Emotionally Focused Therapy With Couples Impacted by Relationship Obsessive-Compulsive Disorder

by

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Abstract

Relationship Obsessive-Compulsive Disorder (ROCD) is a relatively-novel and unknown theme of Obsessive-Compulsive Disorder (OCD) marked by obsessions and compulsions focused upon important figures in sufferers' lives as well as their relationships with them. Despite the documented impacts of this condition on sufferers, their romantic partners, and their relationships with one another, recommendations for its treatment have focused almost exclusively on the mitigation of the former's symptoms. Accordingly, this capstone research project aims to improve therapists' awarenesses and understandings of ROCD and, thus, their abilities to treat this condition by reviewing the literature on its symptoms, epidemiology, etiology, impacts, and treatment. Additionally, it attempts to enhance couples therapists' abilities to support clients impacted by ROCD by providing an overview of the literature on Emotionally Focused Therapy (EFT) as well as recommendations for how this modality might best be conducted with this population. Such recommendations include the use of EFT as an adjunct to individual ROCD treatment and specific ways in which practitioners might leverage knowledge of this disorder as they conduct assessment, establish the therapeutic alliance, and consult on process with clients, as well as mitigate potential issues of symptom contagion and accommodation.

Keywords: relationship obsessive-compulsive disorder, relationship-centered obsessive-compulsive symptoms, partner-focused obsessive-compulsive symptoms, emotionally focused therapy, relationship distress

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Dedication

In recognition of their bravery and perseverance, this capstone research project is dedicated to those impacted by Relationship Obsessive-Compulsive Disorder (ROCD) and the loved ones who support them.

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Chapter One: Introduction

Obsessive-Compulsive Disorder (OCD) is a chronic mental condition which is believed to impact up to 2.3% of the global population at some point in their lives (Shavitt et al., 2022). It is also aptly named, given that its hallmark symptoms include *obsessions*, that is, “recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted” (American Psychiatric Association [APA], 2022, p. 1014-1015), as well as *compulsions* (i.e., ritualistic behaviours and cognitions aimed at mitigating obsession-related distress) (APA, 2022). Though the specific foci of these symptoms may differ between sufferers, several common presentations of OCD have been identified, including those marked by religious and/or moral scrupulosity, as well as pathological concern about dirt and contamination, responsibility for harm and injury, and perfectionism, symmetry, and completeness (Abramowitz et al., 2010; APA, 2022; Clark & Radomsky, 2014; International OCD Foundation [IOCDF], n.d.). As a result of these symptoms, sufferers may experience significant impairments to their physical, emotional, and mental health, as well as their abilities to function (e.g., at school and/or the workplace) (APA, 2022). Likewise, OCD may negatively impact sufferers’ relationships with friends and family, undermining major sources of resilience through which they might otherwise overcome life’s challenges (APA, 2022).

Dysfunctional Appraisal of Cognitive Intrusions in Obsessive-Compulsive Disorder

While there are various theories about how OCD symptoms may develop, many scholars subscribe to Salkovskis (1985, 1989, 1996)’s Cognitive Appraisal Model (CAM) (McHugh O’Leary, 2007). According to the CAM, it is not the experience of cognitive intrusions which is pathological, but the tendency of OCD sufferers to dysfunctionally appraise them as presenting a substantial and immediate threat, as this spawns obsessive distress which is then, ironically, sustained and/or worsened through compensatory engagement in compulsions (Salkovskis, 1985, 1989, 1996). The CAM also assumes that this dysfunctional appraisal may be facilitated by various beliefs commonly held by OCD sufferers,

particularly *inflated responsibility* (i.e., for ensuring that harm does not occur to themselves and/or others) (Salkovskis, 1985, 1989, 1996).

Expanding upon this latter assumption, the Obsessive Compulsive Cognitions Working Group (OCCWG, 1997), of which Salkovskis was a member, posited the existence of six *OCD-related maladaptive beliefs* which might foster sufferers' dysfunctional appraisal of intrusions and, thus, their experience of obsessions and compulsions. In addition to the notion of inflated responsibility previously noted by Salkovskis (1985, 1989, 1996), these beliefs included *overimportance of thoughts*, that is, the attribution of significance to intrusions simply because one experiences them, as well as *excessive concern about the importance of controlling one's thoughts*, including these same intrusions (OCCWG, 1997). Likewise, the OCCWG (1997) identified *overestimation of threat* (i.e., of the risks and/or impacts of harm), *intolerance of uncertainty*, and *perfectionism* (i.e., the perception that one can and, thus, should find the ideal way to solve problems to avoid the repercussions of making a mistake).

Scholars have also suggested that, along with the beliefs mentioned above, individuals with OCD may bear certain *self-vulnerabilities* (i.e., features of their self-concepts which may also predispose them to the dysfunctional appraisal of intrusions) (Doron & Kyrios, 2005; Doron, Szepsenwol, et al., 2012; Melli, Aardema, & Moulding, 2016; Moulding et al., 2014). For example, Doron and Kyrios (2005) have noted that sufferers may possess *sensitive self-domains*, that is, aspects of themselves which they consider important (e.g., morals and/or values), but which they also associate with feelings of inadequacy. Consequently, if the content of a given intrusion targets one of these domains, a sufferer may appraise it as threatening their sense of self-worth, leading them to experience significant distress and, thus, engage in compulsions intended to reduce it (Doron & Kyrios, 2005; Doron, Szepsenwol, et al., 2012). However, it has also been noted that this compulsive response may inadvertently highlight the occurrence of intrusions specific to this self-domain in the future, leading to the sufferer's development of related obsessions (Doron & Kyrios, 2005; Doron, Szepsenwol, et al., 2012). Similarly, *fear of self*,

which has been described as concern over “who one might be, or become” (Fernandez et al., 2021, p. 2), is another factor related to the self-concept which may contribute to the dysfunctional appraisal of intrusions (Aardema et al., 2013; Melli, Aardema, & Moulding, 2016) and, thus, constitute a self-vulnerability.

Overview of Relationship Obsessive-Compulsive Disorder

In the late 2000s, scholar-practitioners Guy Doron and Danny Derby recognized that clients were increasingly presenting in their respective clinics exhibiting obsessions and compulsions focused upon important figures in their lives as well as their relationships with them (IOCDF, 2021). Accordingly, they began to interview these individuals in an effort to describe their symptoms and, in doing so, conceptualized them as constituting an as-of-yet undocumented theme of OCD, known as *Relationship Obsessive-Compulsive Disorder (ROCD)* (IOCDF, 2021). However, Derby has noted that the initial description and conceptualization of these symptoms as ROCD can actually be credited to sufferers who, some years prior, had formed online communities within which to discuss their experiences (IOCDF, 2021). In the intervening years, Doron, Derby, and other researchers have continued to examine this condition, developing measures with which to assess its symptoms (Doron, Derby, & Szepsenwol, 2014; Doron et al., 2016; Doron, Derby, et al., 2012a, 2012b), as well as making recommendations for its treatment (e.g., Doron & Derby, 2017).

Though research suggests that ROCD obsessions and compulsions may revolve around sufferers’ relationships with mentors, friends, family (e.g., parents or children), and even deities (Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014; Doron et al., 2017; IOCDF, n.d.; Levy et al., 2020), they have most frequently been documented as targeting their romantic partners and/or their bonds with them (Parlapan Bas, 2019). In such cases, ROCD symptoms typically manifest as obsessive preoccupation with and, thus, compulsive scrutiny of the sufferer’s love for their partner, the partner’s love for the sufferer, the sufferer’s sense that the relationship feels “right,” and/or the partner’s various qualities (Doron,

Derby, et al., 2012a, 2012b). While such evaluations may seem inherent to the experience of being in a romantic relationship, they are considered pathological symptoms of OCD within this context, given that they occur in response to specific triggers, are often perceived by the sufferer as illogical, and also "impair [their] daily life and relationship quality" (Doron, Derby, et al., 2012b, p. 17), taking up a considerable amount of time within their day (APA, 2022). Likewise, they are experienced as *ego-dystonic* (i.e., in opposition to the sufferer's values and/or typical evaluations of and/or feelings towards their intimate relationship or partner) (Doron et al., 2013). Perhaps unsurprisingly, there is also substantial evidence that ROCD symptoms may negatively impact sufferers' partners and/or their relationships with them (e.g., Cebeci, 2019; Dar-Perl, 2018; Doron, Derby, & Szepsenwol, 2014; Doron, Derby, et al., 2012b; Kasalova et al., 2020).

Purpose of This Project and Contribution to the Field

Despite the above, ROCD remains relatively understudied (Akkaya & Yılmaz, 2021) and unrecognized by the APA (2022)'s *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*) as a formal subtype of OCD. This leads to concerns that therapists may generally be unaware of and/or unfamiliar with this condition and, thus, inadequately prepared to recognize, assess, and/or treat it. Moreover, while recommendations have been made for the treatment of ROCD (e.g., Doron & Derby, 2017), they have almost exclusively focused on the mitigation of sufferers' symptoms, rather than their documented impacts on these individuals' intimate relationships and/or partners.

Accordingly, the purpose of this capstone research project is twofold. First, it aims to legitimize ROCD as a matter of concern amongst therapists by increasing their awarenesses and understandings of this condition and, thus, their abilities to address its impacts on clients. With this purpose in mind, the first section of chapter two comprises a literature review guided by the following research question: what must therapists know about ROCD in order to competently treat those who have been negatively impacted by it?

However, the primary aim of this capstone is to address the gap in the literature pertaining to how ROCD sufferers, their romantic partners, and their relationships with one another might be supported through couples therapy. As such, the second section of chapter two reviews the literature on *Emotionally Focused Therapy (EFT)*, a prominent, evidence-based couples therapy (Beasley & Ager, 2019; Spengler et al., 2022; Wiebe & Johnson, 2016) which may benefit ROCD sufferers and their partners, as it seeks to answer a second research question, specifically: what must couples therapists intending to practice EFT with clients impacted by ROCD know about this modality?

In working further towards this project's main aim, chapter three provides specific recommendations for therapists intending to practice EFT with this population, answering a final research question, namely: how might EFT practitioners best serve couples impacted by ROCD?

Theoretical/Conceptual Frameworks

In answering the above research questions, this project utilizes various theoretical/conceptual frameworks, including the *DSM-5-TR* (APA, 2022)'s definition of OCD as a formal mental health condition, which it applies, by extension, to ROCD. Likewise, it relies heavily upon the aforementioned CAM (Salkovskis, 1985, 1989, 1996), as the vast majority of scholarship on ROCD (e.g., Doron, Derby, et al., 2012a, 2012b) also assumes that this particular theme of OCD stems from the dysfunctional appraisal of cognitive intrusions. As such, chapter two describes many cognitive factors implicated in ROCD's etiology as well as numerous cognitive-behavioural approaches to its mitigation. However, given the dyadic nature of ROCD and the specific focus of this project upon its potential treatment through couples therapy, this examination also privileges a systemic lens, highlighting between-partner interactions as central to the symptoms, etiology, impacts, and treatment of this disorder. Consequently, only the findings most relevant to the dyadic treatment of ROCD are included in chapter two's literature review.

Additionally, the concept of *attachment*, as described within Bowlby (1969, 1973, 1980, 1988)'s

Attachment Theory, is woven throughout much of the research on ROCD and, thus, frequently invoked within chapters two and three of this project. According to the tenets of this theory, an infant who receives reliable care from their *attachment figure* (i.e., primary caregiver) will develop *secure attachment* and, thus, come to anticipate similar support in the future. By contrast, if they fail to receive such care, they will develop one of two styles of *insecure attachment* (i.e., anxious or avoidant). *Anxious attachment* is said to be marked by exaggerated concern about the responsiveness of one's attachment figure and to develop due to the latter's inconsistent provision of care. As a result, anxiously-attached individuals tend to manage emotional distress through maladaptive strategies which hyperactivate the attachment system, actively seeking reassurance and affection from their attachment figures. *Avoidant attachment*, on the other hand, involves distrust of an attachment figure's ability to provide adequate care due to their consistent unavailability or even abuse of the child. Consequently, when experiencing distress, avoidantly-attached children often engage in maladaptive strategies of emotional regulation which, instead, deactivate the attachment system, minimizing their need for interpersonal support (e.g., by withdrawing from others). Critically, it has also been posited that attachment styles remain largely consistent into adulthood, at which time one's intimate partner generally replaces their childhood caregiver as their attachment figure (Brennan et al., 1998; Mikulincer & Shaver, 2007). Accordingly, one's tendency towards either maladaptive strategy of emotional regulation in early childhood may significantly influence their behaviour within intimate relationships as adults (Brennan et al., 1998; Mikulincer & Shaver, 2007).

Reflectivity and Positionality Statement

My decision to explore this issue and, in doing so, answer the research questions above is, to a great extent, rooted in personal experience. Indeed, I have suffered the ill effects of obsessions and compulsions at several points in my own life, beginning at a very young age. Likewise, I have been fascinated with romantic relationships as a central aspect of the human condition for as long as I can

remember. Consequently, as a therapist, I have always intended to work with fellow OCD sufferers as well as couples to directly benefit these populations. Through the convergence of these two clinical interests, I have also been not only captivated by ROCD as an inherently relational condition since I first became aware of it nearly a decade ago, but dismayed by the lack of scholarly attention paid to the potential amelioration of its impacts on sufferers, their romantic partners, and their relationships through dyadic approaches. Further, my choice to examine EFT as a specific means through which this might be accomplished stems from both my awareness of its strong evidence base as a couples therapy as well as my upbringing in an environment which afforded me the opportunity to witness its tenets (e.g., vulnerable expression of one's emotional experience to others) benefit many people close to me.

As my personal experience has contributed to my passion for this topic, it is also important to address its potential influence on my exploration of it. Indeed, having had firsthand experience with OCD, it is possible that I hold preconceptions about how ROCD, as a specific theme of this disorder, might impact sufferers, their partners, as well as their relationships with one another. Accordingly, within this project, I have done my best to avoid making assumptions about the experiences of those impacted by ROCD and to remain as objective as possible about the information gathered herein. I also acknowledge that, as a practicing therapist, I, like many of my peers, harbour conflicting feelings about the use of medicalized language (i.e., formal mental health diagnoses) and, by extension, diagnostic manuals like the *DSM-5-TR* (APA, 2022). For instance, I know that the ability to label my own obsessions and compulsions as symptoms of OCD was incredibly validating and served to normalize my own experience, thus alleviating much of the stress which these symptoms imposed upon me; however, I also recognize that, for many individuals, these same labels can feel pathologizing and harmful. Likewise, while I concede that formal mental health diagnoses may provide practitioners with a shorthand through which to refer to various symptom presentations, I do not believe that the dissemination of information about their treatment necessarily hinges upon their description within diagnostic manuals.

Indeed, it is my hope that, by making recommendations about the treatment of a condition which does not currently exist within the *DSM-5-TR* (APA, 2022) (i.e., ROCD), this project may be demonstrative of this position. Therefore, throughout this undertaking, I have striven to bear in mind the tension between the potential harm and benefit of utilizing medicalized terminology to describe ROCD sufferers' symptoms, whilst making a conscious decision to do so such that I am able to engage with the existing literature on this condition.

Notably, the relative dearth of such literature in the form of peer-reviewed, academic journal articles has informed my decision to also draw information about ROCD from a variety of alternative sources during the completion of this project. These include interviews and books centring the expertise of clinicians well-versed in the treatment of ROCD as well as theses and dissertations detailing research conducted with sufferers by graduate students under the guidance of doctorate-level supervisors, many of which have been published in languages other than English. There is no question that there is some potential for the information gleaned from these sources to be relatively inaccurate (e.g., due to their comparative lack of academic rigour and/or possible errors in translation); however, I believe that the inclusion of such information is not only warranted by the need to advance scholarship on and, thus, spread awareness of ROCD, but in alignment with Doron and Derby's approach to doing so by privileging information from non-academic sources (i.e., the firsthand accounts of sufferers and expert clinicians who have treated them) (Doron, Derby, et al., 2012a, 2012b; IOCDF, 2021). Further, though I am passionate about couples therapy and particularly optimistic about EFT's ability to mitigate ROCD's impacts on sufferers and their partners, I have made a concerted effort to refrain from blindly trumpeting the possible benefits of such an approach. Instead, I have endeavoured to be cognizant of the potential limitations of couples therapies, including EFT, whilst remaining mindful of the ways in which the challenges imposed by ROCD might be better remedied through individual therapies, explicitly speaking to these understandings in chapters two and three.

