerings as a result of validity and reliability studies. Applying this scale or different individuals who have different characteristics can contribute to scale's validity and reliability. With that scale, there can be possibilities to create researches to improve and increase the relationship skills of individuals. It can also be used as a data-collector for the ones who have troubles in marriage, with their partners, the couples having unhappy marriages and helping them. It can be used for psychological guidance and counselling to improve individual's life. At that phase, this scale may create possibilities in revise studies and increase its affect relation studies and experiments about subject and comparing other results may highly contribute to the scale. Finally, the researches that use this scale may contribute to measure the scale's effect.

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Appendix 1.

Relationship Assessment Scale

1. Arkadaşların/akrabaların ihtiyaçlarını ne kadar iyi karşılıyor.

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Hiç iyi değil

Çok iyi

2. Genel olarak arkadaşlarıyla/akrabalarıyla kurduğun ilişkilerinden ne kadar tatmin olursun.

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Hiç tatmin değil

Çok tatminim

3. Diğer birlikte olduğun kişilerle karşılaştığında arkadaşlarıyla/akrabalarıyla ilişkilerin ne kadar iyidir.

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Hiç iyi değil

Çok iyi

4. Arkadaşlarıyla/akrabalarıyla ilişkinidevam ettirmemeyi ne sıklıkla düşünüyorsun.

1_____2_____3_____4_____5_

Hiç düşünmem

Çok sık düşünürüm

5. Arkadaşlarıyla/akrabalarıyla ilişkilerinde beklentilerin ne ölçüde karşılanır.

1_____2_____3_____4_____5_

Hiç karşılanmaz

Çok karşılanır

6. Arkadaşlarını/akrabalarını ne kadar çok seviyorsun.

1_____2_____3_____4_____5_

Hiç sevmem

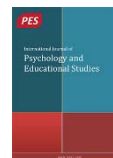
Çok severim

7. Arkadaşlarıyla/akrabalarıyla ilişkilerinde ne kadar problem var.

1_____2_____3_____4_____5_

Hiç yok

Çok var



Somatic Expression of Psychological Problems (Somatization): Examination with Structural Equation Model

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ABSTRACT

The main purpose of the research is to define which psychological symptoms (somatization, depression, obsessive-compulsive, hostility, interpersonal sensitivity, anxiety, phobic anxiety, paranoid ideation and psychoticism) cause somatic reactions at most. Total effect of these psychological symptoms on somatic symptoms had been investigated. Study was carried out with structural equation model to research the relation between the psychological symptoms and somatization. The main material of the research is formed by the data obtained from 492 people. SCL-90-R scale was used in order to obtain the data. As a result of the structural equation analysis, it has been found that 1)Psychoticism, phobic anxiety, and paranoid ideation do not predict somatic symptoms.2)There is a negative relation between interpersonal sensitivity level and somatic reactions.3)Anxiety symptoms had been found as causative to occur the highest level of somatic reactions.

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Keywords:

Structural equation model, somatization, mental health

1. Introduction

Somatization Disorder is a psychiatric disorder and has a major impact on our health care system, but patients are reluctant to see and be treated by psychiatrists. They frequently are managed by nonpsychiatric physicians who have limited understanding of the condition (Mai, 2004;Weiss et al., 2009). Somatization disorder is the most severe and refractory of the somatoform disorders (Mai, 2004; Woolfolk& Allen, 2010).

Somatization Disorder (historically referred to as hysteria or Briquet's syndrome) is a polysymptomatic disorder that begins before age 30 years, extends over a period of years, and is characterized by a combination of pain, gastrointestinal, sexual, and pseudoneurological symptoms(APA,2000). There is no single cause for Somatization disorder, as with most psychiatric conditions, the disorder is the end result of the interplay between genetic factors and various events in the antecedent life history of the individual (Mai, 2004). Various psychological, social, pathophysiological, familial, and genetic mechanisms have been proposed to explain the origin of somatization disorder. At present, strong evidence supports an increased risk of somatization disorder in first- degree family relatives, indicating a familial or genetic effect (Smith, 1990). A definite diagnosis requires the presence of all of the following: (a) At least 2 years of multiple and variable physical symptoms for which no adequate physical explanation has been found; (b) Persistent refusal to accept the advice or reassurance of several doctors that there is no physical explanation for the symptoms; (c) Some degree of impairment of social and family functioning attributable to the nature of the symptoms and resulting behavior (WHO, 1993).

