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The Validity and Reliability Evaluation of the Turkish Version of the Perceptions of Threats from Emotion Questionnaire (PTEQ)*

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The Perceptions of Threats from Emotion Questionnaire (PTEQ) assesses beliefs about threats related to seven basic emotions and 'strong emotions in general' that may contribute to understanding psychopathologies based on psychological disorders. The aim of this study was to translate and evaluate the psychometric properties of the Turkish version of the four subscales of the PTEQ (anxiety, anger, disgust, guilt). One hundred fourteen patients with clinical obsessive-compulsive disorder (OCD) and one hundred forty individuals from the general population (GP) were recruited. Confirmatory factor analyses and internal reliability analyses were conducted, and the divergent and discriminant validity of the PTEQ was examined with the Beck Depression Inventory, Beck Anxiety Inventory, and Obsessive Beliefs Questionnaire-Perfectionism/Intolerance of Uncertainty. The findings revealed that the four models for the PTEQ subscales showed an acceptable and good fit in the factor analysis and had satisfactory internal consistency (all ≥ .70) and test–retest reliability in the clinical OCD and GP samples. The 6-item subscale obtained by removing the 7th item from the PTEQ-guilt subscale is appropriate for OCD and GP samples in Turkish culture. The results support the divergent and discriminant validity of four subscales of the PTEQ in GP and OCD samples. The suggested Turkish versions of the four subscales of the PTEQ showed adequate reliability and validity, but further investigations are needed in different populations with larger samples.

Keywords: emotion, PTEQ, validation, reliability

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Consent of Patients. The participants were informed in detail, and informed consent was obtained.

Ethical considerations. Local ethics committee approval was received for this study (Jan 11th, 2021, numbered 102/16), conducted under the ethical standards in the 2013 Helsinki Declaration.

Declaration of interest statement. On behalf of all authors, the corresponding author states that there is no conflict of interest.

Data Availability Statement. All relevant data are within the paper and they are available from the corresponding author on reasonable request.

Author note. All authors equally contributed to the present manuscript.

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Highlights:

- Confirmatory factor analysis of the four models (anxiety, anger, disgust, and guilt) of the PTEQ subscales yielded an acceptable and good fit for the clinical OCD and the GP samples when the 7th item was removed from the PTEQ-guilt subscale.
- The four subscales of the PTEQ had adequate internal consistency and test–retest reliability in the OCD and GP samples.
- The PTEQ, a measure of the emotional appraisal of emotional threats, may contribute to identifying the needs of individuals in this direction and planning studies that may provide the potential for change in clinical OCD and GP samples.

Individuals' psychophysical mechanisms undergo multiple alterations in response to events or situations that are meaningful to the organism, which are collectively referred to as emotions. These alterations entail affective, cognitive, physiological, motivational, and expressive-behavioral components (Pekrun et al., 2023). Emotions and emotion regulation strategies appear to be crucial for understanding the nature of psychopathologies and psychotherapies and evaluating the effectiveness of psychotherapy (Ekici et al., 2023; McKay, 2006). Experiencing some emotions more frequently, more intensely, and for more extended periods than others can lead to difficulty in functionality and well-being in relation to specific psychopathologies, such as anxiety (Yap et al., 2018), disgust (Knowles et al., 2019), guilt (Stewart & Shapiro, 2011), and anger (Piacentino et al., 2016).

Individuals with anxiety disorders have difficulty with emotions in general, including impaired ability to understand emotions, negative responses to emotions (Mennin et al., 2005), and the use of maladaptive strategies to regulate their emotions (Khosravani et al., 2020a). Difficulties with emotional regulation may also occur in other psychiatric disorders, such as obsessive compulsive disorder (OCD) (Khosravani et al., 2020b), depression (Stikkelbroek et al., 2016), and eating disorders (Harrison et al., 2010). Emotional appraisals are plans and strategies that may be critical for coping with emotions and are related to emotion regulation (Bartsch et al., 2008; Schmidt et al., 2010); therefore, maladaptive emotional plans and strategies lead to further emotion dysregulation (Carpenter & Trull, 2013; Smith et al., 2014). Research indicates variability in individuals' emotional appraisal processes (Mayer & Gaschke, 1988; Smith et al., 2012). OCD is just one of several disorders that can be understood as involving difficulty in emotion regulation. Therefore, previous studies have investigated emotion regulation problems in individuals with OCD, such as anxiety about negative emotions, emotional clarity, the suppression or nonacceptance of emotions, and the use of nonadaptive strategies (Coleman et al., 2011; Fergus & Bardeen, 2014; Khosravani et al., 2020b; Robinson &

Freeston, 2014; Stern et al., 2014). Disgust (Krause et al., 2022), anxiety (Ekici et al., 2023), guilt (Ferrante & D'Olimpio, 2022), and anger (Radomsky et al., 2007) are significantly associated with obsessive-compulsive symptoms in the OCD literature, whereas other emotions, such as happiness, sadness, and lust, are not (Lee et al., 2023; Smith et al., 2014). Emotions of guilt, disgust, anger, and anxiety may precede, motivate, progress, or result from OCD symptoms (Melli et al., 2015; Piacentino et al., 2016; Poli et al., 2019). Perceived threats from emotions are associated with and predict obsessive–compulsive symptoms (McCubbin & Sampson, 2006; Smith et al., 2014; Smith et al., 2012; Wetterneck et al., 2021).

The Perceptions of Threat from Emotions Questionnaire (PTEQ) is valuable because it emphasizes that measuring the appraisal of emotions may contribute to the recognition of psychiatric disorders. A few studies have examined the psychometric properties of the original PTEQ. McCubbin and Sampson (2006) evaluated the psychometric properties of the PTEQ with undergraduate university students. The PTEQ evaluates beliefs about threats through *seven basic emotions*: fear/anxiety, guilt, disgust, anger, happiness, sadness, lust, and *strong emotions in general*, characterized by difficulty in distinguishing between emotions. The PTEQ has shown good Cronbach's alphas for all subscales with no specific subscale test–retest reliability. The authors calculated the test–retest reliability of only the total PTEQ (the sum of scores for the perception of threats related to fear, disgust, guilt, anger, lust, sadness, happiness, and strong emotions) (r = .830, p <.001). They also examined the percentage of responses to some of the questions to ascertain whether the scale pertains to emotions that respondents have experienced and can distinctly identify. In the original study, the authors noted that it was impossible to define concurrent validity for the PTEQ, while divergent validity was supported by nonsignificant correlations with the other measures (including the Beck Anxiety Inventory, Beck Depression Inventory, Responsibility Attitude Scale, and Thought Action Fusion Scale). However, only correlations between the PTEQ-anxiety subscales and fear/anxiety scores and between the PTEQ-sadness and depression scores have been reported (McCubbin & Sampson, 2006). This scale has shown good internal consistency and divergent validity in previous studies (Smith et al., 2012; Wetterneck et al., 2021).

In the literature beyond emotions, emotion regulation-related emotional appraisals have been thoroughly investigated (McCubbin & Sampson, 2006; Smith et al., 2014; Smith et al., 2012; Wetterneck et al., 2021). An advantage of the PTEQ is that it evaluates the perception of threats related to basic emotions and strong emotions separately, whereas other appraisals of emotions, such as Individual Beliefs About Emotions (Veilleux et al., 2021a) and the Leahy Emotional Schema Scale (Leahy, 2012), assess them in general. However, defining the emotional appraisals that are associated with psychiatric symptoms separately for each emotion may lead to a deeper understanding of their etiology and to more targeted interventions for individuals that address symptoms with different presentations and maladaptive emotion regulation strategies, especially OCD. The PTEQ was developed to evaluate emotional appraisal, but its

psychometric properties have yet to be assessed in Turkiye. We examined four subscales (anxiety, guilt, anger, and disgust) rather than all of the subscales in the present study because of their theoretical coherence with OCD symptoms (Ekici et al., 2023; Smith et al., 2012), which are weakly associated with sadness, happiness, lust, and strong emotions in general (Lee et al., 2023). We aimed to adapt the anger, anxiety, disgust, and guilt subscales of the PTEQ to Turkish and evaluate the factor structure, divergent and discriminant validity, and reliability of the PTEQ in clinical OCD and general population (GP) samples.

Method

Participants

One hundred fourteen individuals who were diagnosed with OCD according to the DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association*, 2013) participated in a three-month training and research hospital psychiatry polyclinics using the Structured Clinical Interview for Diagnostic and Statistical Mental Disorders 5-Clinician Version (SCID 5-CV) for clinical OCD conducted by a psychiatrist in 2021 (Elbir et al., 2019). The exclusion criteria for the study included a diagnosis of substance abuse disorders, neurocognitive disorders, schizophrenia, other psychotic disorders, and bipolar affective disorders on the basis of the DSM-5. One hundred forty volunteers who had no history of receiving psychiatric treatment and did not have current psychiatric complaints were drawn from OCD patients' relatives as well as hospital staff and their relatives and participated as GP sample. To evaluate the test–retest reliability of the four subscales of the PTEQ, a second assessment was conducted with a smaller subset of the initial OCD sample of 17 participants (10 females and seven males, aged 18 – 65) two weeks after the initial measurement (Watson, 2004).