As the author of this project, a therapist, and a human being, I also believe that it is critical for me to continuously reflect upon my intersectional identity and its embeddedness within structures of power and oppression. With regard to this specific work, I would like to, first, acknowledge my privilege as a descendant of White, European settlers to so-called Canada who has benefited from the colonization of Indigenous lands. Indeed, I am incredibly grateful to have had the opportunity to complete this project while residing upon the unceded and stolen ancestral territories of the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and səlilwətaɬ (Tsleil-Waututh) peoples, despite the fact that such efforts may not directly benefit these communities. I would also like to acknowledge that, as a relatively well-educated, married, heterosexual, cisgender person who practices monogamy, I share many identity locations with those who have typically served as participants within studies on ROCD. Accordingly, while my intention with this project is to leverage the power afforded to me to assist an underserved population (i.e., those impacted by ROCD), I recognize that it may do little for those with whom I have less in common (e.g., members of the LGBTQ2S+ community and/or those who practice non-monogamy), despite them being just as worthy of being represented within and, thus, benefitting from research conducted in this area.

Outline of Capstone Project Chapters

The second chapter of this project consists of a literature review, the first section of which focuses on ROCD, beginning with findings related to its symptoms, their assessment, as well as various aspects of its epidemiology. Factors implicated in ROCD's etiology are also examined, followed by its potential impacts on sufferers and their partners. Subsequently, existing recommendations for the treatment of both individuals and couples impacted by ROCD are described.

The second section of this literature review examines EFT, beginning with an overview of its development and philosophical underpinnings, the role of the emotionally focused therapist, and the various interventions they may utilize. Following this, the sequence of EFT is elucidated, along with

findings related to its efficacy and effectiveness. Research on relevant process variables is then discussed, as are recommendations related to the use of EFT with specific populations.

Finally, the third chapter of this project serves as a synthesis of the information detailed in chapter two, taking into consideration the challenges which ROCD sufferers and their partners may face, as well as the various aspects and strengths of the EFT model, to provide practitioners with recommendations on how they might utilize this approach to best support this population.

Definition of Terms

The following definitions are intended to facilitate readers' comprehension of the content covered within this project.

Anxious Attachment

A style of insecure attachment which develops due to the inconsistent responsiveness of one's attachment figure during infancy, resulting in a tendency to regulate emotional distress through hyperactivation of the attachment system (e.g., by seeking reassurance from and/or proximity to their attachment figure) (Bowlby, 1969, 1973, 1980, 1988). Anxious attachment is often operationalized as a construct referred to as *attachment anxiety* within the ROCD literature (e.g., Doron et al., 2013).

Attachment

The evolved emotional bond between an infant and their primary caregiver (Bowlby, 1969, 1973, 1980, 1988). If successfully developed through adequate responsiveness from the latter, an infant is said to develop *attachment security*, contributing to their sense that others are safe and/or trustworthy, thus leading to adaptive patterns of interaction with other close individuals, particularly intimate partners, in later life (Bowlby, 1969, 1973, 1980, 1988; Brennan et al., 1998; Mikulincer & Shaver, 2007).

Attachment Figure

The individual (i.e., primary caregiver) with whom an infant develops an attachment bond, often

replaced in later life by their romantic partner (Bowlby, 1969, 1973, 1980, 1988; Brennan et al., 1998; Mikulincer & Shaver, 2007).

Attachment Injury

An emotionally impactful event often marked by abandonment and/or betrayal (e.g., infidelity) during which one's attachment figure may be unresponsive to their needs, thus challenging their sense that the latter can be trusted and, consequently, the security of their attachment bond (Johnson & Williams-Keeler, 1998; Makinen & Johnson, 2006).

Avoidant Attachment

An insecure attachment style which develops due to the general unavailability or even abuse of an infant by their attachment figure and which is, thus, characterized by attempts to regulate emotional distress through deactivation of the attachment system (e.g., avoidance of and/or withdrawal from the latter) (Bowlby, 1969, 1973, 1980, 1988; Brennan et al., 1998; Mikulincer & Shaver, 2007). Avoidant attachment is often operationalized as a construct referred to as *attachment avoidance* within the ROCD literature (e.g., Doron et al., 2013).

Between-Partner Symptom Contagion

The transmission of ROCD symptoms (e.g., obsessions and compulsions) between a sufferer and their romantic partner upon the latter's exposure to those of the former (Doron, 2017; Doron, Derby, & Szepsenwol, 2014; Littman et al., 2023).

Catastrophic Relationship Beliefs

Three beliefs (i.e., overestimation of the negative impacts of ending a relationship, remaining in one that is less than perfect, and of not being in one) which may facilitate the dysfunctional appraisal of typical relationship doubts, thus spawning ROCD sufferers' symptoms (Doron et al., 2016; Doron, Derby, et al., 2012a, 2012b). These beliefs are assessed via Doron et al. (2016)'s Relationship Catastrophization Scale (RECATS).

Cognitive Appraisal Model (CAM)

A theoretical model developed by Salkovskis (1985, 1989, 1996) which posits that OCD symptoms emerge due to sufferers' dysfunctional appraisal of commonly-occurring cognitive intrusions as being significantly threatening, leading to their experience of obsessive distress and, in turn, compulsions.

Cognitive-Behavioural Therapy (CBT)

A therapeutic modality informed by research on learning and cognition as well as the assumption that thought, behaviour, and emotion may influence one another (APA, n.d.). CBT seeks to alleviate dysfunction at the level of thought and behaviour through various interventions borrowed from both cognitive and behavior therapy traditions (APA, n.d.)

Compulsions

Repeated behaviours and patterns of cognition which are intended to alleviate, but paradoxically reinforce the distress caused by obsessions, leading to disability and functional impairments in OCD sufferers' lives (APA, 2022). Along with obsessions, compulsions constitute one of two core symptoms of OCD (APA, 2022).

Dysfunctional Relationship Beliefs

Five particular beliefs about relationships identified by Eidelson and Epstein (1982) (i.e., disagreement is destructive, sex must be perfect, men and women are fundamentally different, one should be able to read their partner's mind, and one's partner cannot change) which are believed to contribute to ROCD symptoms (Ghomian et al., 2019a, 2019b, 2021a, 2022a). Dysfunctional relationship beliefs are assessed through Eidelson and Epstein (1982)'s Relationship Beliefs Inventory (RBI).

Emotionally Focused Therapy (EFT)

A time-limited, highly-structured, evidence-based, systemic, and humanistic couples therapy initially developed by Greenberg and Johnson (1988). EFT aims to alleviate relationship distress by

facilitating romantic partners' abilities to engage with and vulnerably share their emotional experiences with one another such that they develop more secure attachment and more adaptive patterns of interaction (Johnson, 2019a, 2019b).

Extreme Love Beliefs

Unrealistic beliefs/ideals about love and romantic relationships (e.g., one should feel consistent euphoria and never be attracted to anyone other than their partner) which may facilitate the emergence of ROCD (Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014). Extreme love beliefs are measured by Doron et al. (2014, as cited in ROCD.net, n.d.-a)'s Extreme Love Beliefs Scale (EXLS).

Fear of Self

A self-vulnerability implicated in the etiology of OCD and ROCD which involves concern about one's true nature and/or the type of person whom they may become in the future (Fernandez et al., 2021). Fear of self may foster feelings of guilt, low worth, and questions about one's morality (Fernandez et al., 2021).

Insecure Attachment

The lack of a secure attachment bond between an individual and their primary caregiver or romantic partner which may result in the former's possession of an anxious or avoidant attachment style (Bowlby, 1969, 1973, 1980, 1988; Brennan et al., 1998; Mikulincer & Shaver, 2007). Insecure attachment is often operationalized as a construct referred to as *attachment insecurity* in the ROCD literature and may represent a particularly strong contributor to the etiology of this disorder (Doron, Derby, et al., 2012a, 2012b; Doron, Szepsenwol, et al., 2012; Doron et al., 2013)

Obsessions

Persistent, unwelcome, and anxiety-provoking cognitive intrusions (i.e., thoughts, images, and/or urges) which spawn compulsions as well as significant disability and functional impairment for sufferers (APA, 2022). Obsessions constitute one of two core symptoms of OCD (APA, 2022).

Obsessive-Compulsive Disorder (OCD)

A chronic mental condition involving distressing obsessions and compulsions which cause significant disability (i.e., take up more than an hour of the day) for sufferers as well as functional impairments in their lives (e.g., in their performance at work) (APA, 2022).

Obsessive Distrust

A specific domain of Partner-Focused Obsessive Compulsive (PFOC) symptoms focused upon the fidelity, trustworthiness, and/or reliability of one's partner (Brandes et al., 2020). Obsessive distrust is assessed through administration of the Obsessive Distrust Inventory (ODIS) (Brandes et al., 2020).

OCD-Related Maladaptive Beliefs

Six maladaptive beliefs identified by the OCCWG (1997) which are believed to contribute to OCD and ROCD symptomatology by exacerbating sufferers' dysfunctional appraisal of cognitive intrusions. These include inflated responsibility, overimportance of thoughts, excessive concern about the importance of controlling one's thoughts, overestimation of threat, intolerance of uncertainty, and perfectionism (OCCWG, 1997).

Partner-Focused Obsessive-Compulsive (PFOC) Symptoms

One of two distinct types of ROCD symptoms, sometimes referred to as *ROCD Type II*, which involves obsessions and compulsions related to the qualities of one's romantic partner, including their physical appearance, sociability, sense of humour, emotionality, morality, competence, intelligence, trustworthiness, and/or reliability (Brandes et al., 2020; Doron, Derby, et al., 2012a). The severity of Partner-Focused Obsessive-Compulsive (PFOC) symptoms is assessed through administration of the Partner-Related Obsessive-Compulsive Symptom Inventory (PROCSI) (Doron, Derby, et al., 2012a) and the Obsessive-Distrust Inventory (ODIS) (Brandes et al., 2020).

Partner-Value Contingent Self-Worth

A self-vulnerability implicated in ROCD's etiology which involves the derivation of a significant

proportion of one's self-worth from the relative value of their romantic partner (Doron & Szepsenwol, 2015). The value of one's partner, thus, constitutes a sensitive self-domain for individuals who exhibit partner-value contingent self-worth (Doron & Kyrios, 2005; Doron & Szepsenwol, 2015).

Relationship-Centered Obsessive-Compulsive (RCOC) Symptoms

One of ROCD's two distinct symptom types, sometimes referred to as *ROCD Type I*, which is marked by obsessive preoccupation with and, thus, compulsive scrutiny of one's love for their romantic partner, the partner's love for the sufferer, and/or the sufferer's sense that the relationship feels "right" (Doron, Derby, et al., 2012b; Doron, Szepsenwol, et al., 2012). Relationship-Centered Obsessive Compulsive (RCOC) symptom severity is assessed through administration of the Relationship Obsessive-Compulsive Inventory (ROCI) (Doron, Derby, et al., 2012b).

Relationship-Contingent Self-Worth

A self-vulnerability implicated in ROCD's etiology which involves the derivation of a significant proportion of one's self-worth from the quality of their romantic relationship (Doron et al., 2013). The quality of one's romantic relationship, thus, constitutes a sensitive self-domain for individuals who exhibit relationship-contingent self-worth (Doron & Kyrios, 2005; Doron et al., 2013).

Relationship Obsessive-Compulsive Disorder (ROCD)

A relatively-novel, understudied, and unknown theme of OCD not yet formally recognized by the APA (2022) in which sufferers' obsessions and compulsions revolve around close others, particularly romantic partners, and their relationships with them (Doron, Derby, et al., 2012a, 2012b; Doron, Szepsenwol, et al., 2012).

Self-Vulnerabilities

Facets of one's self-concept which may increase their susceptibility to the dysfunctional appraisal of cognitive intrusions and, thus, their development of OCD symptoms (Doron & Kyrios, 2005; Doron, Szepsenwol, et al., 2012; Melli, Aardema, & Moulding, 2016; Moulding et al., 2014). ROCD

sufferers may possess three such self-vulnerabilities, particularly partner-value contingent self-worth (Doron & Szepsenwol, 2015), relationship-contingent self-worth (Doron et al., 2013), and fear of self (Fernandez et al., 2021).

Sensitive Self-Domains

Important aspects of oneself (e.g., morals and values) which are also associated with feelings of inadequacy (Doron & Kyrios, 2005). OCD sufferers may, thus, dysfunctionally appraise intrusions which target these domains as a threat to their self-worth, causing significant distress and, in turn, the development of related obsessions and compulsions (Doron & Kyrios, 2005; Doron, Szepsenwol, et al., 2012). Sensitive self-domains implicated in ROCD's etiology include the quality of one's romantic relationship, leading to relationship-contingent self-worth (Doron et al., 2013), and the relative value of their romantic partner, causing partner-value contingent self-worth (Doron & Szepsenwol, 2015).

Symptom Accommodation

The facilitation of an OCD sufferer's compulsions (e.g., through the provision of reassurance) by another individual which, though intended to alleviate the former's experience of obsession-related distress, may sustain and/or exacerbate it (Abramowitz et al., 2012). Symptom accommodation may represent a significant and central challenge for ROCD sufferers and their partners (Doron & Derby, 2017; Doron, Derby et al., 2012b).

Within-Person Symptom Contagion

The tendency for one's experience of Relationship-Centered Obsessive-Compulsive (RCOC) symptoms to facilitate their development of Partner-Focused Obsessive-Compulsive (PFOC) symptoms and vice versa (Doron, Derby, & Szepsenwol, 2014).

Chapter Two: Literature Review

Relationship Obsessive-Compulsive Disorder

The first section of this chapter seeks to answer research question one by determining what therapists must know about Relationship Obsessive-Compulsive Disorder (ROCD) in order to competently treat those who have been negatively impacted by it. To do this, it examines findings related to ROCD's symptoms, assessment, epidemiology, etiology, and impacts on both sufferers and their partners, followed by recommended approaches for the treatment of each.

Symptoms

In describing the symptoms of ROCD, scholars have identified two distinct types (Doron, Derby, et al., 2012a, 2012b; Doron, Szepsenwol, et al., 2012).

Type I: Relationship-Centered Obsessive-Compulsive Symptoms. *Relationship-Centered Obsessive-Compulsive (RCOC) symptoms*, which are sometimes referred to as *ROCD Type I*, involve obsessive concern and/or doubts about one's love for their intimate partner, the partner's love for the sufferer, and/or "the «rightness» of [their] relationship" (Doron, Szepsenwol, et al., 2012, p. 73). RCOC obsessions are often triggered by circumstances which provoke sufferers to scrutinize the quality of their intimate relationships (e.g., observation of other couples) and/or their commitment to them (e.g., discussion of marriage) (Doron & Derby, n.d.; Doron, Derby, & Szepsenwol, 2014). Similarly, dissolution of the partnership and/or exposure to negative emotional states associated with one's experience of it (e.g., boredom) may also serve as triggers for RCOC intrusions (Doron, Derby, & Szepsenwol, 2014; Mısırlı & Kaynak, 2023).

In order to manage the distress brought on by RCOC intrusions, sufferers often compulsively avoid these triggers (Doron, Derby, et al., 2012b), for example, by abstaining from socializing with other couples, consuming media depicting romantic relationships, and/or pursuing them entirely (Doron & Derby, n.d.). RCOC symptom sufferers may also practice thought substitution by forcing themselves to

think about pleasant moments in which they were more certain about their feelings for their partners, their partners' feelings towards them, and/or how right the relationship feels (Doron, Derby, & Szepsenwol, 2014). Likewise, they may engage in compulsive checking by monitoring their internal states, including thoughts, behaviours, emotions, and/or physical sensations (e.g., their level of arousal during intercourse) in attempts to achieve certainty about their intrusive concerns (Boulton, 2020; Derby et al., 2021; Doron & Derby, 2017; Doron, Derby, et al., 2012b). Conversely, those afflicted might turn to external sources of information by seeking reassurance from others (e.g., friends, family, and/or people on The Internet) about whether they are in a good relationship and/or have found the right partner (Doron, Derby, et al., 2012b). Additionally, an RCOC symptom sufferer may take a more direct approach, interrogating their partner about their feelings and/or possible intention of abandoning their relationship (Doron, Derby, et al., 2012b), or by "confessing relationship doubts to close family, friends, or [their partners]" (Littman et al., 2023, para. 10).