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Somatization disorder is far more prevalent in women than men. It does occur in men, however, and should be considered in the differential diagnosis of unexplained somatic complaints in men and usually starts in early adult life (Smith, 1990). Menstrual difficulties may be one of the earliest symptoms in women (APA, 2000).

Some researchers have suggested that Asian populations tend to react to excessive stress with somatic symptoms, whereas Western populations tend to respond more with affective or depressive symptoms (Weiss et al., 2009; Carlton, 2001). In patients who have experienced Somatization Disorders for a long time, loss of social ability is at issue. If they acknowledge psychosocial problems, they usually deny vigorously their possible effects on their presenting physical symptoms, despite clear temporal relationships. Such patients frequently view psychological difficulties as weaknesses, and they often feel angry and blamed if they receive a psychiatric diagnosis (Stewart, 1990).

Childhood sexual abuse is an important factor in the multifactorial etiopathogenesis of somatization disorder (Spitzer et al., 2008; Samelius et al., 2007). Some evidence indicates that women with somatization disorder are likely to have been neglected, sexually molested, and were only given attention when physically ill (Smith, 1990; Mai, 2004). However, women with somatization disorder appear to selectively mate with men with antisocial personality disorder and alcoholism (Smith, 1990; APA, 2000). A research's result showed that mothers' somatization problems, showing that low maternal warmth and harsh punishment still predicted multiple child problems at ages 9 to 11 even when the mothers' somatization problems (Loeber et al., 2009). Children of patients with the disorder may develop unexplained somatic complaints that represent the onset of the disorder (Smith, 1990). According to Gilleland et al. (2009), Mothers' and fathers' report of children's somatic complaints may be significantly influenced by their own somatic functioning.

Most of somatization disorder patients have severe problems with comorbid psychiatric illnesses. Unnecessary surgery, addiction to prescription medicines, depression and attempted suicide are common complications of this syndrome (Seligman, Rosenhan, 1997). More than 90 percent of patients with somatization disorder acknowledge a history of depression (the form of major depressive episodes and dysthymic disorder) (Smith, 1990). Öztürk and Sar (2008), demonstrated that concurrent somatization disorder diagnosis was the only predictor of suicidal ideation. Somatization was significantly related to traumatic events and posttraumatic symptoms (Aragona et al., 2010). Somatization Disorder patients had an eightfold higher risk for lifetime diagnosis of complex Post Traumatic Stress Disorder and a fifteen fold higher risk for current complex Post Traumatic Stress Disorder (Spitzer et al., 2008). Much cross-sectional research has been carried out, and most studies show a positive correlation between alexithymia and somatization (Wai, 2004). Somatization is encountered among a wide range of syndromes in dermatology (Gupta, 2006).

Individuals with somatization disorder use extensive amounts of drug and that effects economy of the country in a negative way. Drug use causes adverse effects in individuals. This situation affects the marriage, business and social life in a negative way. In this context, the research can be said to be important because of the contribution to the economy of the country and awareness levels of the people with regards to the fact that it contributes to the field.

2.Method

Study is performed by Structural Equation Model. Structural Equation Model (SEM) has been useful in attacking many substantive problems in the social and behavioral sciences. Such models are now being used in marketing in addition to the traditional areas of sociology, psychology, education, and econometrics (Jöreskog & Sörbom, 1982). SEM is a modeling tool, and not a tool for "descriptive" analysis. It fits models to data. These models require testing in order to determine the fit of a model to the data. Social science, business, marketing, and management journals are littered with the consequences of the use of "approximate fit indices" – a plethora of forgettable, non-replicable, and largely "of no actual measurable consequence" models (Barret, 2007).

SEM is a powerful statistical technique that combines measurement model or confirmatory factor analysis (CFA) and structural model into a simultaneous statistical test (Hoe, 2008). SEM is statistical technique that one can use to reduce the number of observed variables into a smaller number of latent variables by examining the covariation among the observed variables. Observed variables are also termed measured, indicator, and

manifest, and researchers traditionally use a square or rectangle to designate them graphically (Schreiber et al., 2006). SEM allows for analysis of causal patterns among unobserved variables represented by multiple measures. It permits testing of causal hypotheses and theory, examination of psychometric adequacy, and enhancement of the explanatory power of correlational data. That characterizes counseling psychology research (Fassinger, 1987).