Procedure

Initially, we contacted the developers of the original PTEQ and received the necessary permissions. Two bilingual psychiatrists (one of whom is a native Turkish speaker) translated the scale into Turkish. The questionnaire was then back-translated into English by another psychiatrist (a native speaker of Turkish) (Brislin et al., 1973). The participants were fully informed about the study and provided consent for three months. The research received ethical approval from the University of Health Sciences Diskapi Yildirim Beyazit Training and Research Hospital and was conducted following the guidelines outlined in the 2013 Helsinki Declaration (Approval date: Jan 11, 2021; Reference number: 102/16).

Measurements

Perception Threat from Emotions Questionnaire (PTEQ; McCubbin and Sampson, 2006): The PTEQ assesses beliefs about emotions through nine questions for each of eight emotions: happiness, sadness, anger, fear/anxiety, disgust, guilt, lust, and strong emotions in general. The PTEQ measures the experience of individuals' emotions rather than the frequency of specific emotions. Responses are presented on a 5-point scale and correspond to *not at all*, *a little bit*, *moderately*, *quite a bit and definitely*. Each emotion subscale generates a separate subscale score when the responses to each of the first seven items for that emotion are summed, with higher scores indicating a more significant overall threat from emotion. The

responses from Items 8 and 9 for each of the PTEQ subscales indiate whether the questionnaire refers to emotions that the respondents have experienced and are able to identify. This validity and reliability of this self-reported scale (all Cronbach's alphas ≥ .70) (Nunnally, 1970) were found to be satisfactory (McCubbin & Sampson, 2006). In the present study, we used only the anxiety, disgust, anger, and guilt domains of the PTEQ.

Obsessive Beliefs Questionnaire-44 (OBQ-44; Obsessive Compulsive Cognitions Working Group [OCCWG], 2005): The OBQ-44 consists of 44 questions that evaluate obsessive beliefs via an 8-point Likert scale, with scores ranging from 0-7 points for each item. It is divided into three subscales: inflated responsibility/overestimation of threat (OBQ-RT), perfectionism/intolerance of uncertainty (OBQ-PC), and importance of thought/control over thoughts (OBQ-ICT) (OCCWG, 2005). For our research, we focused solely on the OBQ-PC subscale. The Turkish translation of the adapted scale was conducted by Boysan et al. (2010). The Cronbach's alpha value for the OBQ-PC subscale was .89 for the adapted version (Boysan et al., 2010), which was the same as that reported in the original study (OCCWG, 2005). The test–retest reliability for the OBQ-44 subdimensions ranged from .69 to .81, and the three-factor structure remained consistent with the original research, demonstrating a good fit. The Cronbach's alpha values for this subscale were .90 for the OCD group and .91 for the GP group in this research.

Beck Anxiety Inventory (BAI; Beck* et al.*, 1988): The BAI assesses symptoms of anxiety, or state anxiety, via a 21-item self-report. The participants were asked to report the extent to which they had experienced each item in the past week. The BAI is scored between 0 and 3 points, corresponding to *not at all*, *mildly*, *moderately*, or *severely*. The total score is obtained by summing the item scores for individual symptoms. High scores on the questionnaire are related to a high level of anxiety. The original version has demonstrated good psychometric properties. The Cronbach's alpha values of the BAI and test–retest methods were calculated as .92 and .75, respectively (Beck et al., 1988). The validity and reliability of the Turkish adaptation of this scale was examined by Ulusoy et al. (1998). The Cronbach's alpha value of the adapted version of the BAI was calculated as .93.

Beck Depression Inventory (BDI; Beck, 1961): The BDI was developed to evaluate self-reported depression symptoms via a 21-item scale and is scored between 0 and 3 points (Beck et al., 1961). Hisli et al. (1988) adapted the questionnaire into Turkish and demonstrated that the psychometric properties of the Turkish version were comparable with those of the original questionnaire. The Cronbach's alpha values of the BDI were calculated as .79 –.94 for clinical samples and .82 –.90 for nonclinical samples. The Cronbach's alpha values of the BDI, split-half, and test–.retest methods were calculated as .80, .74, and .78, respectively (Hisli, 1988).

Data Analysis

The preliminary analysis was conducted using SPSS software version 25.0. The necessary sample size for the present study was established on the basis of different guidelines for factor analysis. MacCallum et al. (1999) referred to Gorsuch (1983) and Kline (1979), who proposed that N should be at least 100 for factor analysis (MacCallum et al., 1999). However, some authors have suggested that the appropriate sample size calculation focuses on the N:p ratio, which indicates the ratio of subjects to variables rule and a ratio of 3 to 10 (Bryman & Cramer, 2002; Child, 2006; Tavşancıl, 2010). We also used a calculation tool to calculate the smallest sample size required for our study, 107 individuals. This analysis was conducted using an online calculation tool based on Moshagen and Bader (2024) with an alpha level of 0.05, an effect measure with RMSEA, a 1-β (power) of .80, degrees of freedom of 113 and 7 predictors in the model (Moshagen & Bader, 2024). With a sample size of 114 for the

clinical OCD group and 140 for the GP group, this study included sufficient participants for the statistical analyses in the psychometric evaluation.

We evaluated the factor structure of the PTEQ through confirmatory factor analysis (CFA) using LISREL (version 8.80). We also assessed discriminant validity with the JASP (version 0.17.3.0), divergent validity, reliability, and test–retest reliability. We used the expectation maximization (EM) algorithm to replace missing values because of its effectiveness in parameter estimation and its unbiased results with low amounts of missing data (less than 5% in this dataset) (Enders, 2013). The data did not contain extreme values exhibiting a multivariate normal distribution, and the diagonally weighted least squares (DWLS) method was chosen for CFA parameter estimation (Li, 2016). Correlations between the items were examined, and it was determined that there was no correlation greater than .80; in other words, there was no multicollinearity problem. When the graphs (scatter plots) were drawn to determine whether the relationships were linear, there were linear relationships between the variables.

Various fit indices were used to assess the model's goodness of fit in CFA, including the chi-square (χ^2)/degrees of freedom (df) ratio (χ^2 /df), comparative fit index (CFI), goodness-of-fit index (GFI), normed fit index (NFI), nonnormed fit index (NNFI), root mean square error of approximation (RMSEA), and standard root mean square residual (SRMR). The chi-square value is sensitive to sample size. As the sample size increases, a chi-square/df ratio of 2, 3, or even five can indicate that the model is acceptable, and values between 0 and 2 indicate a good fit. The CFI, GFI, NFI, and NNFI values should be close to .95 for a good fit, with values between .90 and .95 indicating an acceptable fit. For the RMSEA, values less than .05 indicate a good fit, and values between .05 and .1 indicate an acceptable fit. For the SRMR, values between .05 and .1 indicate an acceptable fit and values less than .05 suggest a good fit (Browne & Cudeck, 1992; Hu & Bentler, 1999; Kline, 2005).

Results

A total of 114 patients with OCD were included in this study, including 80 females (70.2%), with a mean age of 31.66 years (*SD* = 12.69) and 12.59 years of education (*SD* = 3.84). With regard to their marital status, 52.6% of the patients with clinical OCD (*N* = 60) were single/dating, 41.2% of the patients with OCD (*N* = 47) were married, and 6.2% were divorced/separated (*N* = 7). Twenty-eight percent (*N* = 32) of these patients were smokers. Seventy-three individuals with OCD (64%) were currently receiving psychiatric treatment and/or psychotherapy, and 81 individuals with OCD (71%) had previously received pharmacotherapy and/or psychotherapy. In addition to the clinical OCD sample, our study comprised 140 individuals from the GP, of whom 94 individuals (67.1%) were female. The mean age of these participants was 33.14 years (*SD* = 11.23), and they had an average of 13.18 years of education (*SD* = 3.20). Regarding their marital status, 43.6% of the GP sample (*N* = 61) were single/dating, 52.9% (*N* = 74) were married, and 3.6% were divorced/separated (*N* = 5). A total of 26.4% (*N* = 37) of the GP sample were smokers. No difference was detected between the two samples in term of sex, age, or duration of education. The descriptive characteristics of the sample with OCD and the GP sample are shown in Table 1.

Table 1
Descriptive statistics of the OCD (N = 114) and GP (N = 140) samples

		OCD		GP	
Variables		*f*	%	*f*	%
Gender	Female	80	70.2	94	67.1
	Male	34	29.8	46	32.9
Marital Status	Single/Dating	60	52.6	61	43.6
	Married	47	41.2	74	52.9
	Divorsed/seperate	7	6.2	5	3.6
Occupation	Unemployed	10	8.8	10	7.1
	Student	38	33.3	11	7.9
	Housewife	29	25.4	23	16.4
	Worker/Civil servant	33	28.9	92	65.7
	Retired	3	2.7	4	2.9
	Other	1	0.9	-	-
Smoking	Yes	32	28.1	37	26.4
	No	82	71.9	103	73.6
Past psychiatric treatment	Yes	73	64.0	-	-
	No	41	36.0	-	-
Current psychiatric treatment	Yes	81	71.1	-	-
	No	33	28.9	-	-
		M	SD	M	SD
Age; year		31.66	11.69	33.14	11.23
Years of education; year		12.59	3.84	13.18	3.20

Table 2 shows the means, standard deviations, ranges obtained in this study, skewness, values, and kurtosis values of all the questionnaires.