Assessment of Relationship-Centered Obsessive-Compulsive Symptoms. RCOC symptom severity is assessed via the Relationship Obsessive-Compulsive Inventory (ROCI), an English language, self-report measure developed by Doron, Derby, et al. (2012b). The ROCI comprises 12 statements indicative of RCOC symptoms which were identified by Doron and Derby through their clinical work with sufferers (Doron, Derby, et al., 2012b), including "I constantly doubt my relationship" (p. 23) and "I keep asking my partner whether she/he really loves me" (p. 23). When assessed by the ROCI, individuals are asked to indicate on a five-point Likert scale how true they perceive a given statement to be relative to their own experience, with zero indicating that a statement is not true at all and four denoting that it is very much so (ROCD.net, n.d.-e).[1] The 12 items on the ROCI are distributed evenly across three factors, each of which assess one of the potential targets of RCOC concerns, thus forming a corresponding, four-item subscale (Doron, Derby, et al., 2012b). Statistical analyses have confirmed this structure, as well as

[1] See https://rocd.net/description-and-norms for ROCI scoring standards.

the construct, convergent, and divergent validity of the ROCI, along with its internal consistency and test-retest reliability (Doron, Derby, et al., 2012a, 2012b). The ROCI has also been translated into a variety of languages, including Hebrew and Spanish (ROCD.net, n.d.-d), Italian (Melli et al., 2012, as cited in ROCD.net, n.d.-d), Dutch (Anholt, 2013, as cited in ROCD.net, n.d.-d), Persian (Atary, 2012, as cited in ROCD.net, n.d.-d), Turkish (Inozu & Tirak, 2015, as cited in ROCD.net, n.d.-d), and Albanian (Tahiri, 2016, as cited in ROCD.net, n.d.-d). Analyses of these translations have confirmed the original three-factor structure of the ROCI and suggested that they can also be considered valid and reliable (Ghomian et al., 2019b; Melli, Carraresi, et al., 2018; Trak & İnözü, 2017; Yılmaz, 2015). Additionally, Ghomian et al. (2021a) have modified the Persian translation, producing the Revised ROCI, which, instead, bears a two-factor structure, with one assessing obsessions related to loving and being loved by one's spouse as well as fixing the relationship, and the other testing for compulsions related to each of these targets. Further, Moulding (2019, as cited in Roncero et al., 2019) has produced an as-of-yet unpublished, six-item version of the ROCI dubbed the Relationship Obsessive-Compulsive Inventory - Short Version (ROCI-S). These revisions appear to demonstrate comparable (Roncero et al., 2019) or even superior validity and reliability (Moulding, 2019, as cited in Roncero et al., 2019) relative to the original ROCI.

Type II: Partner-Focused Obsessive-Compulsive Symptoms. Conversely, *Partner-Focused Obsessive-Compulsive (PFOC) symptoms*, also known as *ROCD Type II*, involve pathological preoccupation with an intimate partner's potential shortcomings (Doron, Derby, et al., 2012a; Doron, Szepsenwol, et al., 2012). While Doron, Derby, et al. (2012a) identified the partner's physical appearance, sociability, sense of humour, emotionality, morality, competence, and intelligence as potential areas of concern for PFOC symptom sufferers, Brandes et al. (2020) subsequently posited that these individuals may also become fixated on their partner's lack of trustworthiness and/or reliability. They have also suggested that preoccupation with these latter two attributes constitutes a unique domain of PFOC obsessions known as *obsessive distrust*, which may also involve worry about the ability

of one's partner to remain faithful to the relationship (Brandes et al., 2020). Further, they have clarified that, while infidelity concerns might also be indicative of obsessive jealousy, the focus in obsessive distrust is not on a potential interloper, but the partner's conduct (Brandes et al., 2020). Like RCOC obsessions, PFOC obsessions occur in response to specific triggers, particularly circumstances which highlight for the sufferer any potential deficits in their partner (Brandes et al., 2020; Doron, Derby, et al., 2012a). For instance, a sufferer's fixation on their partner's potential physical deficits may stem from their observation of undesirable parts of the partner's body or their recognition that they are physically attracted to someone other than their partner (Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014; Doron, Derby, et al., 2012a). In the specific case of obsessive distrust symptoms, triggers may include situations in which the partner must be relied upon to complete a certain task (e.g., a household chore) (Brandes et al., 2020). Doron, Derby, et al. (2012a) have also noted a compounding effect wherein incremental exposure to PFOC triggers may lead sufferers to become increasingly aware of and, thus, impacted by them over time.

Like those who experience RCOC symptoms, sufferers of PFOC obsessions may compulsively avoid their specific triggers (e.g., by refraining from looking at pictures of attractive people on social media) or remember times when they felt less bothered by such concerns (i.e., over their partner's potential faults) (Doron & Derby, n.d.; Doron, Derby, & Szepsenwol, 2014; Doron, Derby, et al., 2012a, 2012b). They may also engage in compulsive checking of/for these deficits, for example, by scrutinizing why their partners' past relationship(s) failed and/or by testing their partners (e.g., to assess for lack of intellect) (Doron & Derby, n.d.). Additionally, PFOC obsessions may lead sufferers to weigh the value of certain partner qualities against one another (Brandes et al., 2020; Doron & Szepsenwol, 2015) and/or to compare them with those of past and/or potential future partners to determine whether the sufferer can accept them (Doron, Derby, & Szepsenwol, 2014; Doron, Derby, et al., 2012a). To neutralize PFOC obsessions, sufferers may also seek reassurance from close confidants that, for example, their partners

are smart or trustworthy enough (Brandes et al., 2020; Derby et al., 2021; Doron, Derby, et al., 2012a), or even attempt to modify their partners' shortcomings (e.g., by encouraging them to alter the way they look) (Doron & Derby, n.d.; Littman et al., 2023).

Assessment of Partner-Focused Obsessive-Compulsive Symptoms. The Partner-Related Obsessive-Compulsive Symptom Inventory (PROCSI) is an accompaniment to the ROCI that, instead, assesses PFOC symptom severity (Doron, Derby, et al., 2012a).[2] Like the ROCI, it is an English-language, self-report measure which also uses a similarly-scored, five-point Likert scale to track participants' responses, but in reference to 24 statements indicative of PFOC symptoms, per Doron and Derby's clinical observations (Doron, Derby, et al., 2012a; ROCD.net, n.d.-c). These statements include "I am constantly bothered by thoughts regarding the flaws in my partner's physical appearance" (Doron, Derby, et al., 2012a, p. 23) and "I keep looking for evidence that my partner is moral enough" (p. 23). The 24 items of the PROCSI are uniformly spread across factors representing the domains of partner deficits initially identified by Doron, Derby, et al. (2012a) (i.e., physical appearance, sociability, morality, emotional stability, intelligence, and competence), thus creating six, four-item subscales. Analyses have also confirmed the PROCSI's structure and that it demonstrates relatively-good validity, internal consistency, and test-retest reliability (Doron, Derby, et al., 2012a).

Like the ROCI, the PROCSI has been translated into several languages, including Hebrew and Spanish (ROCD.net, n.d.-d), Italian (Melli et al., 2012, as cited in ROCD.net, n.d.-d), Persian (Atary, 2012, as cited ROCD.net, n.d.-d), and Turkish (Inozu & Tirak, 2015), with many of these translations also having shown to be relatively valid and reliable (Ghomian et al., 2019a; Melli, Carraresi, et al., 2018; Trak and İnözü, 2017; Yılmaz, 2015). Additionally, as was done with the Persian ROCI, the Persian PROCSI was revised by Ghomian et al. (2022a) to produce the 22-item New PROCSI, which spans the same six factors identified by Doron, Derby, et al. (2012a). Likewise, Moulding (2019, as cited in Roncero et al., 2019)

[2] See https://rocd.net/procsi-description-and-norms/ for PROCSI scoring standards.

developed the currently-unpublished, yet accurately-named PROCSI - 6-Item Version (PROCSI-Si). Both of these revisions have been found to have similar, if not superior validity and reliability to Doron, Derby, et al. (2012a)'s original PROCSI (Ghomian et al., 2022a; Moulding et al., 2019, as cited in Roncero et al., 2019).

Further, the Obsessive Distrust Inventory (ODIS) (Brandes et al., 2020) is an extension of Doron, Derby, et al. (2012a)'s PROCSI, assessing only the severity of PFOC symptoms pertaining to obsessive distrust. Like the ROCI and PROCSI, it is an English-language, self-report measure which uses a five-point Likert scale to track participants' responses to a series of items derived from clinical experience with ROCD sufferers (Brandes et al., 2020). However, the ODIS taps only a single factor through participants' agreement with eight statements, such as "I'm troubled by doubts regarding my ability to trust my partner" (Brandes et al., 2020, p. 3) and "I look for evidence that my partner is a trustworthy person" (p. 3). Analyses of the ODIS (Brandes et al., 2020) and its lone Turkish translation (Açar, 2022) have supported this one-factor structure and suggested that each version has good construct validity and internal consistency.

Comorbidity and Within-Person Contagion. There is considerable evidence that RCOC and PFOC symptoms are often comorbid with one another. Indeed, while Doron and Derby (2017)'s clinical experience has suggested as much, significant and sometimes strong correlations have been observed between these two symptom types (Abak & Güzel, 2021; Brandes et al., 2020; Doron & Derby, 2017; Doron et al., 2016; Doron, Derby, et al., 2012a; Doron, Mizrahi, et al., 2014; Fernandez et al., 2021; Kuru, 2022; Szepsenwol et al., 2016). Given this, researchers have speculated that a form of *within-person symptom contagion* might exist, wherein increased concern about a partner's flaws may induce relationship doubts and vice versa (Doron, Derby, & Szepsenwol, 2014). Longitudinal data seems to support this position, as Doron, Derby, et al. (2012a) found that participants' scores on the ROCI and PROCSI were significantly predictive of one another at nine-week follow-up. Similarly, Szepsenwol et al.

(2016) found that baseline PROCSI scores were significantly predictive of those on the ROCI a year later and that, for individuals in longer relationships, higher baseline ROCI scores significantly predicted lower decreases in PFOC symptoms over that same interval.

Epidemiology

Though development of the ROCI (Doron, Derby, et al., 2012b), PROCSI (Doron, Derby, et al., 2012a), and ODIS (Brandes et al., 2020) has allowed for the measurement of ROCD symptoms, there is still a considerable lack of clarity around the epidemiology of this disorder (Clark, 2019; Tinella et al., 2023).

Prevalence and Geographic Distribution. While it is not yet known how many people may suffer from ROCD (Derby et al., 2021), experts have estimated that it may impact as many as one percent of all Israeli Jews (Doron, 2015, as cited in Derby et al., 2021). Similarly, Bar On (2020) has cited OCD researcher Jonathan Abramowitz as suggesting that five percent of all OCD sufferers may experience clinically significant ROCD symptoms. Regardless, ROCD obsessions and compulsions have been documented in many different countries, including Australia, Great Britain, Turkey, Iran, Italy, Israel, and The United States of America (Doron et al., 2016; Doron, Derby, et al. 2012a, 2012b; Fernandez et al., 2021; Ghomian et al., 2019a, 2019b; Trak & İnözü, 2017, 2019). However, it has also been suggested that their frequency and quality may vary due to differential cultural messaging about the nature of love and intimate relationships (Dar et al., 2021; Ghomian et al., 2021b, 2022a). Unfortunately, few studies have yet examined such cultural influences on ROCD symptom presentation (Akkaya & Yılmaz, 2021; Dar et al. 2021).

Gender Differences. Examination of potential gender differences in ROCD presentation have generally yielded mixed results. Though many studies have failed to find significant variation between men and women in terms of the severity of their RCOC symptoms (e.g., Abak, 2019; Bakçepinar, 2019; Cebeci, 2019; Doron, Derby, et al., 2012b; Doron et al., 2013; Tinella et al., 2023; Toroslu & Çırakoğlu,

2022; Trak, 2016; Yıldırım, 2017), others have noted that men may be significantly more concerned about their love for their partner (Kilic & Altinok, 2021) and less so about being loved by them (Yıldırım, 2018) relative to women. Additionally, while Balcı (2021) initially found no significant differences between the scores of men and women on the ROCI and its three subdimensions, when only those with partners were compared, women exhibited significantly higher doubts pertaining to the rightness of their relationships. The majority of studies examining gender differences in PFOC symptoms have also failed to document any (e.g., Bakçepinar, 2019; Brandes et al., 2020; Doron, Derby, et al., 2012a; Tinella et al., 2023; Toroslu & Çırakoğlu, 2022; Trak, 2016). However, others have found that men experience significantly higher levels of PFOC symptoms both overall (Abak, 2019) as well as within specific domains, for example, those related to their partners' sociability (Abak, 2019) and physical appearance (Abak, 2019; Balcı, 2021; Yıldırım, 2017). Yıldırım (2018) also found that women were significantly more concerned than men about their partners' levels of professional competence and morality.

Onset and Age-Related Differences. While there is little empirical data on the precise age at which ROCD obsessions and compulsions typically emerge (Akkaya & Yılmaz, 2021), observations about individuals who have sought clinical help for their symptoms suggest that they may first become aware of them as young adults (Doron, Derby, & Szepsenwol, 2014). Ghomian et al. (2022b) have also noted that sufferers may initially dismiss ROCD symptoms as typical relationship concerns and, thus, only present in clinical settings when these begin to impact their partnerships. Additionally, Doron, Derby, and Szepsenwol (2014) have posited that they may first occur early on in a relationship, and/or when one is considering whether to commit to it further (e.g., by getting married).

Research on possible associations between an individual's age and the severity of their symptoms is more fulsome, but also relatively ambiguous. Indeed, some have noted an inverse relationship, wherein, with increasing age, individuals score significantly lower on the ROCI (Balcı, 2021; Doron, Derby, et al. 2012b; Toroslu & Çırakoğlu, 2022; Trak, 2016) and its subdimensions pertaining to

the partner's love and the rightness of the relationship (Balcı, 2021). However, these findings stand in contrast to those which found no significant associations between age and RCOC symptom severity (Doron et al., 2013; Günhan, 2021; Kılıç & Altınok, 2021; Tinella et al., 2023; Yıldırım, 2017). Relative to PFOC symptoms, both Balcı (2021) and Trak (2016) found that scores on the PROCSI waned significantly with age, with Balcı (2021) also noting that scores on its subdimensions representing a partner's competence, emotional stability, and intelligence followed the same pattern. Alternately, many studies have failed to find any significant associations between age and PFOC symptom severity (Brandes et al., 2020; Doron, Derby, et al., 2012a; Günhan, 2021; Tinella et al., 2023; Toroslu & Çırakoğlu, 2022; Trak, 2016; Yıldırım, 2017).

Differences According to Relationship Status and Duration. Findings related to potential associations between ROCD severity and relationship status are also mixed, at best. Indeed, while Doron et al. (2016) found that individuals' ROCI scores did not differ significantly according to whether they were in a relationship, Balcı (2021) found that those who were single did score significantly higher on the ROCI and two of its subdimensions (i.e., concern over being loved by one's partner and the rightness of their relationship). Additionally, Bakçepinar (2019) observed no significant variance in ROCI scores when comparing those who were in relationships, those who were engaged, and those who were married, whereas Abak (2019) noted that the former scored significantly higher than each of the latter two groups. Further, Rezaei et al. (2023) found that married individuals exhibited significantly less-severe RCOC symptoms than those who were unmarried, but in relationships. Regarding PROCSI scores, Doron et al. (2016) found that they were similar for individuals who were single and those who were in relationships, though Balcı (2021) observed that the former scored significantly higher on the PROCSI as well as several of its subscales (i.e., concern over a partner's morality, sociability, emotional stability, and intelligence). Finally, while both Abak (2019) and Bakçepinar (2019) found PFOC symptom severity to be comparable between those who were merely in relationships, those who were engaged, and those

who were married, Rezaei et al. (2023) noted that the latter scored significantly lower on the PROCSI than those who were coupled, but not engaged or married.

Differences in ROCD severity according to relationship duration are similarly unclear. Indeed, many studies have yielded statistically-significant, negative associations between relationship duration and scores on the ROCI (Abak, 2019; Bakçepinar, 2019; Balcı, 2021; Kılıç & Altınok, 2021; Szepsenwol et al., 2016; Tinella et al., 2023; Toroslu & Çırakoğlu, 2022; Trak, 2016) as well as two of its subscales (i.e., concern over being loved by one's partner and the rightness of one's relationship) (Balcı, 2021). Similar associations have also been observed between relationship duration and scores on the PROCSI (Abak, 2019; Bakçepinar, 2019; Tinella et al., 2023; Toroslu & Çırakoğlu, 2022; Trak, 2016) as well as its subscale pertaining to the partner's competence (Balcı, 2021). However, others have found no such links between relationship duration and RCOC (Doron, Derby, et al., 2012b; Günhan, 2021; Yıldırım, 2017), nor PFOC symptoms (Brandes et al., 2020; Doron, Derby, et al., 2012a; Günhan, 2021; Yıldırım, 2017).