2.1. Participants

The population of the research is consisted of students who study in Sakarya University Faculty of Education in 2010-2011 fall terms. The sample of the research comprises of 492 students in total who have been determined on the basis of voluntary participation. Since participation in study was carried out in accordance with the voluntariness principle, inventories of all participators have been included in the analysis because of the fact that there has been no negativity experienced in the answers given by participators to the inventory. With the sample size of 492, sample error was determined as 0.05% on a confidence level of 95%.

2.2. Instruments

In the collection of research data, "SCL-90-R" was used in order to record the demographic features of the students and to determine the psychological symptom levels of the students, respectively.

2.2.1. Symptom Checklist (SCL-90-R): Developed by Derogotis et al. in 1977, SCL-90-R is a psychological symptom scanning tool with self-evaluation. The validity-reliability studies of the scale, which was developed to measure the psychological and physical symptoms, the level of compulsion experienced by the individual or the negative stress reaction lived, were carried out by Dağ (1991). The test which consists 90 items is based on five-point Likert type evaluation, namely never (0), little (1), medium level (2), quite much (3), high level (4). The test has 10 subscales in total: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism. Turkish translation of the scale was used on samples in some researches in Turkey and it was observed that it distinguishes used and examined groups in a significant level. Reliability study of the scale was carried out by Dağ in 1989 and its Cronbach alpha value was found ".97". A correlation between .10 - .77 was found between general symptom average and MMPI (Bozkurt, 1996).

2.3. Hypothesis

Figure 1 is the graphic concerning the hypothetic model of the relation between the factors and somatization in the study. In the model, it is stated that the psychological symptoms effect the arising of the somatic symptoms. In the model, psychological symptoms are independent latent variables and somatic symptoms are dependent latent variables.

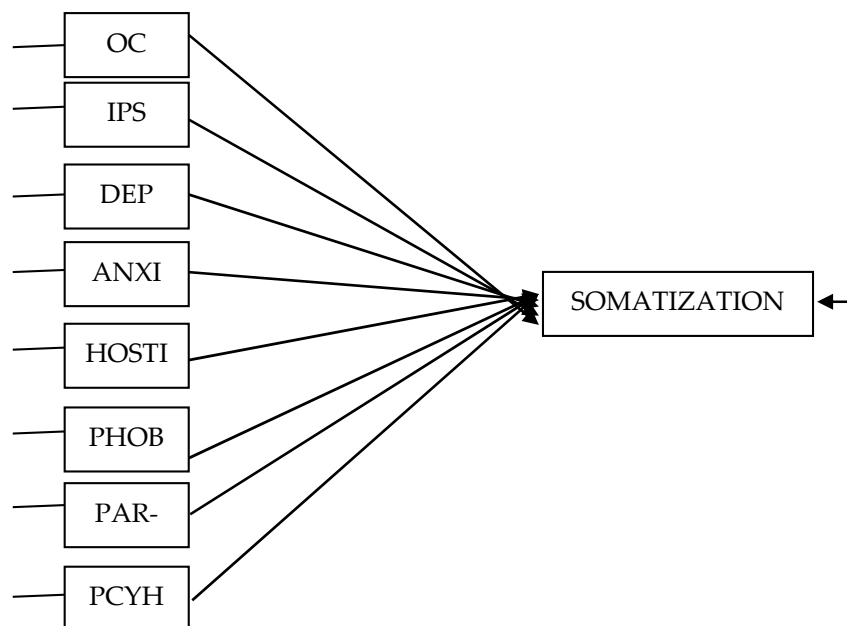


Figure 1. The offered model for the relation between Psychological Symptoms and Somatic Symptoms

3. Results

Table 1: Correlations between obsessive-compulsive (O-C), interpersonal sensitivity (IPS), depression (DEP), anxiety (ANX) and hostility (HOS) symptoms

		SOMAT	OC	IPS	DEP	ANX
O-C	N	492				
	r	0,60**				
	p (2-tailed)	,000				
IPS	N	492	492			
	r	0,51**	,065**			
	p (2-tailed)	,000	,000			
DEP	N	492	492	492		
	r	0,63**	0,67**	0,74**		
	p (2-tailed)	,000	,000	,000		
ANX	N	492	492	492	492	
	r	0,73**	0,62**	0,70**	0,78**	
	p (2-tailed)	,000	,000	,000	,000	
HOS	N	492	492	492	492	492
	r	0,60**	0,55**	0,55**	0,58**	0,67**
	p (2-tailed)	,000	,000	,000	,000	,000