Table 2
Means, standard deviations, skewness and kurtosis values of PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, PTEQ-guilt, BAI, BDI, and OBQ-PC in OCD and GP samples

	OCD (*N* = 114)				GP (*N* = 140)			
Variables	Mean *(SD)*	Range	Skewness	Kurtosis	*Mean (SD)*	Range	Skewness	Kurtosis
PTEQ-anxiety	17.73 (6.11)	23	-0.26	-0.95	12.62 (5.48)	26	0.36	0.31
PTEQ-disgust	12.54 (7.33)	28	0.27	-0.66	8.50 (5.12)	22	0.01	-0.54
PTEQ-anger	16.19 (5.76)	26	-0.20	-0.14	14.29 (5.96)	27	-0.07	-0.41
PTEQ-guilt	15.57 (5.93)	28	-0.25	-0.20	11.86 (6.11)	26	0.08	-0.55
BDI	19.49 (12.08)	51	0.51	-0.56	8.25 (7.09)	35	1.30	2.18
BAI	19.32 (13.01)	55	0.65	-0.24	7.24 (7.66)	35	1.49	2.26
OBQ-PC	69.56 (20.79)	92	-0.01	–0.68	59.73 (21.07)	84	-0.17	-0.74

Note: PTEQ = Perceived Threat from Emotions Questionnaire; BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory; OBQ-PC = Obsessive Beliefs Questionnaire-Perfectionism/Intolerance of Uncertainty.

The participants generally recognized and differentiated various emotions even if they did not experience them frequently. This is crucial because it means that the respondents possessed sufficient recognition of the experiences targeted by the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, and PTEQ-guilt for OCD and GP samples (see Table 3).

Table 3

Description of responses to items 8 ('are you able to clearly identify what you mean by (emotion)?') and 9 ('do you feel (emotion) quite often?'), for PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, PTEQ-guilt in OCD and GP samples

OCD				
	Item 8		Item 9	
PTEQ subscales	Percent responses 0 or 1	Percent responses 2-4	Percent responses 0 or 1	Percent responses 2-4
PTEQ-anxiety	2.6	97.4	17.5	82.5
PTEQ-disgust	2.6	97.4	26.3	73.7
PTEQ-anger	3.5	96.5	24.6	75.4
PTEQ-guilt	2.6	97.4	41.2	58.8
GP				
	Item 8		Item 9	
PTEQ subscales	Percent responses 0 or 1	Percent responses 2-4	Percent responses 0 or 1	Percent responses 2-4
PTEQ-anxiety	4.3	95.7	30.7	69.3
PTEQ-disgust	3.6	96.4	51.4	49.6
PTEQ-anger	4.3	95.7	31.4	68.6
PTEQ-guilt	3.6	96.4	60.0	40.0

Note: PTEQ = Perceived Threat from Emotions Questionnaire.

Table 4 shows that all four models had an acceptable and good fit (Browne & Cudeck, 1992; Hu & Bentler, 1999; Kline, 2005). The fit indices demonstrate that the obtained data fit the model for the PTEQ-anxiety, PTEQ-disgust, and PTEQ-anger. Item 7 was removed from the PTEQ-guilt subscale for the clinical OCD and GP samples. Before Item 7 was removed, $\chi^2/df = 1.514$, RMSEA = .067, NNFI = .985, NFI = .970, CFI = .989, GFI = .987, and SRMR = .069 for the PTEQ-guilt subscale in the clinical OCD sample, and $\chi^2/df = 1.578$, RMSEA = .065, NNFI = .982, NFI = .968, CFI = .988, GFI = .985, and SRMR = .081 for the PTEQ-guilt subscale in the GP sample.

Table 4
Goodness of fit testing the measurement of PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, PTEQ-guilt for clinical OCD and GP samples

	OCD				GP			
Fit indices	PTEQ-anxiety	PTEQ-disgust	PTEQ-anger	PTEQ-guilt	PTEQ-anxiety	PTEQ-disgust	PTEQ-anger	PTEQ-guilt
χ^2 /df	1.179	1.627	1.708	1.493	1.573	1.550	1.258	1.578
RMSEA	0.040	0.075	0.079	0.066	0.065	0.064	0.044	0.065
NNFI	0.997	0.995	0.964	0.978	0.976	0.982	0.991	0.982
NFI	0.986	0.991	0.946	0.962	0.958	0.967	0.973	0.968
CFI	0.998	0.997	0.976	0.987	0.984	0.988	0.994	0.988
GFI	0.993	0.995	0.976	0.985	0.981	0.986	0.987	0.985
SRMR	0.055	0.053	0.094	0.082	0.085	0.075	0.073	0.081

Note. PTEQ = Perceived Threat from Emotions Questionnaire.

Figural representations of the four tested models are provided for the OCD sample. The factor loadings and error variances of the PTEQ-anxiety ranged from .65 to .84 and from .29 to .58, respectively, indicating their suitability for measuring the latent structure (see Figure 1). Similarly, the factor loadings and error variances of the PTEQ-disgust ranged from .73 to .87 and from .24 to .47, respectively (see Figure 2). The factor loadings and error variances of the PTEQ-anger subscale ranged from .59 to .75 and from .44 to .65, respectively (see Figure 3). The factor loadings and error variances of the PTEQ-guilt ranged from .30 to .77 and from .40 to .91, respectively (see Appendix 1). Factor loadings of .30 and above indicate that the items are suitable for measuring the latent structure, and error variances of less than .90 indicate an acceptable amount of error in calculating the latent structure (Kline, 2011)NY: Guilford</secondary-title></titles><periodical><full-title>New York, NY: Guilford</full-title></periodical><dates><year>2011</year></dates><urls></urls></record></Cite></EndNote>. However, Tabachnik et al. (2013) proposed that items with loadings <.32 should not be interpreted (Tabachnick et al., 2013); this guideline led to the deletion of Item G7. We deleted items with incompatible factor loadings and error variances in the PTEQ-guilt model because Item G7 did not have satisfactory factor loading values. The last factor loadings and error variances of the PTEQ-guilt ranged from .66 to .74 and from .45 to .57, respectively (see Figure 4). Consequently, seven items from the PTEQ-anxiety, PTEQ-disgust, and PTEQ-anger scales and six items from the PTEQ-guilt of the original scale were included in further analyses.

Figure 1
Factor loadings of the PTEQ-anxiety in the clinical OCD sample (Standardized path coefficients)

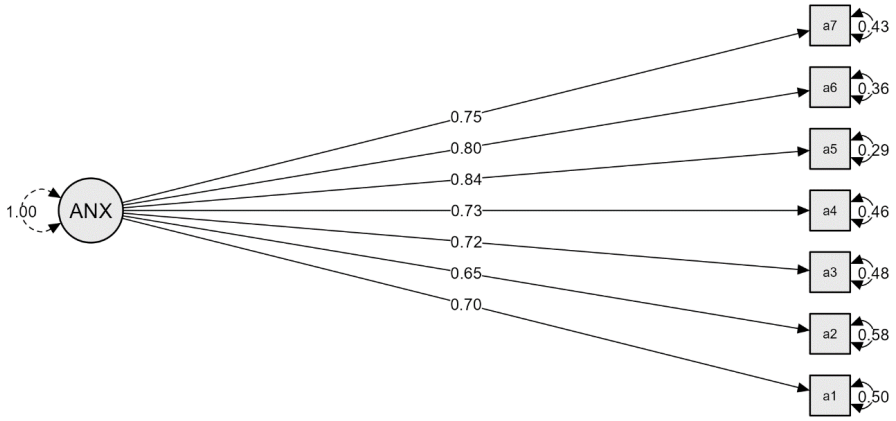


Figure 2
Factor loadings of the PTEQ-disgust in the clinical OCD sample (Standardized path coefficients)

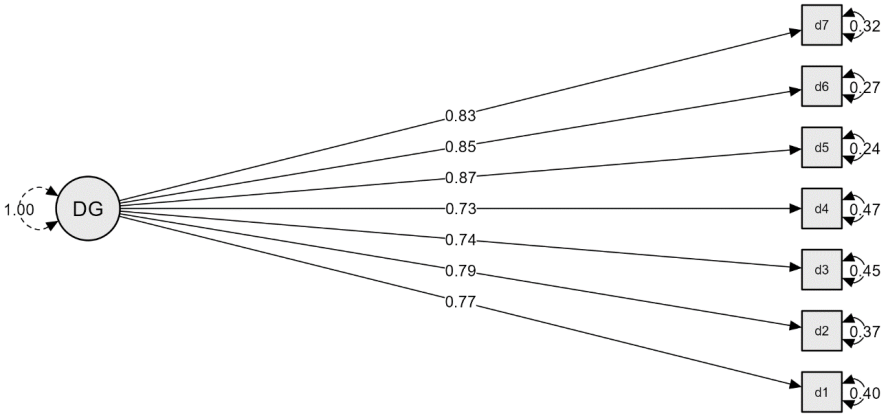


Figure 3
Factor loadings of the PTEQ-anger in the clinical OCD sample (Standardized path coefficients)