Etiology

Numerous factors have been implicated in ROCD's etiology, many of which may be relevant to the treatment of both individuals and couples impacted by this disorder.

OCD-Related Maladaptive Beliefs. Given that ROCD has been conceptualized as a theme of OCD, scholars have proposed that many of the OCD-related maladaptive beliefs identified by the OCCWG (1997) may contribute to its symptomatology (Doron, Derby, et al., 2012a, 2012b). For example, it has been posited that intolerance of uncertainty and perfectionism may specifically contribute to one's doubt that they are in love with their partner and/or that their relationship feels right, while intolerance of uncertainty and overestimation of threat may increase concern that their partner does not love them (Doron, Derby, & Szepsenwol, 2014; Doron, Szepsenwol, et al., 2012). Additionally, it has been suggested that fixation on a partner's flaws may result from overestimation of threat and perfectionism (Doron, Derby, & Szepsenwol, 2014; Doron, Szepsenwol, et al., 2012) and that

overimportance of thoughts and excessive concern about the importance of controlling them may underlie attempts to neutralize ROCD intrusions through compulsive behaviours (Doron, Szepsenwol, et al., 2012).

Empirical research suggests that ROCD sufferers do hold such maladaptive beliefs. Indeed, statements provided by self-identified ROCD sufferers (Tsiugaras, 2012) and those meeting the threshold for a clinical diagnosis of this disorder (Ghomian et al., 2021b) appear to bear themes indicative of the majority, if not all of the beliefs noted by the OCCWG (1997). Likewise, several studies have found that scores on various measures assessing the endorsement of OCD-related maladaptive beliefs correlated significantly with scores on the ROCI, PROCSI, New PROCSI, and many of their subscales (Doron et al., 2016; Doron, Derby, et al., 2012a, 2012b; Fernandez et al., 2021; Ghomian et al., 2022a; Melli et al., 2015; Melli, Carraresi, & Doron, 2016; Melli, Bulli, et al., 2018; Trak & İnözü, 2017). Additionally, several developmental models have highlighted OCD-related maladaptive beliefs (e.g., perfectionism and intolerance of uncertainty) as mediating or moderating the relationship between ROCD symptoms and other factors implicated in the etiology of this disorder (e.g., attachment insecurity and early maladaptive schemas) (Toroslu & Çırakoğlu, 2022; Yıldırım, 2018).

Maladaptive Beliefs About Love and Relationships. Scholarship on ROCD has also suggested that certain maladaptive beliefs about love and/or intimate relationships may facilitate the development of this particular theme of OCD by contributing to sufferers' dysfunctional appraisal of "common relationship concerns" (Doron et al., 2016, p. 2).

Catastrophic Relationship Beliefs. Amongst these are *catastrophic relationship beliefs*, including overestimation of the negative impacts of dissolving a relationship, remaining in one that is imperfect, and/or of being alone (Doron, Derby, et al., 2012b). The first two of these beliefs have been posited to underpin RCOC doubts about the rightness of one's relationship and their love for their partner, while the latter is believed to contribute to concerns about being loved by them (Doron et al., 2016; Doron,

Derby, et al., 2012b). Likewise, it has been stated that various PFOC symptoms may result from overestimating the negative impacts of dissolving one's relationship (Doron, Derby, et al., 2012a) and that fear of regret (Doron, Derby, & Szepsenwol, 2014) and guilt (Tinella et al., 2023) may exacerbate each of these catastrophic beliefs.

The potential role of catastrophic relationship beliefs in ROCD's etiology is, at this time, unclear. Indeed, after developing the Relationship Catastrophization Scale (RECATS) to assess such beliefs, Doron et al. (2016) found that those clinically diagnosed with ROCD were significantly more likely to overestimate the negative consequences of remaining in an imperfect relationship than those diagnosed with other OCD themes as well as those not diagnosed at all; however, they also found that they were no more likely than either group to overestimate the negative consequences of separating from one's partner and that they did not differ significantly from general OCD sufferers in terms of overestimating the negative consequences of being alone (Doron et al., 2016). Additionally, while several other investigations have found significant correlations between ROCD's two symptom types and these catastrophic beliefs (Di Leonardo, 2018; Fernandez et al., 2021; Melli, Bulli et al., 2018; Melli, Carraresi, & Doron, 2016), their findings have varied in terms of exactly which and to what degree.

Dysfunctional Relationship Beliefs. According to Ghomian et al. (2019a, 2019b, 2021a, 2022a), the five *dysfunctional relationship beliefs* assessed by Eidelson and Epstein (1982)'s Relationship Beliefs Inventory (RBI) may also facilitate ROCD symptoms. These include the notions that disagreement is destructive to relationships, sex should always be perfect, the sexes are inherently different, partners should be able to read each other's minds, and that they cannot change (Eidelson & Epstein, 1982). In support of these claims, it has been observed that scores on the PROCSI (Ghomian et al., 2019a), ROCI (Ghomian et al., 2019b), Revised ROCI (Ghomian et al., 2021a), and New PROCSI (Ghomian et al., 2022a), as well as the majority of their subscales have correlated significantly and positively with those on the RBI and many of its own subscales.

Extreme Love Beliefs. Researchers have also stated that exaggerated convictions about what constitutes true love, the right relationship, and/or the partner with whom one is meant to be based on the presence of harmony, euphoria, and relationship doubts may facilitate both RCOC and PFOC obsessions (Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014). Such *extreme love beliefs* are measured by the Extreme Love Beliefs Scale (EXLS), developed by Doron et al. (2014, as cited in ROCD.net, n.d.-a). Though evidence supporting such claims is currently limited, Doron and Derby (2017) have cited unpublished research which allegedly demonstrated positive correlations between extreme love beliefs and ROCD symptoms.

Sociocultural Influences. It is important to note that the maladaptive beliefs about love and intimate relationships described above may be particularly subject to sociocultural influence. Indeed, Lombardi and Rodriguez (2019) have posited that perfectionistic standards and/or intolerance of uncertainty related to intimate relationships and/or partners may be reinforced by societal emphasis on "finding and maintaining a romantic relationship … [as well as] … beliefs and expectations about how romantic relationships should be experienced" (p. 186). Likewise, Doron, Derby, and Szepsenwol (2014) have specified that one's need for certainty about their relationship and/or partner as well as endorsement of catastrophic relationship beliefs may be rooted in religious ideals about committing to a single partner for life and/or their mass exposure to alternative partners via social media. Additionally, Lombardi and Rodriguez (2019) have suggested that portrayals of love in popular culture and oft-repeated beliefs about the existence of soulmates may be particularly problematic in this regard. Similarly, Dar et al. (2021) have hypothesized that ROCD may be more common in cultures which emphasize "love, attraction, and excitement towards the partner [one intends] to marry" (p. 10), rather than where marriages are arranged predominantly out of practicality.

Self-Vulnerabilities. Three specific self-vulnerabilities have been implicated in ROCD's etiology, including *partner-value contingent self-worth*, that is, one's belief that "their partner's deficiencies or

flaws … [reflect] on their own [value]" (Doron & Szepsenwol, 2015, p. 177). Indeed, scores on the Partner Value Contingent Self-Worth Scale (Doron et al., 2014, as cited in ROCD.net, n.d.-b), which assesses the degree to which one may endorse such a notion, have been observed to correlate significantly with those on both the ROCI and PROCSI (Açar, 2022; Trak, 2016; Trak & İnözü, 2019). Likewise, Doron and Szepsenwol (2015)'s observation that participants who scored highly on the PROCSI exhibited significantly greater drops in self-esteem when informed that their partners were less beautiful, intelligent, moral, and/or successful than others suggested that the value of one's partner may, indeed, serve as a sensitive self-domain for those suffering from PFOC symptoms.

Similarly, *relationship-contingent self-worth*, that is, "self-worth … strongly dependent on [the quality of one's] relationship" (Doron et al., 2013, p. 435), has also been proposed as a self-vulnerability relevant to ROCD's etiology. Though participants' scores on a measure assessing this contingency of self-worth did not correlate significantly with those on the ROCI, suggesting that the quality of one's relationship may not serve as a sensitive self-domain for ROCD sufferers, they did significantly moderate the relationship between attachment anxiety and ROCD symptoms (Doron et al., 2013). Accordingly, Doron et al. (2013) have posited that the combination of attachment anxiety and relationship-contingent self-worth may constitute a particularly powerful susceptibility to ROCD, which they have dubbed *double relationship-vulnerability.*

The aforementioned fear of self may also serve as a self-vulnerability which contributes to the presentation of ROCD, predisposing sufferers to "doubts [about] how [they feel] about themselves in a relationship, and/or … who [they are] as a partner" (Fernandez et al., 2021, p. 7). As such, fear of self may contribute to feelings of guilt, low worth, and immorality, thus driving compulsive behaviour (Fernandez et al., 2021). Indeed, in a single study examining fear of self in relation to ROCD, Fernandez et al. (2021) noted significant, positive correlations between this construct and both RCOC and PFOC symptoms.

Attachment Insecurity. Since ROCD was first described, it has been speculated that insecure attachment may play a central role in its etiology (Doron, Derby, et al., 2012a, 2012b). Indeed, Doron, Szepsenwol, et al. (2012) posited that hyperactivation of the attachment system may facilitate RCOC obsessions and compulsions, with one's reliance upon their partner for support being particularly problematic, given that their presence may also trigger such symptoms. Likewise, they implicated deactivation strategies, particularly projection of one's insecurities onto others, in the development of PFOC symptoms (Doron, Szepsenwol, et al., 2012). Doron et al. (2013) have also stated that insecure attachment may contribute to ROCD's emergence specifically by increasing susceptibility to OCD-related maladaptive beliefs.

A plethora of empirical findings have suggested that such assumptions may be true, with significant, positive correlations having been observed between scores on measures of attachment insecurity and those on the ROCI, PROCSI, and/or their subscales (Balcı, 2021; Doron, Derby, et al., 2012a, 2012b; Güler, 2023; Günhan, 2021; Kabiri et al., 2017; Özel & Karakose, 2023; Rezaei et al., 2023; Trak, 2016; Trak & İnözü, 2017, 2019; Yıldırım, 2018; Yılmaz, 2015). However, avoidant attachment has also been observed to be significantly and negatively associated with RCOC symptoms in some cases (Doron, Derby, et al., 2012a; Trak, 2016). Likewise, only a few studies have produced results supporting Doron, Szepsenwol, et al. (2012)'s assertion that anxious and avoidant attachment may be related to RCOC and PFOC symptoms, respectively (Balcı, 2021; Doron, Derby, et al., 2012b; Rezaei et al., 2023; Trak & İnözü, 2017; Pisheh & Jahed, 2020). Regardless, many researchers have utilized regression analyses to produce developmental models of ROCD in which insecure attachment has played a significant role, in some instances, accounting for the effects of other significant contributors (e.g., high parental overprotection and low parental care) (Trak 2016; Trak & İnözü, 2019). These specific results may not be surprising, given that such parent-child dynamics are said to be instrumental in the formation of attachment styles (Mikulincer & Shaver, 2007). Other models have, instead, highlighted

mediating factors, such as relationship/marital satisfaction (Balcı, 2021; Güler, 2023; Özel & Karakose, 2023) and intention of infidelity (Balcı, 2021), which may explain how insecure attachment contributes to ROCD. Notably, many of these variables, including ruminative thinking (Güler, 2023), reassurance seeking (Yıldırım, 2017), experiential avoidance, and poor emotion regulation (Naji Meydani et al., 2022) have previously been identified as consequences of insecure attachment (Mikulincer & Shaver, 2007). Additionally, maladaptive perfectionism has been noted to mediate the relationship between insecure attachment and ROCD (Yıldırım, 2018), supporting Doron et al. (2013)'s claim that attachment insecurity may bolster endorsement of OCD-related maladaptive beliefs. Several developmental models have also highlighted variables which may significantly interact with insecure attachment to contribute to ROCD, including marital satisfaction (Özel, 2021), partner-value contingent self-worth (Trak & İnözü, 2019), and, as mentioned in the context of double relationship-vulnerability, relationship-contingent self-worth (Doron et al., 2013).

Impacts

Researchers have identified many ways in which ROCD might negatively impact sufferers, their relationships with their intimate partners and, consequently, each member of the dyad.

On Relationship Dynamics. In one of the first published studies on ROCD, Doron, Derby, et al. (2012b) proposed that RCOC obsessions might cause relationship distress by leading both the sufferer and their partner to question their connection with one another. Likewise, they suggested that pathological doubt about being loved by one's partner could precipitate the sufferer's overreliance upon the latter to engage in *symptom accommodation*, that is, to facilitate the sufferer's compulsions, particularly by providing reassurance about their concerns. While Abramowitz et al. (2012) have noted that such behaviour may worsen and/or prolong OCD symptoms, Doron, Derby, et al. (2012b) have stated that, in the specific context of ROCD, it may lead to "a hierarchical relationship structure" (p. 23), wherein the sufferer's partner grows frustrated, angry, and/or withdrawn. Additionally, Doron, Derby, et

al. (2012b) have posited that, over time, the sufferer's symptoms might increasingly irritate their partner, causing "hypersensitive annoyance and disgust" (p. 23) and, ultimately, their rejection of the sufferer, who, in turn, worries further about being abandoned (Doron, Derby, et al., 2012b). Similarly, several other scholars have speculated that ROCD may introduce a novel source of both stress and conflict into relationships (Cebeci, 2019; Kasalova et al., 2020), with Doron, Derby, and Szepsenwol (2014) having stated that these may serve as both consequences and triggers of obsessions. Further, it is thought that the above may result in aggression and even intimate partner violence (Bilge et al., 2022; Brandes et al., 2020; Ghomian et al., 2021b).

Depression, Anxiety, and Stress. A notable amount of research has hinted at ROCD's disabling nature by linking it with the experience of depression, anxiety, and stress. Indeed, Ghomian et al. (2021b) identified statements from ROCD sufferers suggestive of each of these factors, while a multitude of studies have observed significant, positive correlations between ROCD symptom severity and levels of depression (Brandes et al., 2020; Doron et al., 2016; Doron, Derby, et al., 2012a; Doron & Szepsenwol, 2015; Doron et al., 2013; Fernandez et al., 2021; Ghomian et al., 2019a, 2019b, 2021a, 2022a; Parlapan Bas, 2019; Trak, 2016; Trak & İnözü, 2017; Yılmaz, 2015), anxiety and stress (Doron, Derby, et al., 2012a, 2012b; Doron & Szepsenwol, 2015; Ghomian et al., 2019a, 2019b, 2021a, 2022a; Parlapan Bas, 2019; Trak, 2016; Yılmaz, 2015), as well as scores on measures assessing the sum of these constructs (Melli, Bulli, et al., 2018; Melli et al., 2015; Melli, Carraresi, & Doron, 2016; Ghomian et al., 2019a). Some of these associations have also remained significant after controlling for oft-related variables (e.g., general OCD symptoms, self-esteem, and attachment insecurity) (Brandes, 2020; Doron, Derby, et al., 2012a, 2012b). However, such results are not without exceptions, as Doron et al. (2016) noted that individuals diagnosed with ROCD exhibited significantly greater depression than community controls, but not those diagnosed with other forms of OCD. Similarly, Trak and İnözü (2017) failed to find a significant correlation between PFOC symptom severity and stress. Regardless, it is also notable that

Dar-Perl (2018) observed increases in sufferers' ROCD symptoms over a four-month period to significantly correspond with those in their partners' levels of depression and stress.

Shame, Guilt, and Negative Self-Perceptions. Scholars drawing upon clinical experience and qualitative interviews with ROCD sufferers have stated that the latter often experience marked shame and guilt due to their symptoms (Doron, Derby, & Szepsenwol, 2014; Doron, Derby, et al., 2012a, 2012b; Ghomian et al., 2021b; Rajaee, 2022). Such feelings may specifically stem from their obsessions, consequently facilitating self-criticism (Doron, Derby, & Szepsenwol, 2014). For example, RCOC obsessions may cause sufferers to believe that they have led their partners on about their feelings and are, thus, bad people (Boulton, 2020), unworthy and/or incapable of being loved (Doron, Derby, & Szepsenwol, 2014; Rajaee, 2022), and/or responsible for the relationship conflict described above (Ghomian et al., 2019b). Likewise, the ego-dystonic nature of PFOC obsessions may contribute to such negative feelings, as Parlapan Bas (2019) observed that sufferers exhibited more anxiety and stress if also highly satisfied with their marriages. Further, the seemingly "uncontrollable and irrational [quality]" (Doron, Derby, & Szepsenwol, 2014, p. 174) of ROCD compulsions may contribute to negative perceptions of self. Empirical findings seem to back these claims, with significant, negative correlations between ROCD symptom severity and self-esteem having been observed (Doron, Derby, et al., 2012a, 2012b; Doron et al., 2013, Yılmaz, 2015), especially amongst individuals exhibiting both PFOC symptoms and partner-value contingent self-worth (Doron & Szepsenwol, 2015).