**p<.01,

Table 1 shows correlations between obsessive-compulsive, interpersonal sensitivity, depression, anxiety and hostility symptoms. As it is seen on the table, there is a positive and significant ($p<.01$) relation between somatization and obsessive-compulsive ($r=0.60$), interpersonal sensitivity ($r=0.51$), depression ($r=0.63$), anxiety ($r=0.73$), hostility ($r=0.60$) symptoms. It means that when somatization symptoms increase, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, and hostility symptoms increase, too. Model includes all these symptoms because correlations between these symptoms are lower than 0.80. As a result of the analysis dimensions of psychoticism, paranoid ideation, and phobic anxiety are taken out of the model since they do not cause somatic reactions.

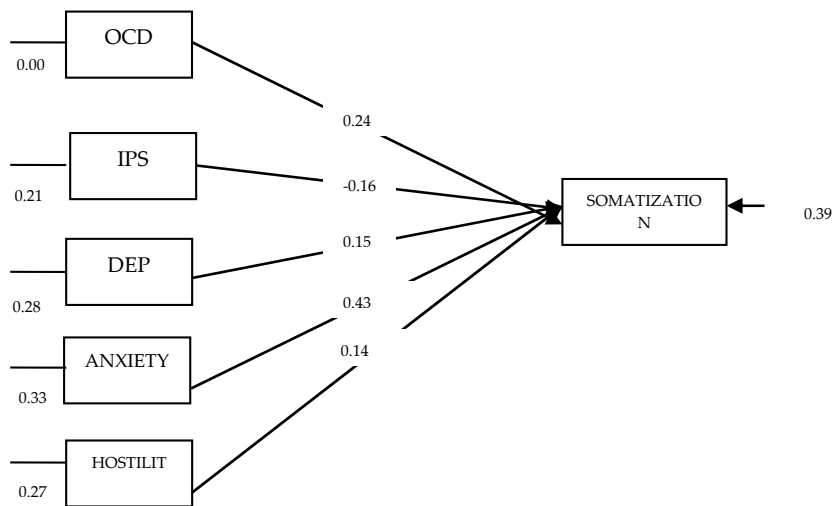


Figure 2. Path diagram of the offered model for the relation between psychological symptoms and somatization

Hypothesized model was examined via structural equation modeling (SEM). Figure 2 presents the results of SEM analysis, using maximum likelihood estimations. The model fitted good ($\chi^2 = 5,71df = 3, p = 0,126$, GFI = 1.00, AGFI = .98, CFI = 1.00, NFI = 1.00, IFI = 1.00, and RMSEA = 0.043). The standardized coefficients in Figure 2 clearly showed that somatization was predicted positively by anxiety (.43), obsessive compulsive disorder (.24), depression (.15), hostility (0.14) and negatively by interpersonal sensitivity (-.16).

4. Discussion

Psychoticism, paranoid ideation, and phobic anxiety symptoms don't cause somatic reactions. Somatization is defined as the 'conversion' of psychological pressure and overwhelming emotions into more acceptable physical symptoms (Gupta, 2006). The patient's need to somatize can be rechanneled into a discussion of psychological issues with a balanced somatopsychological orientation (Carlton, 2001). Why is not such a result experienced in psychoticism, paranoid ideation, and phobic anxiety? The individuals experiencing these psychological problems express the stress they feel with verbal or nonverbal behaviors instead of holding it in. According to Seligman & Rosenhan (1997), the mechanism by which silence hurts may be rumination; the less people talk to others about tragedy or distress, the more they ruminate.

A negative relation was found between interpersonal sensitivity and somatization. The course of disorder is often associated with long-standing disruption of social, interpersonal, and family behavior (WHO,1993). Mai offered 3 reasons for some patients' expression of dysphoria as a somatic symptom: 1) individual differences in temperament and physiological response; 2) social, cultural, and linguistic factors; and 3) previous experience of illness (Mai, 2004). Somatic patients, like anyone else, use the emergent symptoms for interpersonal advantage to make the most of their predicament. This constitutes the secondary psychological gain (Hurwitz, 2004). As the level of linking himself/herself with other individuals increases and this associating is aimed at approving each other's presence and accepting each other's presence as it is, there occurs a decrease in somatic reactions. In other words, close and sincere relations strengthen the ego of the individual. The most important factor preventing the individual from experiencing somatic symptoms is communication which is constructive and emphatic understanding oriented.