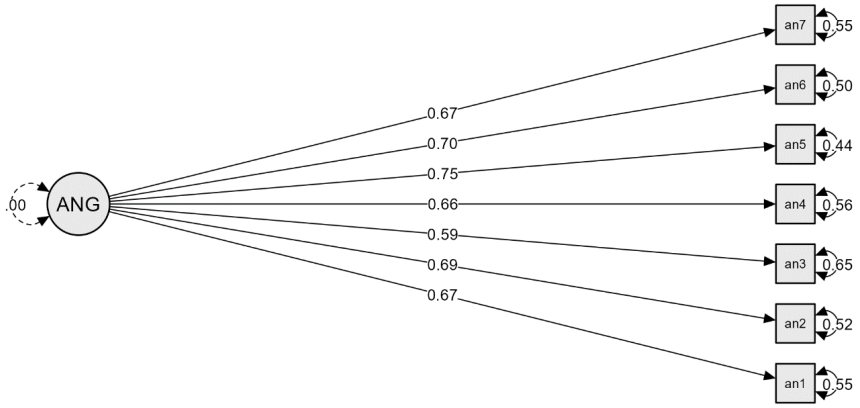
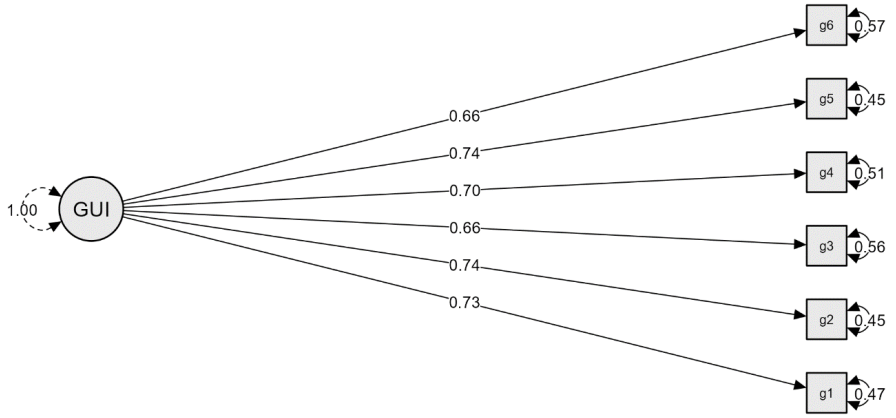


Figure 4
Factor loadings of the PTEQ-guilt with excluded item 7 in the clinical OCD sample (Standardized path coefficients)



Figural representations of the four tested models are also shown for the GP sample. The factor loadings and error variances of the PTEQ-anxiety ranged from .61 to .82 and from .33 to .63, respectively (see Figure 5). The factor loadings and error variances of the PTEQ-disgust subscale ranged from .62 to .81 and from .34 to .62, respectively (see Figure 6). The factor loadings and error variances of the PTEQ-anger subscale ranged from .59 to .81 and from .34 to .65, respectively (see Figure 7). The factor loadings and error variances of the PTEQ-guilt ranged from .57 to .84 and from .30 to .68, respectively (see Appendix 2). Factor loadings of .30 and above indicate that the items are

suitable for measuring the latent structure. In contrast, error variances of less than .90 indicate an acceptable error in calculating the latent structure (Kline, 2011) NY: Guilford</secondary-title></titles><periodical><full-title>New York, NY: Guilford</full-title></periodical><dates><year>2011</year></dates><urls></urls></record></Cite></EndNote>. The analyses obtained better model fit results when G7 was removed from the PTEQ-guilt subscale, as in the OCD group, with the low factor loading removed. The last factor loadings and error variances of the PTEQ-guilt ranged from .66 to .74 and from .45 to .57, respectively (see Figure 8). On the basis of these findings, seven items for the PTEQ-anxiety, PTEQ-disgust, and PTEQ-anger scales and six items for the PTEQ-guilt were included in further analyses.

Figure 5
Factor loadings of the PTEQ-anxiety in the GP sample (Standardized path coefficients)

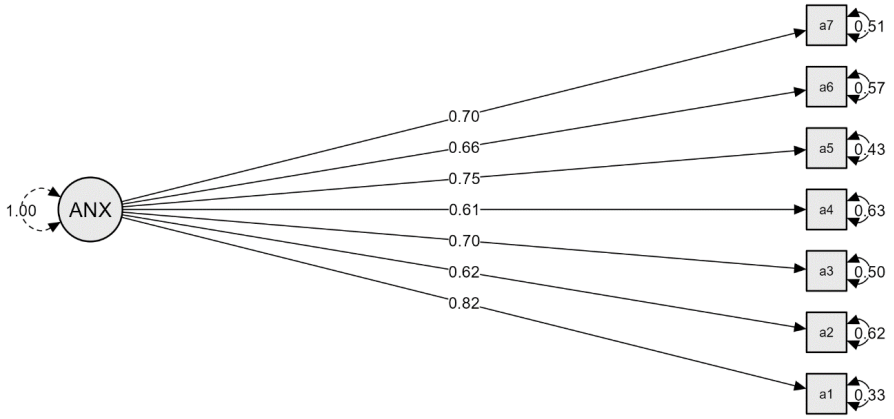


Figure 6
Factor loadings of the PTEQ-disgust in the GP sample (Standardized path coefficients)

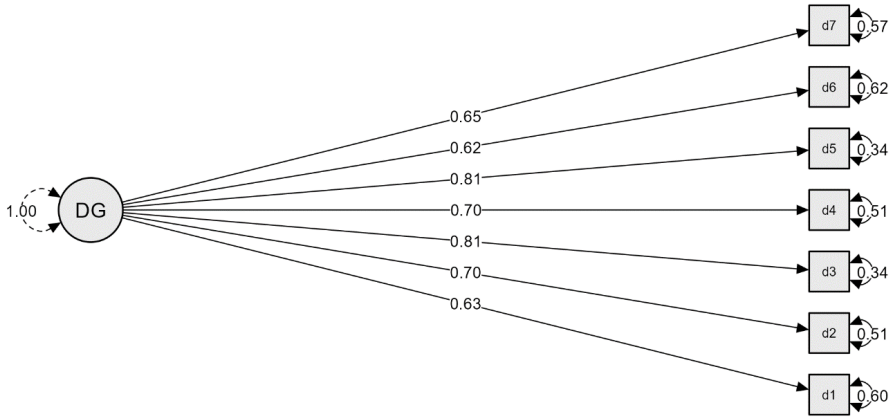


Figure 7
Factor loadings of the PTEQ-anger in the GP sample (Standardized path coefficients)

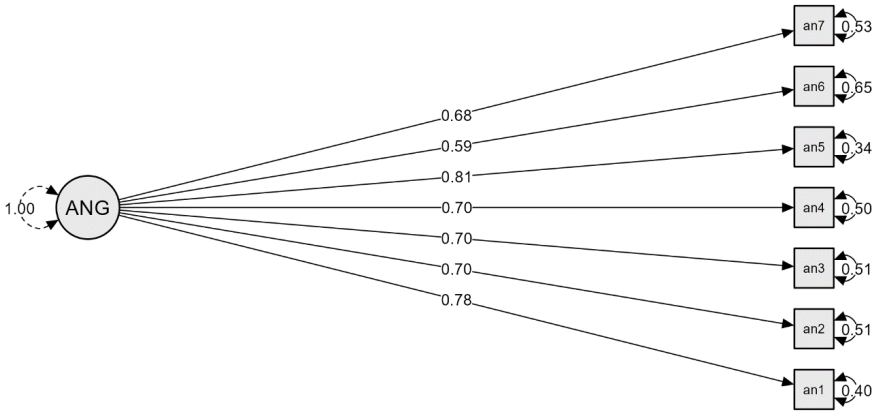
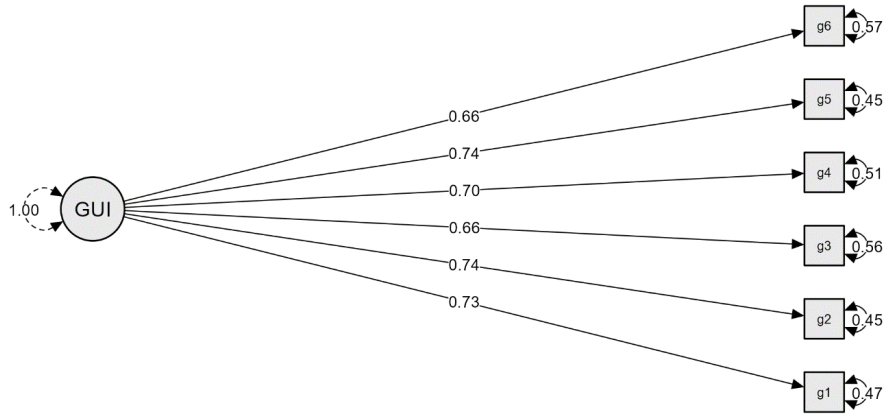


Figure 8
Factor loadings of the PTEQ-guilt with excluded item 7 in the GP sample (Standardized path coefficients)



When interpreting Pearson's correlation coefficients, we considered values below .30 poor, .30 –.50 low, .51 –.70 moderate, .71 –.90 high, and values above .90 very high (Asuero et al., 2006; Mukaka, 2012). There were poor correlations between the OBQ-PC and the PTEQ-anger, PTEQ-disgust, and PTEQ-guilt scores and low correlations between the OBQ-PC, BAI, and PTEQ-anxiety scores in the clinical OCD patients. In addition, for the GP sample, there were poor correlations between the BAI score and the PTEQ-anxiety, PTEQ-disgust, and PTEQ-anger, but no correlation between BAI score and the PTEQ-guilt score. There were also poor correlations between the scores for PTEQ-anxiety, PTEQ-disgust, and PTEQ-guilt and depression in the GP sample (see Table 5).