Sexual Dysfunction. Several studies have also hinted that ROCD may have negative impacts on a sufferer's sexual functioning. Indeed, Doron, Mizrahi, et al. (2014) observed that the severity of RCOC and PFOC symptoms correlated significantly and negatively with sexual satisfaction when accounting for the effects of several confounds (e.g., general OCD symptoms and attachment insecurity). Likewise, online statements provided by self-identified sufferers have indicated that sex may serve as a potent trigger for RCOC and PFOC symptoms, leading to intense anxiety (Tsiugaras, 2012) and even

depersonalization (Boulton, 2020). Such statements seem to align with Doron, Mizrahi, et al. (2014)'s hypothesis that intrusive ROCD stimuli may distract sufferers from sexual encounters, hindering "erotic pleasure … and … satisfaction" (p. 2219). Derby et al. (2021) have also expanded on this position, stating that compulsive monitoring of internal states (e.g., one's level of physiological arousal) may contribute to reductions in sexual satisfaction by directing attention to non-erotic cues. However, Doron, Mizrahi, et al. (2014) have noted that the relationships between both RCOC and PFOC symptoms and sexual dissatisfaction were significantly mediated by relationship satisfaction. Accordingly, they have suggested that, while ROCD may cause dissatisfaction with one's relationship and, thus, detriments to their sex life, poor sexual satisfaction may also lead to relationship discontent and, thus, ROCD symptoms (Doron, Mizrahi, et al., 2014).

Relationship Satisfaction, Quality, and Adjustment. An impressive amount of scholarship has suggested that ROCD may have negative impacts on one's experience of their relationship. Many studies have observed ROCD severity to correlate significantly and negatively with relationship and/or marital satisfaction (Cebeci, 2019; Doron, Mizrahi, et al., 2014; Kılıç & Altınok, 2021; Kuru, 2022; Parlapan Bas, 2019; Trak, 2016; Trak & İnözü, 2017; Yılmaz, 2015), even when controlling for common confounds (Doron, Derby, et al., 2012a, 2012b). Explanations for such findings include the sufferer becoming less able to idealize their intimate relationship and/or partner (Doron, Derby, & Szepsenwol, 2014), perceiving lower support (e.g., emotional and practical) from them (Cebeci, 2019), and/or experiencing more conflict with them due to their symptoms (Cebeci, 2019; Doron, Derby, & Szepsenwol, 2014; Parlapan Bas, 2019). However, as described above, it has also been posited that observed associations between ROCD and both relationship satisfaction and perceived spousal support may be bidirectional (Cebeci, 2019; Doron, Derby, & Szepsenwol, 2014; Parlapan Bas, 2019). Similarly, ROCD severity has been observed to correlate significantly and negatively with relationship quality (Kabiri et al., 2017) and adjustment (Ghomian et al., 2019a, 2019b, 2021a, 2022a; Özel, 2021; Özel & Karakose, 2023; Parlapan

Bas, 2019), as well as many components of the latter (e.g., relationship consensus, satisfaction, cohesion, and affectional expression) (Ghomian et al., 2019a, 2019b, 2021a, 2022a; Özel & Karakose, 2023). However, the association between relationship adjustment and ROCD may also be bidirectional in nature (Özel, 2021; Özel & Karakose, 2023; Parlapan Bas, 2019). Further, Dar-Perl (2018) found that, as ROCD sufferers' symptoms worsened over the course of four months, their partners also became significantly less satisfied with their relationships.

Relationship Stability and Between-Partner Symptom Contagion. The above findings have serious implications for the success of ROCD sufferers' relationships. Indeed, it is thought that repeated conflict may impair one's satisfaction with their relationship and, thus, destabilize it (Amato, 2000, as cited in Doron, Derby, & Szepsenwol, 2014), particularly by reducing their level of commitment to it (Rusbult et al., 1998, as cited in Doron & Derby, 2017). In line with this position, Doron, Derby, et al. (2012b) found that RCOC symptom severity correlated significantly with sufferers' levels of relationship ambivalence.

However, researchers have also noted that disclosure of one's symptoms to their partner might destabilize the relationship by causing the latter to develop ROCD obsessions and compulsions of their own (Doron, Derby, & Szepsenwol, 2014). Doron, Derby, and Szepsenwol (2014) have also suggested that such *between-partner symptom contagion* might constitute a self-fulfilling prophecy, wherein the sufferer's continuous expression of their doubts about the relationship and/or their partner's love, as well as their seeking of reassurance about these concerns, causes the partner to examine whether they may actually be warranted. They have also speculated that the sufferer's comparison of their partner with potential alternatives may lead the latter to reciprocate such behaviour, and that the entire phenomena may occur due to amplification of the partner's own attachment insecurities and overestimation of threat (Doron, Derby, & Szepsenwol, 2014). Several quantitative studies have supported the existence of such between-partner symptom contagion, including Bakçepinar (2019), who

observed that sufferers' scores on each of the ROCI and PROCSI subscales correlated significantly and positively in a moderate-to-strong manner with those of their partners. Notably, it has also been documented that individuals who were informed that their partners were experiencing relatively-severe ROCD symptoms exhibited significantly greater symptoms of their own and were significantly more likely to believe that their partners might be unfaithful (Doron, 2017; Littman et al., 2023). Further, Littman et al. (2023) found that, in such cases, sufferers' partners exhibited significantly-greater doubts about their own ability to remain faithful.

Recommendations for the Treatment of Sufferers

A fair portion of the literature on ROCD consists of recommendations for the treatment of sufferers themselves.

Diagnosis and Assessment. Thorough awareness and understanding of ROCD are thought to be fundamental to practitioners' abilities to treat individuals suffering from this condition (Brandes et al., 2020; Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014). This fulsome knowledge may be particularly crucial to the diagnosis of ROCD, as its symptoms can be difficult to recognize. Indeed, sufferers may be unwilling to disclose their symptoms, given that they may be associated with stigma (Yıldırım, 2017). Likewise, a variety of clients may present in therapy exhibiting concerns about their intimate relationships, difficulty making decisions about them, and/or conflict with their partners, though these aren't necessarily indicative of ROCD (Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014). In situations where it is suspected that a client may be suffering from ROCD, scholars (e.g., Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014; Ghomian et al., 2019b; Yılmaz, 2015) have suggested that practitioners should attempt to diagnose them through the administration of the ROCI (Doron, Derby, et al., 2012b), PROCSI (Doron, Derby, et al., 2012a), and ODIS (Brandes et al., 2020). However, Doron and Derby (2017) have has also recommended that, prior to doing so, they should assess for the presence of general OCD symptoms through the use of structured interviews such as Sheehan et al.

(1998)'s Mini International Neuropsychiatric Interview (MINI), as well as evaluate their severity via measures like as the Obsessive-Compulsive Inventory-Revised (OCI-R) (Foa et al., 2002).

Having comprehensive awareness and understanding of ROCD may also allow practitioners to recognize aspects of sufferers' idiosyncratic experiences which may be worthy of investigation and, thus, to follow Doron and Derby (2017)'s guidance by conducting holistic assessment of them. Indeed, scholars have identified a multitude of domains which may be relevant targets for assessment, including the onset, development, nature, and severity of a given client's symptoms, their triggers, as well as the distress which they cause (Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014; Doron, Derby, et al., 2012a, 2012b; Ghomian et al., 2019b). When working with ROCD sufferers, practitioners are also recommended to explore factors implicated in ROCD's epidemiology and etiology (Balcı, 2021; Caccico et al., 2019; Derby et al., 2021; Doron, Derby, & Szepsenwol, 2014; Doron, Derby, et al., 2012a; Tinella et al., 2023; Trak & İnözü, 2019; Yılmaz, 2015), as well as clients' family, relationship, and attachment histories (Akkaya & Yılmaz, 2021; Doron, Derby, & Szepsenwol, 2014; Kuru, 2020). Existing attachment insecurities (e.g., fear of abandonment) should also be elucidated (Abak, 2019; Doron, Derby, et al., 2012a, 2012b; Özel, 2021; Özel & Karakose, 2023; Trak & İnözü, 2019; Yılmaz, 2015) in addition to dynamics within the client's current relationship, if applicable (Dar-Perl, 2018), especially those related to conflict, as well as their possession of skills for its resolution (Doron, Derby, & Szepsenwol, 2014; Doron, Derby, et al., 2012b). Additionally, practitioners are encouraged to evaluate the potential impacts of relationship conflict on the client's symptoms (Doron, Derby, & Szepsenwol, 2014; Doron, Derby et al., 2012b), as well as their relationship satisfaction (Kuru, 2022), adjustment (Özel, 2021; Özel & Karakose, 2023), and/or commitment (Doron, Derby, & Szepsenwol, 2014). Further, if the sufferer is in a relationship, it should be determined whether their partner is aware of their symptoms and/or has experienced any of their own (Bakçepinar, 2019). If not, the practitioner will need to determine whether disclosure of these symptoms to the partner would benefit the client (e.g., by mitigating the sufferer's

guilt about hiding them and/or by enhancing support from the partner) (Littman et al., 2023). Finally, clinicians should examine whether clients have experienced any of the peripheral impacts of ROCD identified above (Dar-Perl, 2018; Derby et al., 2021; Doron, Derby, & Szepsenwol, 2014; Parlapan Bas, 2019).

Cognitive-Behavioural Therapy. In line with their overwhelming endorsement of Salkovskis (1985, 1989, 1996)'s CAM, the vast majority of scholars who have examined ROCD have recommended that its symptoms, etiological factors, and impacts be addressed through evidence-based Cognitive Behavioural Therapy (CBT) techniques commonly used to treat other themes of OCD (Abak & Güzel, 2021; Akkaya & Yılmaz, 2021; Balcı, 2021; Brandes et al., 2020; Cebeci, 2019; Derby et al., 2021; Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014; Doron, Derby, et al., 2012a, 2012b; Doron & Szepsenwol, 2015; Doron et al., 2013; Lombardi & Rodriguez, 2019; Melli, Bulli et al., 2018; Orihuela Echevarría, 2017; Trak & İnözü, 2019; Yıldırım, 2018).

Psychoeducation. Psychoeducation features prominently as one such technique, with clinicians recommended to introduce ROCD sufferers to the OCD cycle (Orihuela Echevarría, 2017) and assist them in identifying the particular obsessions, compulsions, and triggers which they experience (Doron & Derby, 2017). Psychoeducation about Salkovskis (1985, 1989, 1996)'s CAM (Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014) and ROCD's various etiological factors (Cebeci, 2019; Doron, 2020; Doron et al., 2013; Trak, 2016; Trak & İnözü, 2019) has also been suggested, as doing so may lead to more adaptive appraisal of intrusions as well as alleviation of shame and guilt (Doron, 2020). Shame and guilt might also be lessened by discussing with the client how the intrusive, illogical, and ego-dystonic qualities of ROCD symptoms may contribute to distress (Parlapan Bas, 2019; Trak & İnözü, 2019). Further, acknowledging the uncertainty inherent to engaging in a romantic relationship may help ROCD sufferers to better tolerate obsession-related distress (Lombardi & Rodriguez, 2019).

Cognitive Restructuring. Cognitive restructuring is an additional approach which may be used to

target ROCD obsessions (Yıldırım, 2018) as well as the various cognitive factors which have been implicated in their etiology (Abak, 2019; Balcı, 2021; Brandes et al., 2020; Orihuela Echevarría, 2017; Melli, Bulli, et al., 2018; Melli et al., 2015; Trak, 2016; Trak & İnözü, 2019; Yıldırım, 2018). Specific recommendations for cognitive restructuring include engaging the client in Socratic dialogue in order to challenge automatic negative thoughts, OCD-related maladaptive beliefs, as well as maladaptive relationship beliefs (Akkaya & Yılmaz, 2021; Derby et al., 2021). ROCD-specific self-vulnerabilities may also be addressed through such questioning as well as by having clients consider the perspectives of others around them (Doron & Szepsenwol, 2015). *Imagery rescripting*, that is, assisting clients to re-experience and re-process pivotal moments in their lives, may also derive novel cognitive understandings (Doron & Derby, 2017).

Behavioural Experiments. Behavioural experiments have also been noted as methods through which practitioners might abate ROCD. For example, having clients engage in their compulsions while keeping a log of their subjective experiences might help them to understand how the former may, counterintuitively, sustain and/or worsen their distress (Doron & Derby, 2017). Likewise, Doron and Derby (2017) have highlighted the Identify, Delay, and Respond (I DARE) protocol, wherein clients challenge the automaticity of their dysfunctional appraisals of ROCD stimuli by delaying rumination about them. Further, many scholars have recommended the use of *Exposure with Response Prevention (ERP)*, which exposes clients to the triggers of their obsessions and, thus, distress, but has them refrain from engaging in typically-associated compulsions (Brandes et al., 2020; Derby et al., 2021; Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014; Doron, Derby, et al., 2012a; Doron et al., 2013; Lombardi & Rodriguez, 2019; Trak, 2016; Trak & İnözü, 2019). As clients work through a hierarchy of increasingly-triggering exposures, it is believed that they may increase their tolerance to ROCD-related distress to the extent that the association between their obsessions and compulsions dissolves (Doron & Derby, 2017; Doron et al., 2013). Such exposures might be conducted in vivo or through imaginal

methods (Lombardi & Rodriguez, 2019).

Emphasis on Attachment. Given that attachment insecurities may play a central role in ROCD's etiology, it has been recommended that the CBT techniques described above be used to mitigate them, in particular (Abak, 2019; Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014; Doron et al., 2013; Trak & İnözü, 2019). For example, Doron (2020) has suggested that psychoeducating clients about insecure attachment styles might bolster their resilience to ROCD intrusions, while restructuring OCD-related maladaptive beliefs which are conducive to hyperactivation strategies (e.g., overestimation of threat) may reduce a sufferer's fear of abandonment (Doron, Derby, & Szepsenwol, 2014). Additionally, imagery rescripting of formative attachment-related memories has been speculated to bolster attachment security, leading to improvements in OCD-related maladaptive beliefs and self-vulnerabilities (Abak, 2019; Doron & Derby, 2017). Doron, Derby, and Szepsenwol (2014) have also noted specific ERP protocols in which clients may be exposed to triggers of abandonment fears while asked to refrain from seeking reassurance from their partners.

Delivery via Mobile Apps. The strongest evidence for CBT's ability to treat ROCD likely comes from studies examining the efficacy of GG Relationship Obsession (GGRO), a mobile app co-founded by Guy Doron which is designed to mitigate the dysfunctional appraisal of ROCD intrusions through psychoeducation as well as the cognitive restructuring of OCD-related maladaptive beliefs, catastrophic relationship beliefs, self-vulnerabilities, and attachment insecurities (Abak, 2019; Gorelik et al., 2023; Roncero et al., 2018). Indeed, several studies have found that even brief engagement with this app may lead to significant, moderate-to-large reductions in OCD-related maladaptive beliefs, corresponding improvements in OCD and ROCD symptoms (Cerea et al., 2020; Roncero et al., 2018, 2019), as well as increased self-esteem (Cerea et al., 2020; Roncero et al., 2019). Additionally, Gorelik et al. (2023) found that the use of GGRO by each member of a dyad significantly buffered them against relationship-related intrusions and led to significant reductions in their endorsement of catastrophic relationship beliefs,

attachment anxiety, relationship dissatisfaction, and RCOC symptoms. Given its ease of use, it has also been stated that GGRO may be used as an adjunct to in-person CBT (Cerea et al., 2020), perhaps as a form of homework (Abak, 2019; Brandes et al., 2020).

Provision of Communication and Conflict-Resolution Skills. As conflict may have deleterious effects on sufferers' relationships and trigger their obsessions, practitioners have also been advised to assist clients in the development of contingencies for when conflict arises (Brandes et al., 2020), as well as skills for communicating about this issue with their partners, particularly through role-playing (Doron, Derby, & Szepsenwol, 2014).