Somatic symptoms are a psychological defense against mental instability (Hurwitz, 2004). Mental distress in people's world is expressed through bodily distress (Seligman, Rosenhan, 1997). The psychological disorder which causes somatic reactions at the highest level is anxiety. The reason is the uncertainty about the source of anxiety experienced by the individual. The individual experience restlessness, but the reason, in other words the source is unknown. Living in a way that something bad may happen at any moment causes the

individual to take some precautions necessarily. These precautions are refraining, avoiding and lastly introversion respectively. Introversion is experienced in two ways: First one is physical and second one is psychological introversion. In psychological introversion, the defense mechanism referred by the individual is "repression". This means that: the one who is addressed here is an individual who is trying to control the conflicts in the inner world but at the same time who is experiencing the anxiety of losing control. According to Chaturvedi, Desai and Shaligram(2006), the concept of abnormal illness behavior explains the patients' concerns and distress due to their suffering. As Jongsma (2006), the client with somatization issues is choosing to make his / her bodily concerns the primary or only focus of his / her attention. This can be very disconcerting to significant others around him / her and can also seriously reduce the client's ability to function effectively. These people live the life as they step on glass, any moment you can hear a cracking sound.

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The Validity And Reliability Of The Turkish Version Of The Online Counseling And Face-To-Face Counseling Attitudes Scale

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ABSTRACT

The purpose of this study is to examine the validity and reliability of the Turkish version of the Online Counseling Attitudes Scale (OCAS) and Face-to-Face Counseling Attitudes Scale (FCAS) (Rochlen, Beretvas, & Zack, 2004). OCAS and FCAS loaded on four factors and the factors were named Value of Online Counseling (OC-V), Discomfort with Online Counseling (OC-D), Value of Face-to-Face Counseling (FC-V) and Discomfort with Face-to-Face Counseling (FC-D). The results of confirmatory factor analysis indicated that the four dimensional model was well fit ($\chi^2=323.61$, $df=157$, $p=0.00000$, $RMSEA=.056$, $NFI=.94$, $CFI=.96$, $IFI=.96$, $RFI=.92$, $GFI=.91$, and $SRMR=.071$). Factor loadings ranged from .47 to .88. The internal consistency coefficients of four subscales were .84, .80, .88 and .78. Overall, findings demonstrated that OCAS and FCAS may be used as a valid and reliable instrument in order to assess attitudes toward online counseling and face to face counseling of individuals.

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Keywords:

Online counselling, attitudes, validity, reliability, scale adaptation

1. Introduction

Online Counseling is defined as any delivery of mental and behavioral health services, including but not limited to therapy, consultation and psycho-education, by a licensed practitioner to a client in a non-face-to-face setting through distance communication devices for instance, the telephone, fax, asynchronous e-mail, synchronous chat, and videoconferencing (Mallen, & Vogel, 2005; Rochlen, Zach, & Speyer, 2004; Rochlen, Beretvas, & Zack, 2004). Online counseling is different from other types of computer-related services in that it includes direct communication between a counselor and at least one client and the communication is specifically tried to address mental health concerns, analogous to a "talk therapy" procedure that might be conducted face-to-face in a mental health professional's office (Rochlen, Beretvas, & Zack, 2004). We explain simply online counseling in which you would interact with a counselor via the Internet and face-to-face counseling where you would go to a counselor's office.

Since the advent of online counseling, there has been considerable debate over the effectiveness of online counseling versus traditional face-to-face counseling. Some professionals try to argue online counseling out of existence; others seem to have limitless enthusiasm for this latest development in the interface of counseling and technology (Shaw & Shaw, 2006). Disadvantages of online counseling involve maintaining confidentiality over the Internet, delivery of online counseling services by unqualified practitioners as well as important concerns regarding confidentiality, in emergency situations, the inability to directly intervene in a crisis the lack of nonverbal information such as facial expression, tone of voice, and body language, the dangers of offering online services over state jurisdiction lines, the lack of efficacy studies of online counseling services, the difficulty of developing a therapeutic relationship with a client who is never seen face-to-face and the lack

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of therapeutic control, the lack of visual cues (Barak, 1999; Murphy & Mitchell, 1998; Sampson, Kolodinsky, & Greeno, 1997; Rochlen, Beretvas, & Zack, 2004; Shaw & Shaw, 2006).