Table 5
Correlations between PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, PTEQ-guilt, BAI, BDI, and OBQ-PC in OCD and GP samples

	OCD					
Variables	1.	2.	3.	4.	5.	6.
1. PTEQ-anxiety	-					
2. PTEQ-disgust	0.459**	-				
3. PTEQ-anger	0.475**	0.529**	-			
4. PTEQ-guilt	0.638**	0.560**	0.494**	-		
5. BDI	0.523**	0.414**	0.298**	0.530**	-	
6. BAI	0.434**	0.326**	0.250**	0.445**	0.684**	-
7. OBQ-ICT	0.434**	0.273**	0.241**	0.275**	0.408**	0.254**
	GP					
1. PTEQ-anxiety	-					
2. PTEQ-disgust	0.638**	-				
3. PTEQ-anger	0.536**	0.494**	-			
4. PTEQ-guilt	0.633**	0.615**	0.676**	-		
5. BDI	0.221*	0.214*	0.305**	0.178**	-	
6. BAI	0.189*	0.249**	0.118*	0.051	0.583**	-
7. OBQ-ICT	0.446**	0.407**	0.506**	0.504**	0.264**	0.294**

Note: PTEQ = Perceived Threat from Emotions Questionnaire; BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory; OBQ-PC = Obsessive Beliefs Questionnaire-Perfectionism/Intolerance of Uncertainty. *$p < .05$; **$p < .001$.

We assess these four PTEQ subscales to determine whether a construct has discriminant validity. The analysis relies on evaluating the upper limit confidence interval of the correlation between factors to assess the discriminant validity of the PTEQ subscales. On the basis of these calculations, the upper limits of the 95% confidence intervals for all factor pairs in Tables 6 and 7 are below .85 in the OCD and GP samples (see Tables 6 and 7). In addition, their path diagrams also represent the relationships between the four PTEQ subscales in both samples (see Figures 9 and 10).

Table 6
Results of reliability analyses of the Turkish version of the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, PTEQ-guilt in OCD and GP samples

	OCD		GP	
Variables	McDonald ω	Cronbach α	McDonald ω	Cronbach α
PTEQ-anxiety	0.897	0.893	0.877	0.864
PTEQ-disgust	0.927	0.925	0.874	0.873
PTEQ-anger	0.854	0.852	0.875	0.875
PTEQ-guilt	0.874	0.865	0.883	0.884

Note: PTEQ = Perceived Threat from Emotions Questionnaire.

Table 7
Standard errors, z-values, p-values, and 95% confidence intervals, and standardized estimates for each covariance values for discriminant validity in GP sample

							95% Confidence Interval		
			Estimate	Std. Error	z-value	p	Lower	Upper	Std. Est. (all)
PTEQ-anxiety	↔	PTEQ-disgust	.699	.031	22.672	<.001	.639	.760	.699
PTEQ-anxiety	↔	PTEQ-anger	.699	.026	26.385	<.001	.647	.751	.699
PTEQ-anxiety	↔	PTEQ-guilt	.750	.028	27.134	<.001	.696	.804	.750
PTEQ-disgust	↔	PTEQ-anger	.616	.027	22.657	<.001	.563	.670	.616
PTEQ-disgust	↔	PTEQ-guilt	.735	.029	24.978	<.001	.677	.792	.735
PTEQ-anger	↔	PTEQ-guilt	.812	.026	31.104	<.001	.761	.849	.812

Note: PTEQ = Perceived Threat from Emotions Questionnaire.

Figure 9
Path Diagram of the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, and PTEQ-guilt in OCD sample

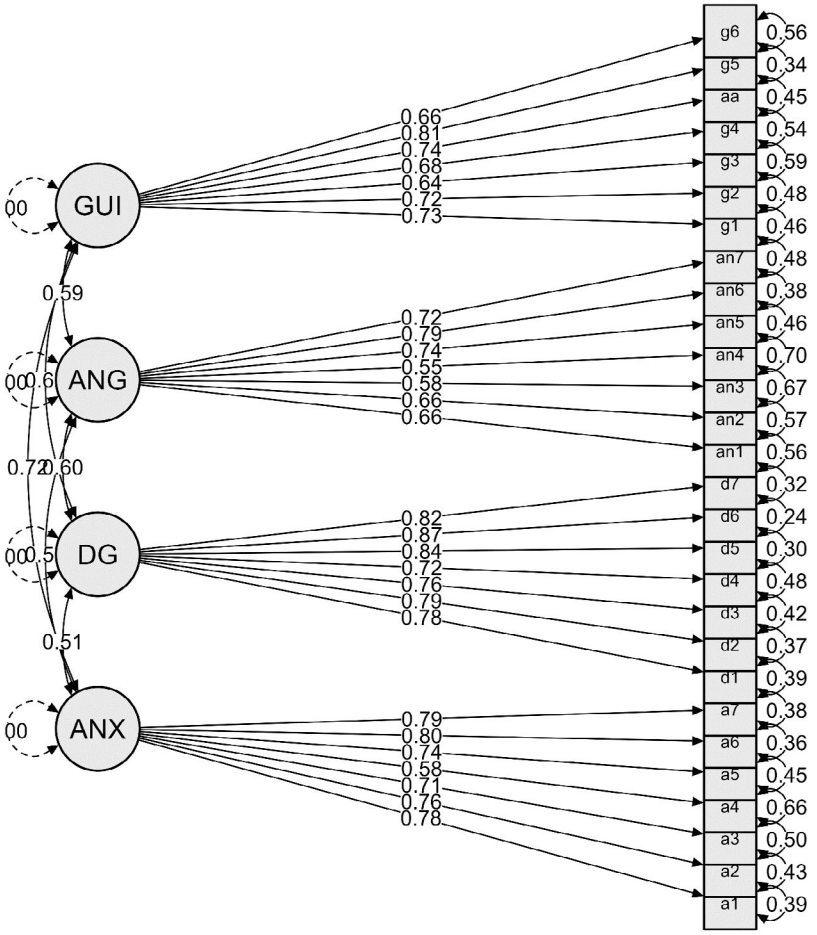
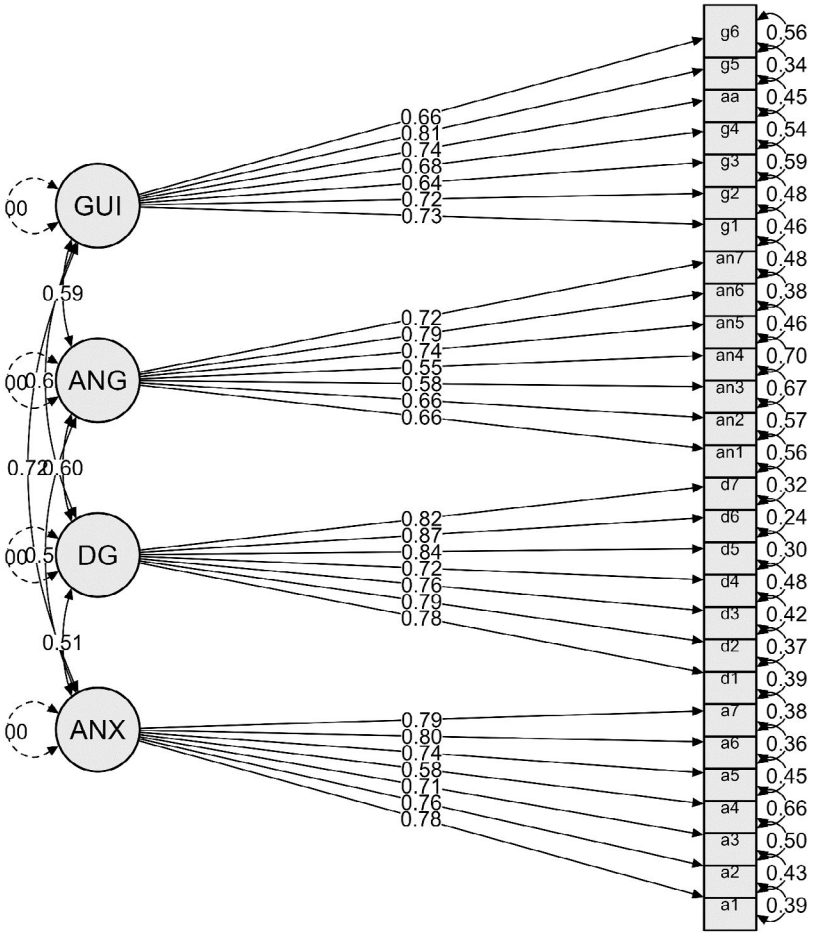


Figure 10
Path Diagram of the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, and PTEQ-guilt in GP sample



Internal consistency was evaluated using Cronbach's α values and McDonald ω coefficients for the four subscales of the PTEQ. The Cronbach's α values for the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, and PTEQ-guilt were .89, .92, .85, and .86, respectively, in the clinical OCD group. The test was conducted with 17 participants (10 females and seven males, aged 18–65 years) over two weeks. The Pearson's *r* correlations for the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, and PTEQ-guilt scores were .77, .64, .80, and .84, respectively. All values were statistically significant ($p < .05$). The Cronbach's α values for the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, and PTEQ-guilt were .86, .87, .88, and .88, respectively, for the GP sample (see Table 8).