Involvement of the Sufferer's Partner. Several scholars have also stated that directly involving ROCD sufferers' partners in the former's treatment may enhance outcomes (Brandes et al., 2020; Mısırlı & Kaynak, 2023; Shapiro, 2020), particularly by improving the assessment of relational dynamics (e.g., patterns of conflict), as well as the aforementioned provision of communication and conflict-resolution skills (Brandes et al., 2020). Likewise, it has been suggested that couples counselling may benefit ROCD sufferers by alleviating relationship distress which does not stem from their symptoms (Lombardi & Rodriguez, 2019), thus removing low relationship satisfaction, adjustment, and quality as potential triggers of their symptoms (Balcı, 2021; Özel, 2021; Özel & Karakose, 2023). Further, Parlapan Bas (2019) has stated that this may remedy the sufferer's experience of depression and stress.

Addressing Symptom Accommodation. According to the literature, the treatment of individuals suffering from ROCD might also prove more fruitful if their partners are present for psychoeducation about the aforementioned dangers of symptom accommodation, as doing so may bolster ERP protocols and externalize the issue from the client themselves (Derby et al., 2021; Doron & Derby, 2017; Doron, Derby, & Szepsenwol, 2014; Doron, Mizrahi, et al., 2014). It is also worth noting that, in cases of *relationship anxiety* (i.e., a condition similar to ROCD which also involves pathological concern about being abandoned by one's partner), psychoeducating an affected couple about symptom

accommodation and encouraging them to, instead, express themselves to one another during times of distress has led to reductions in sufferers' symptoms (Paprocki and Baucom, 2015). Similarly, when utilizing ERP protocols to treat general OCD symptoms, having the sufferer's partner psychoeducated about and, thus, refrain from engaging in symptom accommodation while being emotionally open and encouraging has been observed to enhance their effectiveness (Abramowitz et al., 2012).

Addressing Symptom Contagion. While including one's partner in their treatment may be helpful, Littman et al. (2023) have also highlighted the potential dangers associated with disclosing a sufferer's symptoms to their significant other (i.e., between-partner symptom contagion). Accordingly, they have recommended that, if disclosure is determined to be beneficial, the partner should, first, be psychoeducated about both OCD and ROCD, perhaps through the distribution of literature, before fielding any questions and/or concerns they may have (Littman et al., 2023). They have also suggested that emphasis be placed on the steps which the sufferer is taking towards recovery and the relationship's healthy continuation (Littman et al., 2023). Further, they note that discussion of the sufferer's obsessions should be done in a general, rather than specific manner to spare the partner's feelings and, thus, lower the chance that symptom contagion might occur (Littman et al., 2023).

Pharmacological Approaches. Research on the pharmacological treatment of ROCD is extremely limited; however, Lombardi and Rodriguez (2019) have promoted the psychiatric assessment of clients as a means of determining its potential utility for them. Additionally, Doron, Derby, and Szepsenwol (2014) have reported that, based on clinical experience, high doses of Selective Serotonin Reuptake Inhibitors (SSRIs) may alleviate ROCD symptoms, while Marcatili et al. (2022) have reported the use of esketamine to be effective.

Addressing Sexual Dysfunction. Noting the potential for ROCD symptoms to distract from and, thus, hinder sufferers' sexual experiences, it has been recommended that, when applicable, practitioners incorporate sex therapy techniques, specifically sensate focus, into treatment (Derby et al.,

2021; Doron, Mizrahi, et al., 2014). Psychoeducating clients about the potential negative impacts of ROCD symptoms on their sex lives (Doron, Mizrahi, et al., 2014) and how these may be rooted in unrealistic expectations about intimacy (Rajaee, 2022) may also be prudent.

Additional Recommendations. In addition to the suggestions detailed above, scholars have recommended that treatment be tailored to clients in such a way that it is mindful of their potential symptoms of depression, anxiety, and/or stress (Parlapan Bas, 2019). Likewise, it has been suggested that delaying relationship-related decisions until after therapy has concluded may help a sufferer to more fully engage in their relationship and, thus, come to a better-informed conclusion about their experience of it (Doron & Derby, 2017).

Recommendations for the Treatment of Impacted Couples

Relative to recommendations for the individual treatment of ROCD sufferers, very few suggestions have been made about how practitioners might support couples impacted by ROCD. However, it has been said that bearing knowledge about and, thus, being able to assess for the presence of ROCD's symptoms and etiological factors would generally be prudent for couples therapists (Balcı, 2021; Dehaqin et al., 2023; Yılmaz, 2015). Likewise, it has been suggested that assessment for ROCD should take place when clients present with low relationship satisfaction (Kuru, 2020) and/or when couples seek treatment for relationship conflict (Özel, 2021). When it appears that a couple presenting in therapy has, indeed, been impacted by ROCD, it may be helpful for practitioners to assess the attachment styles of each partner and to work to resolve their experience of relationship dissatisfaction (Balcı, 2021). Additionally, psychoeducating the dyad about the nature of ROCD and its potential influences on problematic patterns of interaction may benefit each client (Doron, Derby, & Szepsenwol, 2014; Doron, Mizrahi, et al., 2014), particularly through externalization of the problem from the sufferer (Derby et al., 2021). Further, Pisheh and Jahed (2020) have suggested that couples therapies which foster secure attachment be used. However, scholars have also stated that it may be wise for ROCD

sufferers to seek individual CBT treatment for their obsessions and compulsions before engaging in couples therapy, particularly if these symptoms may be the main cause of any sexual and/or relationship dysfunction that they and their partners are experiencing (Doron, Mizrahi, et al., 2014), as this may also benefit their intimate relationships (Özel & Karaköse, 2023).

Summary

The findings of the preceding section indicate that, through its two symptom types (i.e., RCOC and PFOC), ROCD represents a troublesome presentation of OCD which warrants further attention from scholars and practitioners alike. Indeed, its impacts on the mental health and interpersonal dynamics of sufferers and their partners appear to be not only dramatic and numerous, but widespread, affecting men and women across the globe regardless of their age, relationship status, and/or the duration of their partnerships. Likewise, while a number of cognitive and/or developmental factors have been implicated in ROCD's etiology and, thus, become targets for treatment within the context of individual sufferers' symptoms, recommendations for the treatment of couples affected by ROCD are far less robust.

Emotionally Focused Therapy

The second section of this chapter investigates research question two, highlighting critical information about EFT for couples therapists intending to practice this modality with clients impacted by ROCD. It begins by describing findings related to EFT's development and philosophical underpinnings, the role of the therapist and the interventions they may use, as well as this modality's sequence of stages and steps. It then details evidence related to EFT's efficacy and effectiveness, key process variables, as well as recommendations for the use of this modality with specific populations.

Development and Philosophical Underpinnings

EFT was initially conceived by Les Greenberg and Sue Johnson (Greenberg & Johnson, 1988) based on their findings about the process of change within couples therapy (Brubacher, 2017). As an

approach to the treatment of romantic partners, it incorporates principles from the humanistic-experiential perspective (Rogers, 1951; Perls, 1969), particularly collaborative, moment-to-moment meaning-making and beliefs about clients' capacities for self-actualization. As such, when clients may be suffering from the symptoms of a psychiatric disorder, EFT practitioners attempt to centre their specific experiences and learn from them, rather than make assumptions about them based on diagnostic labels (Johnson, 2019a). EFT also involves elements from systems theory (Bertalanffy, 1969; Minuchin & Fishman, 1981), specifically the notion that issues may be co-constructed by two parties through reciprocal, maladaptive patterns of interaction (Brubacher, 2017; Johnson, 2019a; Johnson & Greenman, 2006). As its name suggests, EFT has also adopted each of these perspectives' emphases on emotional experience (Johnson, 2019a). Accordingly, Johnson (2019a) notes that EFT is mindful of each of the following factors which have been underscored in the literature on relationship distress:

- The power of negative emotion, for example, as seen in facial expression, to predict long-term stability and satisfaction in relationships.
- The importance of process, or the nature of emotional engagement and how partners communicate (rather than the content or frequency of arguments).
- The toxicity of negative cycles of demand-withdraw and stone-walling behaviors.
- The need for cycles of mutual soothing for relationship stability.
- The power of positive emotion, termed positive-sentiment override in the behavioral literature, but referring to more secure connection in the EFT world. (p. 126)

Subsequent to its conception, Greenberg largely abandoned EFT in favour of an individual approach with similar underpinnings (Brubacher, 2017; Elliott et al., 2003; Greenberg et al., 1993). Johnson, on the other hand, continued to augment EFT according to assumptions about adult love extrapolated from Bowlby (1969, 1973, 1980, 1988)'s Attachment Theory, centring attachment as "a key survival strategy [evolutionarily] designed to keep significant others close and available for support and protection"

(Johnson, 2019a, p. 126). In sum, EFT aims to mitigate relationship distress and dissatisfaction by deepening clients' processing of emotional experiences which stem from attachment insecurities (e.g., fear of abandonment) as well as through modification of the maladaptive patterns of interaction in which they may result (e.g., pursue vs. withdraw) such that they, instead, foster attachment security (Johnson, 2019a).

Role of the Therapist

Emotionally focused therapists occupy several roles, first and foremost as exemplary attachment figures for clients, displaying accessibility, responsiveness, engagement, authenticity, presence, and empathy (Johnson, 2019a). This position also requires them to exude a sense of safety, which may be accomplished through direct validation of the clients' experiences or by speaking, when necessary, "in an especially soft and accepting manner" (Johnson, 2019a, p. 66). EFT practitioners have also been described as relationship/process consultants (Johnson, 2019a; Johnson & Greenman, 2006) who guide couples as they examine and, thus, expand their emotional experiences. At the same time, they are constantly bearing in mind their clients' goals and capacities for growth, encouraging safe contact with deeper, more-uncomfortable emotions as well as their "fragmented, denied, and avoided elements" (Johnson, 2019a, p. 66). Likewise, EFT practitioners draw connections between these experiences and their clients' repetitive cycles of problematic interaction which contribute to distress, attempting to provoke those which, instead, are marked by safety, accessibility, responsiveness, and positive engagement (Johnson, 2019a; Johnson & Greenman, 2006). Further, EFT practitioners often step out of their roles as authority figures, walking alongside clients as individuals who have also encountered personal hardships and normalizing the experiences of those they work with through self-disclosure (Johnson, 2019a).

The Five Moves of the Emotionally Focused Therapy Tango

Throughout the process of EFT, practitioners repeatedly engage in what Johnson (2019a, 2019b)

has termed *the five moves of the EFT Tango*. Each of these may involve the utilization of specific therapeutic skills, including reflection, validation, evocative questions and responses, interpretation, reframing, and the choreographing of interactions and responses between partners (Johnson, 2019a).

Move One: Mirroring Present Process. In the first move, the emotionally focused therapist builds the therapeutic alliance with the couple by displaying empathy and works with them to identify emerging patterns in their management of emotions and, thus, interactions with one another (Johnson, 2019a). Critically, this is done without judgment, intellectualization, nor rationalization of these patterns by any of the parties involved and in such a way that they are externalized from the clients as self-perpetuating cycles (Johnson, 2019a).

Move Two: Affect Assembly and Deepening. The second move involves assisting clients to develop more holistic senses of their emotions and, thus, control over them, through examination of their triggers/cues, how they are initially perceived, physical responses they provoke, meanings they carry, and the actions which typically follow them (Arnold, 1960, as cited in Johnson, 2019a). The practitioner also normalizes and contextualizes these experiences within the clients' relationship dynamics and unmet attachment needs (Johnson, 2019a). Following this, clients are supported in deepening their emotional experiences through acknowledgment of core emotions (i.e., joy, surprise, anger, shame, fear, and sadness) which may not initially be within conscious awareness (Johnson, 2019a).

Move Three: Choreographing Engaged Encounters. The third move sees the practitioner moderate vulnerable discussions between clients about their new emotional understandings, leading to additional depth and integration of their experiences, as well as the accessibility of new behaviours and "positive responses [towards one another]" (Johnson, 2019a, p. 62). Johnson (2019a) has stated that such conversations are analogous to behavioural exposures, with clients encountering distress, but within a context of relative safety such that they can implement new strategies for its management.

"[Slicing] the risk thinner" (Johnson, 2019a, p. 62), that is, lowering the challenge of a given conversation, is one way in which EFT practitioners may support such safety, perhaps by allowing a struggling client to communicate in a less-vulnerable way than was initially planned.

Move Four: Processing the Encounter. During move four, the therapist shifts the clients' focus from their emotional experiences to unpacking the novel, vulnerable exchanges which have taken place during move three, and highlights how these may factor into their presenting problems (Johnson, 2019a). Any negative responses which have been evoked are also examined further, perhaps by having the practitioner "catch the bullet" (Johnson, 2019a, p. 143), that is, channel one client's hostility towards their partner into a constructive conversation about their inability to receive vulnerable disclosures from the latter.

Move Five: Integrating and Validating. Finally, in move five, the therapist underscores the couple's newly gleaned understandings of their emotional experiences and interpersonal interactions to make those which were positive more concrete (Johnson, 2019a). They also validate the challenge inherent to the overall process, bolstering the clients' senses that they will be able to affect change within themselves and their romantic relationship moving forward, both inside and outside of therapy (Johnson, 2019a, 2019b). This final move also makes it more clear to clients that "inner experience … shapes interactional patterns in a self-reinforcing manner [just as] interpersonal connection reciprocally shapes inner experience and the sense of self" (Johnson, 2019a, p. 56).

Sequence of Therapy

EFT is time limited and highly structured, unfolding in nine steps spread across three stages, with a typical course of therapy constituting 13-15 sessions (Makinen & Johnson, 2006; Johnson, 2019a, 2019b).

Stage One: De-Escalation of Negative Interaction Cycles. In the initial stage of EFT, the practitioner primarily utilizes tango moves one, two, and three to accomplish the first four steps of the

model (Johnson, 2019a, 2019b). These include assessing the conflict-related issues which have brought the clients to therapy while building the therapeutic alliance with them (i.e., step one). This typically involves conducting private, individual sessions with each partner such that they can be more open about their experience of the relationship with the practitioner (Johnson, 2019a). Following step one, the therapist begins elucidating the specific negative interaction cycle which is plaguing the partners' relationship (i.e., step two) (Johnson, 2019a, 2019b). Typically, a couple's negative interaction pattern involves one partner criticizing the other, leading the latter to withdraw, though it may, alternately, see each partner attacking one another, withdrawing from each other, or one seeking proximity before withdrawing due to the threat of vulnerability, leading their partner to also withdraw (Johnson, 2019a). Subsequently, the therapist encourages the couple to attend to previously-unrecognized emotions (i.e., step three) and to see that these and related attachment needs are contributing to their negative interaction cycle before highlighting this as the core issue, thus externalizing it from them (i.e., step four) (Johnson, 2019a, 2019b). If done successfully, the partners will exhibit reduced emotional reactivity towards one another by the end of this stage (Johnson, 2019a, 2019b).

Stage Two: Changing Interactional Patterns and Restructuring Attachment. The next three steps of EFT take place during stage two of the model and are largely facilitated through the practitioner's use of more intense forms of tango moves two and three (Johnson, 2019a, 2019b). Step five involves encouraging one partner, typically the more withdrawn, to go beyond mere attention to previously-unrecognized emotions, attachment needs, and their roles in maladaptive patterns of interaction by deepening their understandings of how these may be "related to the way [they perceive] self and other in the relationship" (Johnson, 2019b, p. 100) and then expressing these to their partner. In turn, step six sees the practitioner encouraging the partner, often the pursuer, "to hear, process and respond to this sharing [in a reciprocal manner], so that this new experience can become part of, and begin to reshape, the couple's interactions" (Johnson, 2019b, p. 112). Ideally, steps five and six will

facilitate the couple's engagement in *Hold Me Tight conversations*, that is, exchanges involving the vulnerable sharing of their wants and needs with one another (i.e., step seven), and, consequently, the re-engagement of the withdrawer and softening of the pursuer's attacks (Johnson, 2019a, 2019b). The ultimate goal of stage two is for each member of the dyad to develop a greater sense that their partner is present, open to communicating, and able to provide them with safety and security (Johnson, 2019a, 2019b).

Stage Three: Consolidation and Integration. In the final stage of EFT, the therapist first relies upon tango move five to help the couple solidify the novel understandings which they have come to during the preceding stages (Johnson, 2019a). This allows the practitioner to then utilize tango move one as they encourage the couple to collaboratively use these understandings to solve existing problems within their relationship (i.e., step eight) (Johnson, 2019a). Central to this eighth step is that, as the partners have, ideally, become less reactive by this point in the EFT process, they now have greater overall capacities to interact with one another (Johnson, 2019a). Additionally, their greater senses of secure attachment and safety enable them to be empathetic, responsive, cooperative, accepting, accommodative, and, ultimately, resilient in the face of barriers to solving existing problems together (Johnson, 2019a). At the end of this stage and, thus, the entire process of EFT, the therapist once again engages in tango move one, using it to highlight the positive interaction cycle in which the couple is now able to engage such that they learn to rely upon it when faced with challenges they might encounter outside of therapy (i.e., step nine) (Johnson, 2019a, 2019b).