As for the Advantages of online counseling, advocates for online counseling emphasize such benefits; potential utility in reaching populations that cannot or will not traditional mental health services the convenience of the service, accessibility of services to clients who are in geographically isolated areas, are physically disabled or seriously ill and cannot leave home, would ordinarily not seek traditional counseling, would feel more comfortable expressing themselves in a written format, the ease of record keeping, and the possible decreased costs related with providing these services (Barak, 1999; Murphy & Mitchell, 1998; Rochlen, Beretvas, & Zack, 2004; Shaw & Shaw, 2006).

An attitude may be explained as a positive or negative evaluation of people, objects, event, activities, ideas, or just about anything in environment this is generally referred to as the attitude object. Social psychologists research attitudes in terms of three parts: cognitive, affective, and behavioral. Attitudes are shaped by our experiences or observing experiences, serve to guide our future conducts and can be used to predict behavior (Kağıtcıbaşı, 1999; Köklü, 1995).

Online counseling services and online mental health services are being accessed in a variety of formats and are expected to developed in the future (Norcross, Hedges, & Prochaska, 2002) and online counseling is a field that has seen increase for ten years (Barak, Hen, Boniel-Nissim, & Shapira 2008). Researchers have tried to reveal clients' attitudes toward seeking help in relation to various demographic, psychological, and cultural variables. One of the most glaring reasons for the omission of this information is a lack of research instruments designed to measure the public's perceptions of online counseling services. This scale exhibits attitudes toward online counseling and a comparable measure of attitudes toward face-to-face counseling services. The public's perceptions of online counseling may help to display or explain clinician's perspectives on the need and demand for such services (Rochlen, Beretvas, & Zack, 2004).

Internet-based treatment programs frequently integrate cognitive-behavior therapy principles, are structured, and have an evidence base. Internet-based treatment programs usually also contain rigorous assessment process prior to commencement of treatment to ensure that the consumer has the clinical disorder that the program treats. Online counseling with online cognitive behavioral therapy deal with; anxiety and depression (Topolovec-Vranic et al., 2010; Graaf et al., 2009; Sethi & Campbell, 2010; Newman, Consoli, & Taylor, 2006; Warmerdam, Stratena, & Jongasma, 2010; Graaf et al., 2011; Beattie, Shaw, Kaur, & Kessler, D2009), obsessive-compulsive disorders (Moritz, Wittekind, Hauschildt, & Timpano, 2011; Wootton et al., 2011), alcohol problem (Postel, De Haan, & De Jong, 2010; Blankers, Koeter, & Schippers, 2011), sexual disorders (McKee, 2004), suicidal ideation (Greidanus & Everall, 2010), eating disorder (Fichter et al, 2012), Panic disorder (Pier et al, 2008; Austin & Kiropoulos, 2007; Advocat & Lindsay, 2009), Posttraumatic stress disorder (Kleina et al., 2010), Social phobia (Berger et al., 2011), Sexual abuse (Littleton et al., 2011) such as various mental problems outcomes.

The Online and Face-to-Face Counseling Attitudes Scale (Rochlen, Beretvas, & Zack, 2004): The result of exploratory factor analyze of OCAS consist of two factors, and factors explained 64.6% of the variance in the responses to the 10 items and an interfactor correlation of-.52. The two FCAS factors together explained 62.2% of the variance in the responses to the 10 items and a correlation between the components of-.59. The factors were named Value of Online Counseling (OC-V) and Discomfort with Online Counseling (OC-D). The OC-V subscale represented the general feelings of participants toward the utility of online counseling, including their perceptions of how they and others would benefit from online counseling. The OC-D subscale represented participants' emotional feelings and reactions regarding their ease and comfort associated with using online counseling services. Example of items assessing each of these two factors include "Using an online counseling would help me learn about myself" and "I would dread explaining my problems to an online counselor" for the OC-V and OC-D subscales, respectively. The same base set of 10 items was selected to assess each of the FCAS factors. These factors were similarly named Value of Face-to-Face Counseling (FC-V) and Discomfort with Face-to-Face Counseling (FC-D). Again, each "Using a face-to-face counseling would help me learn about myself" and "I would dread explaining my problems to a face-to-face counselor". And the result of confirmatory factor analysis (CFA) $\chi^2=265,49$, $p<0.05$, RMSEA=.057, CFI=.96, TLI=.95, and SRMR=.57. The pattern coefficients were strong and significant ($p<.001$). Factor loadings ranged from.520 to .921. The Result