Table 8
Results of reliability analyses of the Turkish version of the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, PTEQ-guilt in OCD and GP samples

	OCD		GP	
Variables	McDonald ω	Cronbach α	McDonald ω	Cronbach α
PTEQ-anxiety	.897	.893	.877	.864
PTEQ-disgust	.927	.925	.874	.873
PTEQ-anger	.854	.852	.875	.875
PTEQ-guilt	.874	.865	.883	.884

Note: PTEQ = Perceived Threat from Emotions Questionnaire; OCD = Obsessive Compulsive Disorder; GP = General Population.

Discussion

This study not only demonstrates the psychometric properties of the Turkish version of the PTEQ but also provides crucial insights into threat appraisals related to anxiety, disgust, anger, and guilt among a sample of patients with clinical OCD and a GP sample. These findings, which are broadly consistent with the original research, underscore the validity and reliability of the PTEQ questionnaire in the Turkish context.

We evaluated the reliability of the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, and PTEQ-guilt subscales by establishing Cronbach's α and McDonald ω coefficients for internal consistency and test-retest reliability. The Cronbach's α values of the four subscales of the PTEQ in the OCD and GP samples were consistent with those of the original study. In addition, the test-retest reliability for the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, and PTEQ-guilt subscales was calculated to be high and comparable to that of the original study after two weeks (McCubbin & Sampson, 2006). These results provide empirical support for adequate internal consistency and test-retest reliability (Salvucci et al., 1997).

The result of the factor analysis show that all four models of the PTEQ subscales indicate an acceptable and good fit (Browne & Cudeck, 1992; Hu & Bentler, 1999; Kline, 2005) in the clinical OCD and GP samples. All items have satisfactory factor loadings and error variances in the GP and clinical OCD samples, with the exception of Item 7 in the PTEQ-guilt subscale for the sample with clinical OCD. Factor loadings of .32 and above imply that these items are suitable for measuring the latent structure, and error variances of less than .90 imply an acceptable amount of error in calculating the latent structure (Kline, 2011; Tabachnick et al., 2013)2011; Tabachnick et al., 2013. Therefore, we deleted Item 7 in the PTEQ-guilt from the scale for the sample with clinical OCD. We obtained better model fit index results when G7, which had a low factor loading, was removed from the PTEQ-guilt subscale in the GP sample. Therefore, we also deleted Item 7 in the PTEQ-guilt subscale from the scale

for the GP. These differences from the original study may be related to Item 7 itself due to an overlap between perceived threats, guilt, and self-blame in the Turkish version (i.e., "Could guilt overwhelm you so that you are unable to function?"). Since guilt is already a moral emotion (Paulhus et al., 2004), unlike other emotions in the Turkish version, this item may measure the perceived threats related to the entirety of individuals' guilt and self-blame rather than individuals' guilt specifically. Because the roots of the two words (guilt and self-blame) are very similar, they can sometimes be used interchangeably in Turkish. While other items in the subscale are more specific to guilt, this item may have led to different results in the Turkish version because it covers a general measurement of functionality related to guilt that includes self-blame and decreased functionality. With regard to these changes, the 6-item subscale obtained by removing the 7th item from the PTEQ-guilt subscale may be appropriate for OCD and GP samples in Turkish culture.

McCubbin and Sampson (2006) proposed that concurrent validity cannot be assessed because no other measures are available with a comparable reference domain. They also did not assess convergent validity for PTEQ. We found poor correlations between the BAI score and the PTEQ-anxiety, PTEQ-disgust, and PTEQ-anger scores, but no correlation between the BAI score and the PTEQ-guilt score in the GP sample. There were also poor correlations between PTEQ-anxiety, PTEQ-disgust, and PTEQ-guilt and depression in the GP sample, which is consistent with the findings of the original study (McCubbin & Sampson, 2006). In addition, we found poor correlations between the OBQ-PC and the PTEQ-anger, PTEQ-disgust, and PTEQ-guilt scores and low correlations between the OBQ-PC, the BAI, and the PTEQ-anxiety in the clinical OCD sample, which is consistent with the findings of the original study (McCubbin & Sampson, 2006). Divergent validity may exist when measures of different variables are significant but are only slightly correlated or not correlated (Engellant et al., 2016). However, DeVellis and Thorpe (2012) suggest that there is no definitive threshold for correlation strength that determines construct validity, highlighting the complexity of establishing such validity (DeVellis & Thorpe, 2012). Therefore, our results support the divergent validity of the four subscales of the PTEQ in the GP and OCD samples. In the original study, consistent with our results, the PTEQ total score and other subscales were not strongly associated with mood, responsibility, or thought–action fusion. Recent research has proposed that a moderate or small correlation between measures does not always indicate that two constructs are separate, whereas a high correlation does not necessarily imply that they are not (Rönkkö & Cho, 2022). Therefore, we also calculated discriminant validity by evaluating the upper limit confidence interval of the correlation between factor calculations. The upper limits of the 95% confidence intervals for all factor pairs were below .85 (Rönkkö & Cho, 2022), which indicates empirical support for the discriminant validity of the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, and PTEQ-guilt in the OCD and GP samples.

Limitations

This is the first study to test the psychometric properties of the Turkish version of the four subscales of the PTEQ. However, several limitations of the present study should be considered, such as the gender distribution and limited age of the samples (Veilleux et al., 2021a; Veilleux et al., 2021b) and comorbid conditions with OCD (Manos et al., 2010) during the COVID-19 pandemic (Guzick et al., 2021), which influence the measurement of the emotional appraisal of threats from emotion. The data for this study were collected via self-reports; thus, shared method variance may have biased and inflated the relationships among the study variables (Hunt et al., 2003; Pekrun, 2020). The fact that rating scales related to emotions, that are less closely related to OCD (e.g., lust, happiness, sadness, strong emotions) and have rarely been studied in the literature were not included in the study can be considered a limitation. Future studies should use a larger sample size that is more representative and includes equal gender distributions and multiple ages in addition to using all PTEQ subscales and controlling for comorbidities in the clinical OCD and GP samples to increase generalizability. The examination of measurement invariance in all models to establish differences by age, sex, and race is also proposed.

Conclusion

Our evaluation of the psychometric properties of the PTEQ-anxiety, PTEQ-disgust, PTEQ-anger, and PTEQ-guilt in the clinical OCD and GP samples has significant implications. The CFA of the four models for the PTEQ subscales showed an acceptable and good fit for the GP sample (Browne & Cudeck, 1992; Hu & Bentler, 1999; Kline, 2005), with the exception of Item 7 in the PTEQ-guilt subscale for the OCD and GP samples. Therefore, this item was removed from the scale for both the OCD and the GP samples. All four subscales of the PTEQ had adequate internal consistency and divergent and discriminant validity in the clinical OCD and GP samples. The PTEQ measures the appraisal of emotional threats, so it is reasonable to consider it a specialized measure. The four subscales (anxiety, disgust, anger, guilt) are designed to assess individuals' appraisals of emotional threat rather than serving as a cue for general dysphoria. The PTEQ can contribute significantly to identifying individuals'needs and planning studies that may have the potential for change in clinical OCD and GP samples. Studies of this scale consistently provide opportunities for refinement by delineating the measured constructs more distinctly. Thus, longitudinal investigations with more diverse samples are necessary.

References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)*. https://doi.org/10.1176/appi.books.9780890425596

Asuero, A. G., Sayago, A., & González, A. (2006). The correlation coefficient: An overview. *Critical Reviews in Analytical Chemistry, 36*(1), 41–59. https://doi.org/10.1080/10408340500526766

Bartsch, A., Vorderer, P., Mangold, R., & Viehoff, R. (2008). Appraisal of emotions in media use: Toward a process model of meta-emotion and emotion regulation. *Media Psychology, 11*(1), 7–27. https://doi.org/10.1080/15213260701813447

Beck, A., Ward, C., Mendelsohn, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561–571. https://doi.org/10.1001/archpsyc.1961.01710120031004

Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: psychometric properties. *Journal of Consulting and Clinical Psychology, 56*(6), 893–897. https://doi.org/ 10.1037//0022-006x.56.6.893

Boysan, M., Besiroglu, L., Çetinkaya, N., Atli, A., & Aydin, A. (2010). Obsesif Inanislar Ölçegi–44'ün (OIÖ–44) Türkçe Formunun Geçerlik ve Güvenirligi [The Validity and Reliability of the Turkish Version of the Obsessive Beliefs Questionnaire-44] (OBQ–44). *Noro-Psikyatri Arsivi, 47*(3), 216–222. https://doi.org/10.4274/npa.5454

Brislin, R. W., Brislin, R. W., Lonner, W. J., & Thorndike, R. M. (1973). *Cross–Cultural Research Methods* (Vol. 11). John Wiley and Sons.

Browne, M. W., & Cudeck, R. (1992). Alternative ways of assessing model fit. *Sociological Methods & Research, 21*(2), 230–258. https://doi.org/10.1177/0049124192021002005

Bryman, A., & Cramer, D. (2002). Q*uantitative data analysis with SPSS release 10 for Windows: a guide for social scientists*. Routledge.