Efficacy and Effectiveness

Having initially emerged from couples therapy process research and undergone extensive empirical examination since its inception, EFT is now considered by many to be an evidence-based treatment for relationship distress (Beasley & Ager, 2019; Spengler et al., 2022; Wiebe & Johnson, 2016). Indeed, many studies have suggested that EFT may evoke significant, moderate-to-large

improvements in relationship distress and, thus, satisfaction, as well as in relationship adjustment and stability, attachment security, intimacy, and sexual satisfaction (Doss et al., 2021; Wiebe et al., 2019; Wiebe & Johnson, 2016). Likewise, there is considerable evidence that such benefits might persist after treatment has ceased and that they may be experienced by couples whose relationships have been impacted by depression, post-traumatic stress, and/or serious illness (Doss et al., 2021; Wiebe et al., 2019; Wiebe & Johnson, 2016).

The results of several meta-analyses have also aligned with the conclusions drawn above. For instance, Beasley and Ager (2019) examined seven randomized controlled trials which investigated EFT's effectiveness in improving marital satisfaction amongst relatively-diverse populations, finding a significant and impressively-strong effect size. Likewise, they found that, in nearly 75% of the studies which included post-treatment follow-up, such "improvements … were completely maintained" (Beasley & Ager, 2019, p. 154) at such time. In perhaps the most extensive meta-analysis on EFT's efficacy to date, Spengler et al. (2022) examined treatment outcomes for 330 couples who took part in randomized controlled trials, quasi-experiments, as well as dissertation studies, finding that 70% of them no longer exhibited signs of relationship distress post-treatment, with these "gains [lasting] up to 2 years" (p. 2).

Process Research

Process research on EFT has highlighted the practitioner's ability to develop a therapeutic alliance with a given couple (i.e., the explicit goal of stage one) as crucial to improving the latter's satisfaction with their partnership (Brubacher & Wiebe, 2019). Brubacher and Wiebe (2019) have also stated that the task aspect of this alliance, that is, the couple's "confidence that the tasks they are being asked to engage in are relevant to their presenting issues" (p. 295) is particularly critical. Likewise, they have posited that this may be accomplished by remaining transparent about as well as in control of the EFT process with clients, monitoring for and validating feelings of discomfort with it, and working to address any ruptures which might occur (Brubacher & Wiebe, 2019).

Additionally, it has been noted that the depth of each partner's experiential processing and sense of affiliation with one another may be imperative to treatment outcomes (Brubacher & Wiebe, 2019; Dalgleish et al., 2015; Greenman & Johnson, 2013; Wiebe et al., 2017). Brubacher and Wiebe (2019) have posited that these variables may be addressed through each of the five moves of the EFT tango, but particularly the enactments used within the third and fourth. The re-engagement of withdrawn partners and softening of attacking partners' hostile stances are also thought to signal not only gains in experiential processing and the couple's sense of affiliation with one another, but the relative success of EFT overall (Burgess Moser et al., 2018; Greenman & Johnson, 2013).

Recommendations for Use With Specific Populations

While quantitative evidence has suggested that EFT may be an effective treatment for couples dealing with a variety of issues (Wiebe et al., 2019; Wiebe & Johnson, 2016), scholars have also made recommendations for how it might be adapted for use with specific populations.

With Attachment-Injured Couples. *Attachment injuries* (i.e., emotionally poignant events which shatter expectations that one's partner will respond to them in a time of need) have been identified as potential barriers to therapeutic outcomes in EFT, as they may lead to disengagement and, thus, stalemates between partners (Johnson & Williams-Keeler, 1998; Makinen & Johnson, 2006). Such challenges to secure attachment are often "characterized [by] perceived abandonment, betrayal, or breach of trust" (Makinen & Johnson, 2006, p. 1055). Thus, it may not be surprising that they are typically associated with infidelity (Makinen & Johnson, 2006). However, they may also result from one partner's failure to provide a secure base to the other while the latter is struggling with grief, life transitions, and/or health issues (Halchuk et al., 2010). Additionally, it has been posited that coming out as bisexual to one's monosexual partner (Cannon & Boccone, 2019) or as transgender to one's cisgender partner (Chapman & Caldwell, 2012) might also lead to attachment injury in one or both partners. Regardless of the cause of the attachment injury, the offender may become "both the source of and

solution to pain and fear" (Chapman & Caldwell, 2012, p. 45), leading to extreme dysregulation on the part of the injured partner.

Accordingly, through clinical observation of couples who were able to resolve attachment injuries during EFT, the appropriately named Attachment Injury Resolution Model (AIRM) was developed (Makinen & Johnson, 2006).[3] This model comprises an eight-step addition to EFT's second stage, with the injured partner vividly describing the event which precipitated the attachment injury as well as the emotions they felt as if they were happening in the moment (Brubacher, 2015; Makinen & Johnson, 2006). In turn, their partner is encouraged to provide the support which they had previously failed to (Makinen & Johnson, 2006). Empirical research has suggested that use of the AIRM may facilitate forgiveness, trust, and attachment security between partners as well as significant improvements in their levels of emotional engagement, hostility, relationship distress, relationship/marital satisfaction, and intimacy (Dehghani & Dehghani, 2023; Halchuk et al., 2010; Makinen & Johnson, 2006). Likewise, the AIRM may stimulate significant gains relative to their dyadic adjustment and subjective appraisal of the severity of the attachment injury even three to five years later (Halchuk et al., 2010).

With Gay Couples. However, scholars have also noted that tailoring EFT to the needs of a specific population may not necessitate significant modification of its structure. Indeed, Allan and Johnson (2017) have stated that, because heterosexual and gay couples experience relationship distress and, conversely, satisfaction for similar reasons, emotionally focused therapists working with the latter population need only integrate knowledge of the "unique challenges and … attachment research specific to [them]" (p. 288).

In working with gay men during stage one of EFT, such an approach might include broaching the subject of proximal and distal stressors which may uniquely impact them (e.g., internalized and overt homophobia) to foster the therapeutic alliance and determine whether these play a role in their

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[3] See Makinen and Johnson (2006) for a full description of the AIRM.

negative interaction cycles (Allan & Johnson, 2017). Doing so in an ongoing, accepting, validating, and normalizing manner may also be critical and involve acknowledgment of the practitioner's sexual orientation, mistaken assumptions about the gay experience, and repair of any ruptures (Allan & Johnson, 2017). It is also thought that investigation of the couple's negative interaction cycle and experience of attachment insecurity should examine potential influences, such as ambiguous feelings and/or beliefs about relationships (e.g., uncertainty about commitment), non-monogamous arrangements, and negative views of self stemming from internalized homophobia (Allan & Johnson, 2017). Additionally, it is recommended that practitioners be aware that gay men may have difficulty attuning to emotional experiences in a relatively-deep way and that they may be prone to prematurely dissolving their relationships (Allan & Johnson, 2017). Finally, in working to externalize the couple's negative interaction cycle, therapists should also highlight homonegativity as a problem separate from the two partners themselves (Allan & Johnson, 2017).

In stage two of EFT, deepening of the couple's emotions, senses of selves, and, thus modification of their negative interaction cycle might be enhanced through continued focus on the potential influence of homonegativity as well as "exposure to social support from or engagement with other gay men, services, social networks, or organizations whose behavior counteracts [it]" (Allan & Johnson, 2017, p. 297). Emotionally focused therapists should also bear in mind that, as gay men confront deeper aspects of their experiences, they may also need to confront the challenging realities of the discrimination which they have been subjected to (Allan & Johnson, 2017). However, Allan and Johnson (2017) have also noted that promoting responsiveness and, thus, attachment security between gay partners may also provide them with the resources needed to challenge homophobia. As this stage of EFT comes to a close and couples are encouraged to engage with one another in a vulnerable manner, therapists should also consider that sociocultural discrimination may make such engagement more difficult for gay men (Allan & Johnson, 2017).

Finally, it has been recommended that, in the third stage of EFT, in which the therapist assists the couple to find ways to sustain their new, positive patterns of interaction beyond therapy, they also attempt to solidify "the gay positive resources that have been identified as relevant for the couple" (Allan & Johnson, 2017, p. 298). Likewise, scholars have suggested that gay couples should be guided through conversations regarding how they might identify and address internalized and/or overt homonegativity in the future (Allan & Johnson, 2017).

Summary

The section above highlights a wealth of empirical evidence suggesting that, as a systemic, humanistic, experiential, and attachment-based approach, EFT may be an effective and efficacious mitigator of relationship distress. Additionally, it suggests that EFT may be not only well structured, with clearly defined stages and steps, but versatile in its adaptability for use with diverse populations. Likewise, EFT appears to be well understood, with process research having identified the specific mechanisms through which the positive therapeutic outcomes noted above might be enacted (e.g., development of the therapeutic relationship and the depth of clients' experiential processing). Accordingly, emotionally focused therapists, occupying clearly-defined roles and armed with specific interventions (e.g., the five moves of the EFT tango), seem well positioned to affect positive change in working with distressed couples.

Chapter Three: Discussion and Applied Practices

Emotionally Focused Therapy With Impacted Couples

This chapter addresses the third and final research question of this project by synthesizing the findings of the literature review above to provide EFT practitioners with recommendations on how they might best utilize this modality with couples impacted by ROCD.

As an Adjunct to Individual Cognitive-Behavioural Therapy

Based on the findings of chapter two's literature review, it appears that EFT may serve as a much-needed and highly-appropriate intervention for couples impacted by ROCD. Indeed, its dyadic context may provide sufferers and their partners with a particularly apt forum in which to vulnerably discuss and, thus, collaboratively address factors believed to contribute to ROCD's emergence, including maladaptive beliefs about love and relationships as well as attachment insecurities. As such discussions may also provoke ROCD-related distress, but within an environment of relative safety, they may function similarly to the behavioural exposures which many researchers have recommended be used to mitigate sufferers' symptoms. Moreover, ROCD researchers have specifically called for the use of couples therapies which address attachment insecurities (Balcı, 2021; Pisheh & Jahed, 2020), which is the precise aim of EFT. Notably, several of the attachment insecurities which are specifically targeted in EFT (i.e., concern over being abandoned by one's partner and/or the latter's trustworthiness and reliability) also represent core ROCD obsessions.

Secondly, EFT may resolve many of the deleterious effects which ROCD is thought to impose upon sufferers, their partners, and/or their relationships. For instance, Balcı (2021) has explicitly recommended that dyadic approaches be used to address ROCD's potential impact on relationship satisfaction, while evidence has suggested that, as such an approach, EFT may be an effective remedy for this variable. Likewise, EFT has been shown to alleviate relationship dissatisfaction in couples who have been significantly impacted by stress and depression, as may often be the case for ROCD sufferers

and their partners. Additionally, it's been observed that EFT might mitigate sexual dissatisfaction, intimacy issues, distressing emotional experiences (e.g., shame), as well as clients' negative perceptions of self, all of which may stem from the presence of ROCD. Further, EFT targets factors which have been implicated as both antecedents and consequences of ROCD, including relationship conflict and maladaptive patterns of interaction (e.g., clinging/dependence vs. avoidance/withdrawal), relationship distress and dissatisfaction, as well as a perceived lack of support from one's partner.

Given the above information, it might be tempting to view EFT as a panacea for ROCD. However, as its focus is on alleviating relationship distress and dissatisfaction through a couple's engagement with attachment-related emotions, EFT may be less effective than CBT at addressing certain factors implicated in ROCD's etiology which involve individual tendencies towards the dysfunctional appraisal of cognitive intrusions (e.g., OCD-related maladaptive beliefs). Likewise, EFT has never been investigated as an intervention for ROCD nor better-researched presentations of OCD, whereas CBT may constitute an evidence-based treatment for the latter. Accordingly, EFT is likely best suited as a complementary adjunct to, rather than a substitute for the cognitive-behavioural treatment of ROCD.

Leveraging Knowledge of Relationship Obsessive-Compulsive Disorder

Beyond being generally prudent for couples therapists, the possession of thorough awareness and understanding of ROCD may enhance emotionally focused therapists' work with couples impacted by this disorder. Indeed, in line with Allan and Johnson (2017)'s approach to conducting EFT with a specific population, it is likely that practitioners need not reinvent this model to support romantic partners whose relationships have been negatively affected by ROCD; however, they do need to be knowledgeable about this disorder and considerate of the specific challenges which it may impose upon intimate relationships and their constituents. Accordingly, the section below outlines specific ways in which EFT practitioners might leverage knowledge of ROCD within key aspects of the model to enhance their work with this population.

Assessment of Presenting Issues. Given their explicit focus on resolving relationship conflict and dissatisfaction, emotionally focused therapists should heed suggestions that practitioners evaluate whether clients presenting with such issues may be suffering from ROCD (Kuru, 2022; Özel, 2021). It is recommended that this assessment occur within the very first step of EFT, wherein practitioners identify the conflictual issues which have brought the couple to therapy. Of course, it may be difficult for emotionally focused therapists to recognize when ROCD is present due its status as a relatively-novel, unknown condition whose symptoms may be hidden by sufferers due to associated stigma and/or mistaken for typical relationship concerns. Therefore, knowledge of ROCD symptomatology as well as the types of clients most likely to exhibit this disorder (e.g., young adults in newer, less-committed relationships and those from cultures which emphasize love over practicality in the choosing of a romantic partner) would undoubtedly be an asset for practitioners of this modality. If ROCD is suspected, emotionally focused therapists should also know to, first, assess for the presence of general OCD symptoms by utilizing the structured interviews and measures recommended by Doron and Derby (2017) before administering the ROCI, PROCSI, and ODIS. If not qualified to do the above, it is recommended that they, instead, refer clients to a professional who is.

If ROCD symptoms are present, even at a subclinical level, it is advised that clinicians practicing EFT utilize their knowledge of this disorder to gain a comprehensive understanding of the client's idiosyncratic experience of it. This would include gathering information pertaining to ROCD's onset, development, and nature (i.e., the specific obsessions and compulsions which the client experiences, as well as their triggers, frequency, and severity). Any of the factors implicated in ROCD's etiology which may be relevant to the client's specific presentation of this condition should also be investigated thoroughly, particularly their potential possession of an insecure attachment style (i.e., anxious or avoidant). Such investigation will also undoubtedly require inquiry into their family, relationship, and attachment histories. Likewise, pertinent information should be gathered about any deleterious impacts

which the client's symptoms have had on themselves, their partner, and/or their relationship (e.g., conflict, relationship dissatisfaction, and/or sexual dysfunction). In gathering this information, it may be helpful for the EFT practitioner to begin conceptualizing the sufferer's experience of ROCD in terms of proximal and distal stressors. For these individuals, proximal stressors may include their particular symptom presentations (e.g., obsessions relating to fear of abandonment and/or compulsive avoidance of discussions about commitment), as well as their specific etiological underpinnings (e.g., extreme love beliefs), and/or impacts (e.g., internalized shame and negative self-perceptions). Conversely, distal stressors might include any sociocultural views which contribute to these ROCD-specific proximal stressors, including the prevailing emphasis in many cultures on finding one's soulmate and/or the stigma surrounding mental disorders and, more specifically, ROCD.

Answers should also be sought about the client's current level of knowledge about OCD and ROCD and, accordingly, their potential need for psychoeducation on these topics. Likewise, it should be determined whether they have and/or are currently seeking individual treatment for either disorder, including through pharmacological means. Such data may inform a practitioner's determination that a given client is ready to engage in EFT alongside their partner, even if this is done in parallel to individual CBT, or, conversely, whether it may be more appropriate for them to complete a course of the latter prior to doing so. Such a decision should also be made in a holistic manner, utilizing all of the information gathered above and in particular consideration of the severity of a client's symptoms, their current level of functioning, as well as their capacity to regulate their emotions while discussing their relationship in the presence of their partner.