of multiple Group CFA $\chi^2=601,52$, $p<0.05$, RMSEA=.041, CFI=.95, TLI=.95, GFI=.96, and SRMR=.77. Internal consistency estimates ranged from .77 to .90 over multiple studies for scores on both the Online Counseling and Face to Face Counseling subscales, and test–retest correlations of .70 to .88 were observed over a 3-week period on both subscales. Responses are made on a 6-point Likert scale (1-strongly disagree, 6-strongly agree).

2. Method

2.1. Participants

Participants were 345 (173 were female and 172 were male) university students.

2.2. Procedure

Primarily the Online Counseling and Face-to-Face Counseling Attitudes Scale were translated into Turkish by six academicians. After that the Turkish form was back-translated into English and examined the consistency between the Turkish and English forms. Turkish form has reviewed by five academicians from educational sciences department. Finally they discussed the Turkish form and along with some corrections this scale was prepared for validity and reliability analyses. In this study confirmatory factor analysis was executed to confirm the original scale's structure in Turkish culture. As reliability analysis internal consistency coefficients and the item-total correlations were examined. Data were analyzed by LISREL 8.8 and SPSS 20.0.

3. Results

3.1. Construct Validity

The results of confirmatory factor analysis indicated that the four dimensional model was well fit and Chi-Square value ($\chi^2=323.61$, $df=157$, $p=0.00000$) which was calculated for the adaptation of the model was found to be significant. The goodness of fit index values of the model were RMSEA=.056, NFI=.94, CFI=.96, IFI=.96, RFI=.92, GFI=.91, and SRMR=.071. Factor loadings ranged from .47 to .88. The correlation between the OC-V and OC-D subscales of the OCAS was $-.40$ ($p<.001$), and the correlation between the FC-V and FC-D subscales was $-.28$ ($p<.001$) for the FCAS. The correlation between the OC-V and FC-V subscales was $.37$, $p<.001$. The correlation between the OC-D and FC-D subscales was $.49$, $p<.001$.