Carpenter, R. W., & Trull, T. J. (2013). Components of emotion dysregulation in borderline personality disorder: A review. *Current Psychiatry Reports, 15*, 1–8. https://doi.org/10.1007/s11920-012-0335-2

Child, D. (2006). *The essentials of factor analysis*. A&C Black.

Coleman, S. L., Pieterefesa, A. S., Holaway, R. M., Coles, M. E., & Heimberg, R. G. (2011). Content and correlates of checking related to symptoms of obsessive compulsive disorder and generalized anxiety disorder. *Journal of Anxiety Disorders, 25*(2), 293–301. https://doi.org/10.1016/j.janxdis.2010.09.014

DeVellis, R. F., & Thorpe, C. T. (2012). *Scale development: theory and applications*. Sage Publications.

Ekici, E., Ugurlu, M., Yigman, F., Safak, Y., & Ozdel, K. (2023). How much are they predictive for obsessive-compulsive symptom dimensions: beliefs, emotions, emotional schemas? *Current Psychology, 42*(33), 29481–29498. https://doi.org/10.1007/s12144-022-03969-0

Elbir, M., Alp Topbaş, O., Bayad, S., Kocabaş, T., Topak, Z., Cetin, Ş., Ozdel, O., & Aydemir, O. (2019). DSM-5 Bozuklukları için Yapılandırılmış Klinik Görüşmenin Klinisyen Versiyonunun Türkçeye Uyarlanması ve Güvenilirlik Çalışması [Adaptation and reliability of the structured clinical interview for DSM-5-disorders clinician version (SCID-5/CV) to the Turkish language]. *Türk Psikiyatri Dergisi, 30*(1), 51–56. https://doi.org/10.5080/u23431

Enders, C. K. (2013). Dealing with missing data in developmental research. *Child Development Perspectives, 7*(1), 27–31. https://doi.org/10.1111/cdep.12008

Engellant, K. A., Holland, D. D., & Piper, R. T. (2016). Assessing convergent and discriminant validity of the motivation construct for the technology integration education (TIE) model. *Journal of Higher Education Theory and Practice, 16*(1), 37–50.

Fergus, T. A., & Bardeen, J. R. (2014). Emotion regulation and obsessive–compulsive symptoms: A further examination of associations. *Journal of Obsessive-Compulsive and Related Disorders, 3*(3), 243–248. https://doi.org/10.1016/j.jocrd.2014.06.001

Ferrante, D., & D'Olimpio, F. (2022). Who guards over obsessive fear of guilt? The case of Not Just Right Experiences and disgust. *Journal of Affective Disorders Reports, 9*, https://doi.org/100364. 10.1016/j.jadr.2022.100364

Group, O. C. C. W. (2005). Psychometric validation of the obsessive belief questionnaire and interpretation of intrusions inventory—Part 2: Factor analyses and testing of a brief version. *Behaviour Research and Therapy, 43*(11), 1527–1542. https://doi.org/10.1016/j.brat.2004.07.010

Harrison, A., Sullivan, S., Tchanturia, K., & Treasure, J. (2010). Emotional functioning in eating disorders: attentional bias, emotion recognition and emotion regulation. *Psychological Medicine, 40*(11), 1887–1897. https://doi.org/10.1017/S0033291710000036

Hisli, N. (1988). Beck Depresyon Envanterinin gecerliligi uzerine bir calisma [A study on the validity of Beck Depression Inventory]. *Psikoloji Dergisi, 6*, 118–122.

Hu, L. t., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: a Multidisciplinary Journal, 6*(1), 1–55. https://doi.org/10.1080/10705519909540118

Hunt, M., Auriemma, J., & Cashaw, A. C. (2003). Self-report bias and underreporting of depression on the BDI–II. *Journal of Personality Assessment*, *80*(1), 26–30. https://doi.org/10.1207/S15327752JPA8001_10

Khosravani, V., Samimi Ardestani, S. M., Mohammadzadeh, A., Sharifi Bastan, F., & Amirinezhad, A. (2020a). The emotional schemas and obsessive-compulsive symptom dimensions in people with obsessive-compulsive disorder. *International Journal of Cognitive Therapy, 13*, 341–357. https://doi.org/10.1007/s41811-020-00075-6

Khosravani, V., Ardestani, S. M. S., Bastan, F. S., & Malayeri, S. (2020b). Difficulties in emotion regulation and symptom dimensions in patients with obsessive-compulsive disorder. *Current Psychology, 39*(5), 1578–1588. https://doi.org/10.1007/s12144-018-9859-x

Kline, R. B. (2005). *Principles and practice of structural equation modeling* 2nd ed. Guilford.

Kline, R. B. (2011). *Principles and practice of structural equation modeling* 3th ed. Guilford.

Knowles, K. A., Cox, R. C., Armstrong, T., & Olatunji, B. O. (2019). Cognitive mechanisms of disgust in the development and maintenance of psychopathology: A qualitative review and synthesis. *Clinical Psychology Review, 69*, 30–50. https://doi.org/10.1016/j.cpr.2018.06.002

Krause, S., Ouellet-Courtois, C., Sandstrom, A., & Radomsky, A. S. (2022). Thinking About Disgust: Cognitive Processes Mediate the Associations Between Disgust Proneness and OCD Symptom Domains. *International Journal of Cognitive Therapy, 15*(3), 231–254. https://doi.org/10.1007/s41811-022-00138-w

Leahy, R. (2012). Leahy Emotional Schema Scale II (LESS II). *Unpublished manuscript,* American Institute for Cognitive Therapy.

Lee, E., Wetterneck, C., McIngvale, E., Williams, M., & Bjorgvinsson, T. (2023). Rethinking Unacceptable Thoughts: Validation of an Expanded Version of the Dimensional Obsessive-Compulsive Scale (DOCS). *Behavior Therapy, 55*(4), 786–800. https://doi.org/10.1016/j.beth.2023.11.003

Li, C. H. (2016). The performance of ML, DWLS, and ULS estimation with robust corrections in structural equation models with ordinal variables. *Psychological Methods, 21*(3), 369–387. https://doi.org/10.1037/met0000093

MacCallum, R. C., Widaman, K. F., Zhang, S., & Hong, S. (1999). Sample size in factor analysis. *Psychological Methods, 4*(1), 84–99. https://doi.org/10.1037/1082-989X.4.1.84

Manos, R. C., Cahill, S. P., Wetterneck, C. T., Conelea, C. A., Ross, A. R., & Riemann, B. C. (2010). The impact of experiential avoidance and obsessive beliefs on obsessive-compulsive symptoms in a severe clinical sample. *Journal of Anxiety Disorders, 24*(7), 700–708. https://doi.org/10.1016/j.janxdis.2010.05.001

Mayer, J. D., & Gaschke, Y. N. (1988). The experience and meta-experience of mood. *Journal of Personality and Social Psychology, 55*(1), 102–111. https://doi.org/10.1037/0022-3514.55.1.102

McCubbin, R., & Sampson, M. (2006). The relationship between obsessive–compulsive symptoms and appraisals of emotional states. *Journal of Anxiety Disorders, 20*(1), 42–57. https://doi.org/10.1016/j.janxdis.2004.11.008

McKay, D. (2006). Treating disgust reactions in contamination-based obsessive–compulsive disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 37*(1), 53–59. https://doi.org/10.1016/j.jbtep.2005.09.005

Melli, G., Chiorri, C., Carraresi, C., Stopani, E., & Bulli, F. (2015). The role of disgust propensity and trait guilt in OCD symptoms: A multiple regression model in a clinical sample. *Journal of Obsessive-Compulsive and Related Disorders*, *5*, 43–48. http://doi.org/10.1016/j.jocrd.2015.01.007

Mennin, D. S., Heimberg, R. G., Turk, C. L., & Fresco, D. M. (2005). Preliminary evidence for an emotion dysregulation model of generalized anxiety disorder. *Behaviour Research and Therapy, 43*(10), 1281–1310. https://doi.org/10.1016/j.brat.2004.08.008

Moshagen, M., & Bader, M. (2024). semPower: General power analysis for structural equation models. *Behavior Research Methods*, *56*(4), 2901–2922. https://doi.org/10.3758/s13428-023-02254-7

Mukaka, M. M. (2012). A guide to appropriate use of correlation coefficient in medical research. *Malawi Medical Journal, 24*(3), 69–71.

Nunnally, J. C. (1970). *Introduction to psychological measurement.* McGraw-Hill.