Therapists should also know to undertake the above assessments within the individual, private sessions which are typically conducted with each partner at the beginning of EFT. This would not only facilitate a client's forthcomingness about their symptoms in spite of the intense shame and/or guilt which may accompany them, but mitigate the risk of between-partner symptom contagion. Accordingly,

if either client exhibits ROCD symptoms, it would also be wise to ascertain whether they have already disclosed them to their partner and, if so, in what capacity this took place, what impacts this might have had (i.e., on the sufferer, their partner, and/or their relationship), as well as what their partner's current level of knowledge about OCD and ROCD might be. If ROCD symptoms are present, but disclosure has not occurred, the practitioner should work with the sufferer to determine whether doing so might be of benefit. If it is likely to be, they may then discuss with the client how this might best be done (e.g., through psychoeducation and emphasis on generalities, rather than specific details). If disclosing a sufferer's symptoms to their partner is not likely to be of help, this may serve as a contraindication to EFT and the therapist may need to make appropriate referrals for the couple rather than proceed with treatment.

Establishment of the Therapeutic Alliance. As Allan and Johnson (2017) have posited, bearing knowledge of the stressors which may impact clients from a given population allows therapists to broach these in conversation with them during the first step of EFT and, consequently, to establish the therapeutic alliance through empathy, acceptance, validation, and normalization of their experiences. To do the above with couples impacted by ROCD, EFT practitioners may exercise transparency through appropriate self-disclosure, perhaps about times in which they have similarly experienced anxiety due to uncertainty about a romantic relationship and/or pressure to find their soulmate. Likewise, they may wish to discuss their own experiences of internalized shame due to the stigma associated with mental illness, particularly if they have ever suffered from OCD and/or ROCD symptoms themselves. At the same time, therapists are cautioned against making assumptions about the stressors which clients have endured merely because the latter have exhibited ROCD symptoms. Instead, they are encouraged to couch these conversations in curiosity about clients' particular experiences, monitor for discomfort as they unfold, leave room to be corrected if assumptions are mistakenly made, and repair any ruptures which might occur as a result.

At times, the above discussions may need to be more psychoeducational in nature and, thus, require an additional level of depth to the practitioner's understanding of ROCD. This may particularly be the case when their initial assessment determines that one or both of the partners have limited and/or no knowledge of OCD and/or ROCD. In such instances, it is advised that the therapist provide the couple with information about the general OCD cycle and on ROCD, specifically, including the intrusive, illogical, and ego-dystonic nature of its symptoms, as well as its various etiological underpinnings and impacts. Distribution of reading materials to clients and their adjunctive use of mobile apps such as GGRO may be of particular utility in this endeavour. As a general rule of thumb, clinicians should also discuss the above in a relatively-broad manner, emphasizing process (e.g., ROCD's generic impacts on sufferers and their partners) over content (e.g., detailed description of sufferers' symptoms) so as not to trigger attachment insecurities in one's partner through symptom contagion.

The benefits of doing the above may be multi-faceted. Indeed, psychoeducating clients about the nature of ROCD early on in the EFT process may allow the practitioner to demonstrate expertise on the subject and, thus, immediately step into an authoritative role, potentially bolstering task alliance and, consequently, positive therapeutic outcomes. Likewise, it may work to legitimize, normalize, destigmatize, and externalize ROCD as an issue, as is done with clients' negative interaction cycles during the fourth step of EFT. In turn, this may mitigate the impacts of proximal stressors associated with ROCD (i.e., internalized stigma, shame, guilt, and/or negative self-perceptions) and, thus, the sufferer's resistance to the overall therapy process. Further, it might lay the foundation for the therapist to reference ROCD as an influential factor within a couple's experience of attachment-related distress, negative perceptions of self, and, thus, maladaptive patterns of interaction within subsequent steps of the EFT model (see below).

Consulting on Process. Within their roles as process consultants, emotionally focused therapists are tasked with elucidating clients' negative interaction cycles and facilitating their attendance to and

deepening of their emotional experiences such that they recognize how these may contribute to the former (Johnson, 2019a, 2019b). Likewise, they aim to enable clients to modify these maladaptive patterns of interaction by sharing their emotional experiences such that they re-engage with one another (Johnson, 2019a, 2019b). Through thorough awareness and understanding of ROCD, EFT practitioners should recognize that these processes may be incredibly challenging for couples impacted by this disorder. Indeed, while ROCD sufferers may struggle with experiential avoidance and emotional regulation in general, they may also experience significant obsession-related distress due to the mere presence of their partners, let alone discussion of their relationships, and/or any accompanying negative feelings. Additionally, both sufferers and their partners may be prone to responding to one another with frustration, irritation, anger, and even aggression due to their experience of ROCD-related conflict. Fortunately, knowledge of ROCD may allow emotionally focused therapists to anticipate such challenges and, thus, identify optimal ways to guide clients through these processes.

Elucidating Negative Interaction Cycles. As emotionally focused therapists work to identify the particular negative interaction cycle which a couple impacted by ROCD has co-created during the second step of this modality, they might rely upon their knowledge of these individuals' behavioural tendencies. For example, given Doron, Derby, and Szepsenwol (2014)'s observation that ROCD sufferers may engage in compulsive behaviours marked by clinging and dependence, leading their partners to withdraw, it is likely that EFT practitioners might encounter the pursue-withdraw cycle which Johnson (2019a) has described as archetypal of many distressed couples. However, emotionally focused therapists might also expect this pattern to occur in reverse, with the ROCD sufferer compulsively withdrawing due to their partner's presence serving as an obsessive trigger, causing their partner to respond with pursuit due to their own fear of abandonment, as might develop through symptom contagion. In other instances, some combination of the above might occur, with each partner pursuing or withdrawing from one another at different times. Regardless, by developing a mental playbook of the ways in which these clients might

interact with one another, clinicians may be better able to recognize the exact pattern of conflict which may be plaguing a given couple's relationship. Consequently, it may be easier for them to highlight this cycle for the couple and, thus, externalize it from them within the fourth step of EFT, as well as to determine which partner should be encouraged to share first during step five (Johnson, 2019a, 2019b).

Facilitating Attendance to and Deepening of Emotional Experience. Familiarity with the ways in which ROCD sufferers and their partners commonly feel might assist emotionally focused therapists as they facilitate clients' attendance to and, subsequently, deepening of their emotional experiences in steps three and four of this model, respectively (Johnson, 2019a). Indeed, similar to the development of a mental playbook, as described above, knowledge of these clients' typical emotions might provide EFT practitioners with a mental thesaurus of feeling words (e.g., furious, terrified, and guilty) through which to better recognize, reflect, and/or validate their experiences. Likewise, knowledge of ROCD's various etiological factors and impacts might afford EFT practitioners valuable insight into these clients' deeper feelings and, consequently, enable them to assist the latter in examining their core emotions (Johnson, 2019a). For example, a clinician utilizing EFT may initially reflect a client's description of a relatively-accessible secondary emotion, such as irritability. However, given their knowledge that ROCD may be related to attachment insecurity, self-vulnerabilities, maladaptive beliefs about love and relationships, and negative self-perceptions, EFT practitioners may also interpret this irritability as stemming from a core emotion such as fear, perhaps of being abandoned by one's partner, single (and, thus, worthless), and/or unworthy of love.

At this point in the EFT process, practitioners should continue to share information about ROCD with clients through psychoeducation, specifically on its etiology and impacts. This may provide sufferers and their partners with important context for the aforementioned interpretations and, consequently, greater opportunity, during EFT's fourth step, to consider how their emotional experiences, rooted in attachment needs as well as understandings of love, relationships, and self, may contribute to their

negative interaction cycles (Johnson, 2019a). In facilitating this latter understanding, it may be particularly helpful to invoke the CAM and highlight similarities between its various components (i.e., dysfunctional appraisal and resulting distress, obsessions, and compulsions) as well as the key elements of emotion identified by Arnold (1960, as cited in Johnson, 2019a) (i.e., their triggers, associated perceptions and meanings, and resulting action tendencies).

Fostering Re-Engagement and Modification of Negative Interaction Cycles. Given that romantic partners who have been impacted by ROCD may struggle with emotional dysregulation and reactivity, emotionally focused therapists should recognize the need to centre these clients' senses of safety in stage two of this model as they foster re-engagement and, thus, modification of their negative interaction cycles (Johnson, 2019a, 2019b). While clients will ideally be less reactive by this point in the process, it is critical that clinicians continue to monitor for and address signs of significant distress, as this may hinder a couple's reciprocal sharing of emotional understandings and, thus, ability to derive positive therapeutic outcomes from EFT (Johnson, 2019a, 2019b). Accordingly, EFT practitioners should be prepared to use a particularly-soothing tone of voice, slice thin certain interventions, and, thus, work slowly with this population, potentially even planning to extend the course of therapy beyond the typical number of sessions from the very outset of treatment (Johnson, 2019a). Likewise, they should continue to psychoeducate clients about ROCD and its potential impacts to maintain control of the sessions, but also to convey that they are understanding, attuned to, and validating of their hardships.

Addressing Between-Partner Symptom Contagion. The contagion of ROCD symptoms between partners, especially fears about being abandoned by one another, may result in some of the most intense manifestations of attachment-related distress and, thus, emotional dysregulation and reactivity which emotionally focused therapists might encounter in working with couples impacted by this condition. However, through understanding of the role that attachment insecurity may play in ROCD's etiology, EFT practitioners might also recognize opportunities to reframe each partner's obsessive

doubts and/or compulsions about their relationship and/or partner as stemming from their longing for certainty about their attachment bond with one another. To this end, emotionally focused therapists may find it especially helpful to interpret the relative intensity of a sufferer's ROCD-related distress as a signal that their symptoms have challenged something which is extremely valuable to them, thus soothing any doubts which they may have about their love for their partner and/or quelling the latter's fear of abandonment. Likewise, highlighting a sufferer's attempts to address their ROCD symptoms and experience of relationship distress by coming to therapy may dispel their partner's abandonment fears by alluding to the former's motivation to ensure the continuation of their relationship. By incorporating psychoeducation into the above steps, a clinician may also work to further externalize, normalize, and destigmatize the issue of ROCD, bolstering a couple's sense of agency in managing it along with their attachment security (Johnson, 2019a, 2019b).

In examining this issue, emotionally focused therapists might also recognize that an ROCD sufferer's disclosure of their intrusive doubts about their romantic relationship and/or partner to the latter may constitute a source of attachment injury, particularly if coinciding with compulsive avoidance of the partner. Indeed, the literature suggests that such a revelation may lead one's partner to feel betrayed and/or to develop attachment-related concerns pertaining to the sufferer's responsiveness, trustworthiness, and/or fidelity (Doron, Derby, and Szepsenwol, 2014; Doron, 2017; Littman et al., 2023), all of which are hallmarks of previously-documented sources of attachment injury (Halchuk et al., 2010; Johnson & Williams-Keeler, 1998; Makinen & Johnson, 2006). Accordingly, in situations in which between-partner symptom contagion has occurred, practitioners may opt to mitigate its potential deleterious effects on the EFT process by implementing the steps of the AIRM. Like imagery reprocessing, which Doron & Derby (2017) have promoted as a potentially-beneficial means of addressing attachment insecurities with individual ROCD sufferers, the steps of the AIRM may provide clients with an opportunity to revisit and, thus, repair key moments of attachment rupture. However,

through the AIRM, this may be accomplished in a less-abstract, more-enacted, and dyadic manner, thus making it a relatively-powerful intervention for couples impacted by the between-partner contagion of ROCD symptoms.

Addressing Symptom Accommodation. Emotionally focused therapists well-informed about ROCD might also anticipate ways in which their promotion of responsiveness between partners impacted by this disorder may, ironically, facilitate, rather than mitigate their experience of relationship distress. Indeed, if ROCD sufferers' vulnerable sharing of their emotional experiences with their partners takes the form of compulsive reassurance-seeking which is then accommodated by the latter, their symptoms may be sustained and/or exacerbated, potentially perpetuating and/or worsening ROCD's impacts on the couple. Accordingly, as EFT practitioners encourage these clients to share with and respond to one another, it is critical that they ensure this be done in the thoughtful, intentional manner described by Johnson (2019a, 2019b) to foster a relatively-deep, lasting, and felt sense of attachment, rather than in a superficial way which merely dispels ROCD-related distress in the short-term.

To do this, EFT practitioners might, once again, turn to psychoeducation. By informing ROCD sufferers and their partners about the dangers of symptom accommodation, emotionally focused therapists can facilitate the former's recognition of their need to abstain from requesting and/or offering this misguided form of support as they share their attachment-related emotional understandings with each other. To the extent that this sharing may constitute a type of behavioural exposure (Johnson, 2019a), it also becomes critical for clients to recognize their need to, instead, offer aid and support to their partners during this process to maximize its benefits (Doron, Mizrahi, et al., 2014). To this end, it is notable that, when exposure tasks are used to treat similar issues (i.e., OCD and relationship anxiety), outcomes may be enhanced by psychoeducating impacted couples about symptom accommodation as well as by having them be emotionally open with and encouraging of one another (Abramowitz et al., 2012; Paprocki & Baucom, 2015). Indeed, this seems to hint that, if partners

impacted by ROCD are educated about and, thus, abstain from engaging in symptom accommodation, but also adhere to EFT's principles of vulnerable and responsive communication, the process of sharing their emotional experiences with one another may be of greater benefit to them.

Concluding Thoughts

This capstone research project sought to raise awareness and understanding of ROCD amongst therapists and to provide those who conduct couples therapy with recommendations for how they might best support partners impacted by this condition. Its first chapter laid the framework for the investigation which followed, introducing ROCD as a relatively-new and unexplored, yet consequential theme of OCD. It also outlined the rationale for this exploration, namely, the lack of scholarship and practitioner knowledge about ROCD and, in particular, guidelines for the treatment of couples impacted by it. It then provided the reader with the theoretical and conceptual frameworks utilized within the project, a statement of reflectivity and positionality from the author, an outline of subsequent chapters, as well as the definitions of key terms used therein.

Chapter two consisted of a comprehensive literature review composed of two subsections, the first of which served to educate the reader about critical information on ROCD, including findings on its two distinct symptom types (i.e., RCOC and PFOC) and their assessment, as well as the epidemiology (e.g., prevalence and geographic distribution) and etiological factors (e.g., attachment insecurity) of this disorder. ROCD's numerous, significant impacts on sufferers, their romantic relationships, and, thus, partners (e.g., relationship dissatisfaction and infidelity concerns) were also described, along with recommendations for the treatment of this disorder in both individual and dyadic contexts (e.g., through CBT and psychoeducation, respectively). The second subsection introduced the reader to EFT, an attachment-based, systemic, and experiential modality of couples therapy which may be of particular benefit to clients impacted by ROCD. Emotionally focused therapists' roles as model attachment figures and process consultants were also illustrated, as were the various interventions which these

practitioners may utilize (i.e., the five moves of the EFT tango). Following this, the sequence of EFT and its various stages (i.e., de-escalation of negative interaction cycles, changing interactional patterns and restructuring attachment, and consolidation and integration) as well as their steps were highlighted, along with findings related to this modality's efficacy and effectiveness as a treatment for relationship distress. Relevant process variables (i.e., the development of the therapeutic relationship, depth of clients' experiential processing, and their sense of affiliation with one another) were then discussed, along with recommendations for the use of EFT with specific populations (i.e., attachment-injured couples and gay men).

Finally, the third chapter of this project synthesized findings from the above literature review, highlighting EFT's potential benefit for couples impacted by ROCD, particularly as an adjunct to individual therapy. It also provided practitioners with specific recommendations about ways in which they might leverage knowledge of ROCD within different facets of the EFT model to best serve these couples. Such recommendations included conducting comprehensive assessment for and, potentially, diagnosis of ROCD, the use of psychoeducation to foster the therapeutic alliance, and reliance upon knowledge of this condition's etiology and impacts to bolster one's ability to consult with clients on process. Suggestions were also provided about ways in which EFT practitioners might address critical ROCD-related issues, including the between-partner contagion and/or accommodation of its symptoms.

While it is my hope that this project has further legitimized ROCD as an issue which warrants therapists' attention as well as armed those who work with couples with the knowledge sufficient to benefit those impacted by it, there is much work yet to be done in this area. Indeed, though it is heartening that there has been increased attention paid to ROCD in the academic literature over the past decade, further scholarship is needed on this topic, particularly from a wider range of researchers and through more advanced, empirically-rigorous methodologies. Ideally, such research will be facilitated by the formal recognition of ROCD as a distinct OCD subtype by the APA, IOCDF, and/or other

organizations in the near future. Additionally, noting ROCD's numerous serious impacts on sufferers' romantic relationships and partners, more research examining how they might be supported together in therapy is a dire need at this time. Indeed, this project remains but one of a few to examine this particular topic, if not the only to do so in a relatively-comprehensive manner. Regardless, the findings of this project behoove couples therapists to familiarize themselves with ROCD as a clinical issue which they are likely to encounter if they have not already done so.

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