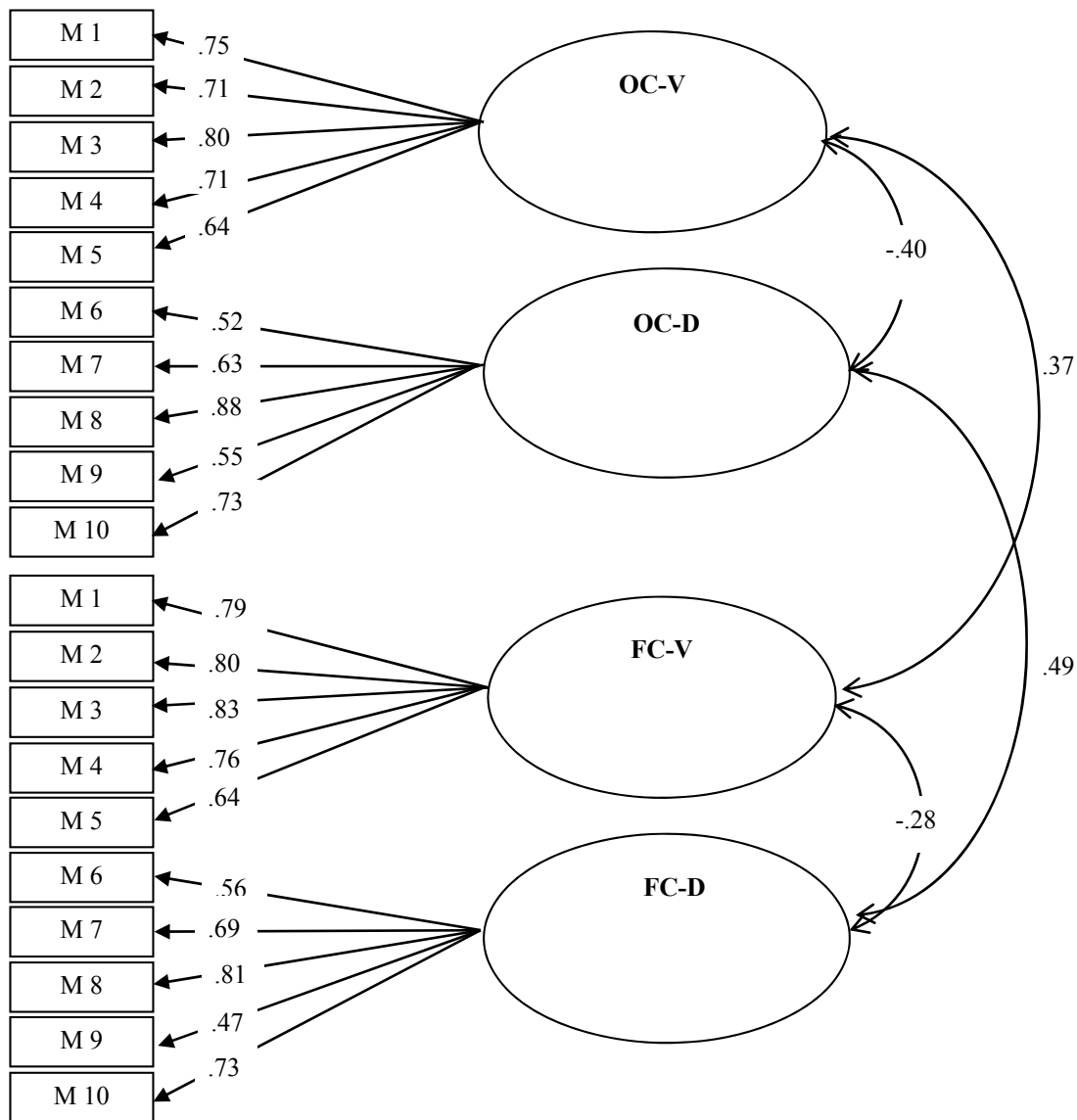


Figure 1: OCAS and FCAS Path Diagram and Factor Loading

3.2. Reliability

The internal consistency coefficients of OCAS and FCAS four subscales were OC-V, .84, OC-D, .80, FC-V, .88 and FC-D, .78. The corrected item-total correlations of OC-V ranged from .59 to .70, OC-D ranged from .50 to .71, FC-V ranged from .71 to .73 and FC-D ranged from .43 to .68.

Table 1: OCAS Item-Total Correlation

OC-V		OC-D	
Mad. No	R	Mad. No	r
1	.69	6	.50
2	.62	7	.62
3	.70	8	.71
4	.63	9	.49
5	.59	10	.61

Table 2: FCAS Item-Total Correlation

FC-V		FC-D	
Mad. No	r	Mad. No	r
1	.73	6	.43
2	.73	7	.61
3	.74	8	.68
4	.71	9	.43
5	.62	10	.64

4. Discussion and Conclusion

The aim of this study was to translate the OCAS and FCAS into Turkish and examine its psychometric properties. Numerous fit indexes are used for the aim of presenting the adequacy of the model tested in Confirmatory factor analysis (CFA). For GFI, CFI, NFI, RFI and IFI indexes, acceptable fit value is considered to be 0.90 and best fit value is 0.95 (Bentler, 1980; Bentler & Bonett, 1980; Marsh, Hau, Artelt, Baumert, & Peschar, 2006). As for the RMSEA, acceptable fit value is considered to be 0.08 and best fit value is 0.05 (Brown & Cudeck, 1993; Byrne & Campbell, 1999). CFA was conducted so as to indicate whether the factor structure of the original form would be confirmed in the Turkish sample. The OCAS and FCAS loaded on four factors. The results of CFA indicated that the model was well fit. Thus, it can be said that the structural model of the OCAS and FCAS which consists of four factors was well fit to the Turkish culture. The internal consistency coefficients of four subscales were high. Overall, findings demonstrated that OCAS and FCAS had high validity and reliability scores (Büyüköztürk, 2004; Tabachnick & Fidell, 1996; Tezbaşaran, 1996) and OCAS and FCAS may be used as a valid and reliable instrument in order to assess attitudes toward online counseling and face to face counseling of individuals and accurate comparisons between the two types of counseling services. Nevertheless, further studies that will use the OCAS and FCAS are important for its measurement force.

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