Paulhus, D. L., Robins, R. W., Trzesniewski, K. H., & Tracy, J. L. (2004). Two replicable suppressor situations in personality research. *Multivariate Behavioral Research, 39*(2), 303–328. https://doi.org/10.1207/s15327906mbr3902_7

Pekrun, R. (2020). Self-report is indispensible to assess students' learning. *Frontline Learning Research*, *8*(3), 185–193. https://doi.org/10.14786/flr.v8i3.637

Pekrun, R., Marsh, H. W., Elliot, A. J., Stockinger, K., Perry, R. P., Vogl, E., Goetz, T., van Tilburg, W. A. P., Lüdtke, O., & Vispoel, W. P. (2023). A three-dimensional taxonomy of achievement emotions. *Journal of Personality and Social Psychology, 124*(1), 145–178. https://doi.org/10.1037/pspp0000448

Piacentino, D., Pasquini, M., Tarsitani, L., Berardelli, I., Roselli, V., Maraone, A., & Biondi, M. (2016). The association of anger with symptom subtypes in severe obsessive-compulsive disorder outpatients. *Psychopathology, 49*(1), 40–46. https://doi.org/10.1159/000443900

Poli, A., Melli, G., & Radomsky, A. S. (2019). Different disgust domains specifically relate to mental and contact contamination fear in obsessive-compulsive disorder: Evidence from a path analytic model in an Italian clinical sample. *Behavior Therapy*, *50*(2), 380–394. https://doi.org/10.1016/j.beth.2018.07.006

Radomsky, A. S., Ashbaugh, A. R., & Gelfand, L. A. (2007). Relationships between anger, symptoms, and cognitive factors in OCD checkers. *Behaviour Research and Therapy, 45*(11), 2712–2725. https://doi.org/10.1016/j.brat.2007.07.009

Robinson, L. J., & Freeston, M. H. (2014). Emotion and internal experience in obsessive compulsive disorder: reviewing the role of alexithymia, anxiety sensitivity and distress tolerance. *Clinical Psychology Review, 34*(3), 256–271. https://doi.org/10.1016/j.cpr.2014.03.003

Rönkkö, M., & Cho, E. (2022). An updated guideline for assessing discriminant validity. *Organizational Research Methods, 25*(1), 6–14. https://doi.org/10.1177/1094428120968614

Salvucci, S., Walter, E., Conley, V., Fink, S., & Saba, M. (1997). *Measurement error studies at the national center for education statistics*. National Center for Education Statistics.

Schmidt, S., Tinti, C., Levine, L. J., & Testa, S. (2010). Appraisals, emotions and emotion regulation: An integrative approach. *Motivation and Emotion, 34*, 63–72. https://doi.org/10.1007/s11031-010-9155-z

Smith, A. H., Norton, P. J., & Wetterneck, C. T. (2014). Emotion appraisal and anxiety symptomatology in a university sample. *Cognitive Behaviour Therapy, 43*(2), 145–152. https://doi.org/10.1080/16506073.2014.890642

Smith, A. H., Wetterneck, C. T., Hart, J. M., Short, M. B., & Björgvinsson, T. (2012). Differences in obsessional beliefs and emotion appraisal in obsessive compulsive symptom presentation. *Journal of Obsessive-Compulsive and Related Disorders, 1*(1), 54–61. https://doi.org/10.1016/j.jocrd.2011.11.003

Stern, M. R., Nota, J. A., Heimberg, R. G., Holaway, R. M., & Coles, M. E. (2014). An initial examination of emotion regulation and obsessive compulsive symptoms. *Journal of Obsessive-Compulsive and Related Disorders, 3*(2), 109–114. https://doi.org/10.1016/j.jocrd.2014.02.005

Stewart, S. E., & Shapiro, L. (2011). Pathological guilt: A persistent yet overlooked treatment factor in obsessive-compulsive disorder. *Annals of Clinical Psychiatry, 23*(1), 63–70.

Stikkelbroek, Y., Bodden, D. H., Kleinjan, M., Reijnders, M., & van Baar, A. L. (2016). Adolescent depression and negative life events, the mediating role of cognitive emotion regulation. *PLoS One, 11*(8), e0161062. https://doi.org/10.1371/journal.pone.0161062

Tabachnick, B. G., Fidell, L. S., & Ullman, J. B. (2013). *Using multivariate statistics* (Vol. 6). Pearson Education.

Tavşancıl, E. (2010). *Tutumların ölçülmesi ve SPSS ile veri analizi.* Nobel.

Ulusoy, M., Şahin, N., & Erkmen, H. (1998). Turkish Version Of The Beck Anxiety Inventory: Psychometric Properties. *Journal of Cognitive Psychotherapy: An International Quartely, 12*(2), 163–172.

Veilleux, J. C., Chamberlain, K. D., Baker, D. E., & Warner, E. A. (2021). Disentangling beliefs about emotions from emotion schemas. *Journal of Clinical Psychology, 77*(4), 1068–1089. https://doi.org/10.1002/jclp.23098

Veilleux, J. C., Pollert, G. A., Skinner, K. D., Chamberlain, K. D., Baker, D. E., & Hill, M. A. (2021). Individual beliefs about emotion and perceptions of belief stability are associated with symptoms of psychopathology and emotional processes. *Personality and Individual Differences, 171*, 110541. https://doi.org/10.1016/j.paid.2020.110541

Watson, D. (2004). Stability versus change, dependability versus error: Issues in the assessment of personality over time. *Journal of Research in Personality*, *38*(4), 319–350. https://doi.org/10.1016/j.jrp.2004.03.001

Wetterneck, C. T., Rouleau, T. M., Williams, M. T., Vallely, A., La Torre, J. T., & Björgvinsson, T. (2021). A new scrupulosity scale for the dimensional obsessive-compulsive scale (DOCS): Validation with clinical and nonclinical samples. *Behavior Therapy, 52*(6), 1449–1463. https://doi.org/10.1016/j.beth.2021.04.001

Yap, K., Mogan, C., Moriarty, A., Dowling, N., Blair-West, S., Gelgec, C., & Moulding, R. (2018). Emotion regulation difficulties in obsessive-compulsive disorder. *Journal of Clinical Psychology, 74*(4), 695–709. https://doi.org/10.1002/jclp.22553

Procena validnosti i pouzdanosti turske verzije upitnika o percepciji emocionalne pretnje (PTEK)

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Upitnik za percepciju pretnji od emocija (PTEK) procenjuje uverenja o pretnjama od strane svake od sedam osnovnih emocija i „jakih emocija uopšte“ koje mogu doprineti razumevanju psihopatologija povezanih sa psihološkim poremećajima. Ova studija je imala za cilj da prevede i proceni psihometrijske osobine četiri podskale PTEK turske verzije (anksioznost, bes, gađenje, krivica). Studija je regrutovala sto četrnaest pacijenata sa kliničkim opsesivno-kompulzivnim poremećajem (OKP) i sto četrdeset osoba iz opšte populacije (GP). Dobijene su potvrdne faktorske analize i interne analize pouzdanosti. Osim toga, divergentna i diskriminirajuća validnost PTEK-a je ispitana pomoću Bekovog inventara depresije, Bekovog inventara anksioznosti i upitnika opsesivnih uverenja – perfekcionizam/netolerancija neizvesnosti. Nalazi su otkrili da su četiri modela za PTEK podskale smatrana prihvatljivim i dobrim za faktorsku analizu i da su imali zadovoljavajuću unutrašnju konzistentnost (svi ≥ .70) i test-retest pouzdanost u kliničkim uzorcima OCD i GP. Podskala od 6 stavki dobijena uklanjanjem 7. stavke sa podskale PTEK-krivice mogla bi biti prikladna za tursku kulturu za uzorke OKP i GP. Naši rezultati podržavaju divergentnu i diskriminantnu validnost četiri podskale PTEK u uzorcima GP i OKP. Predložene turske verzije četiri podskale PTEK pokazale su adekvatnu pouzdanost i validnost, ali je potrebno dalje istraživanje u različitim populacijama sa većim uzorcima.

Ključne reči: emocija, PTEK, validnost, pouzdanost

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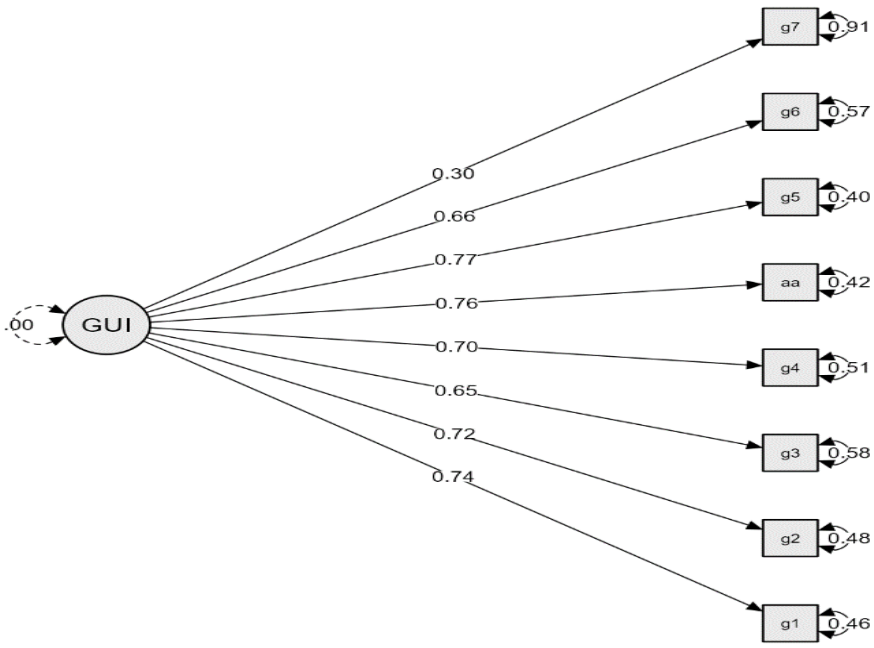
Appendix 1
Factor loadings of the PTEQ-guilt in the clinical OCD sample (Standardized path coefficients)



Appendix 2
Factor loadings of the PTEQ-guilt in the GP sample (Standardized path coefficients)