

Right or Flawed: Relationships Obsessions and Sexual Satisfaction

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Key Words: Sexual functioning, Cognitive Theory; Obsessive Compulsive Disorder;
Cognition; Relationships, Relationship Obsessive Compulsive Disorder (ROCD);
Sexual Satisfaction

Abstract

Introduction. Relationship Obsessive Compulsive Disorder (ROCD) is marked by the presence of obsessions and compulsions focusing on romantic relationships. ROCD symptoms were previously linked with decreased relationship quality and might interfere with sexual functioning.

Aim. To examine the association between ROCD symptoms and sexual satisfaction.

Methods. Participants completed an online survey assessing ROCD symptoms, relationship and sexual satisfaction levels. Depression, general worry, obsessive compulsive disorder (OCD) symptoms and attachment orientation were also measured.

Results. ROCD symptoms were associated with decreased sexual satisfaction over and above symptoms of depression, general worry, OCD and attachment orientation. The link between ROCD symptoms and sexual satisfaction was mediated by relationship satisfaction.

Conclusions. Identifying and addressing ROCD symptoms may be important for treatment of sexual functioning.

Key Words. Sexual functioning, Cognitive Theory; Obsessive Compulsive Disorder; Cognition; Relationships, Relationship Obsessive Compulsive Disorder (ROCD); Sexual Satisfaction

Introduction

Obsessive-compulsive disorder (OCD) is a disabling and prevalent disorder with a variety of clinical presentations and obsession themes [1-3]. It involves unwanted and disturbing intrusive thoughts, images, or impulses (obsessions) and repetitive behaviors or mental acts (compulsions), aimed at reducing distress or preventing the occurrence of feared events associated with the intrusions [4, 5]. OCD has been associated with severe personal and dyadic consequences including sexual dysfunction [4, 6]. One theme of OCD that has gained recent attention is Relationship OCD [ROCD; 7, 8, 9]. In ROCD, the focus of obsessive-compulsive (OC) symptoms is the relationship or relationship partner. ROCD symptoms have been previously linked with poor relationship functioning and mood [7, 8]. Sex, however, is considered to be one of the building blocks of romantic relationships [10]. The focus of the present research, therefore, was to evaluate the link between ROCD symptoms and sexual functioning.

ROCD Forms and Manifestations

Two presentations of ROCD have been identified: (1) *relationship-centered* [7], in which the focus of intrusions is the relationship itself (e.g., “is this the right relationship?”), and (2) *partner-focused* [8], in which the focus of intrusions is perceived deficits of one's romantic partner (e.g., “is he beautiful enough?”). ROCD obsessions often manifest in thoughts (e.g., “is he the right one?”) or images (e.g., of a current or previous romantic partners), but may also occur in the form of urges (e.g., to leave one's current partner). Compulsive behaviors in ROCD include, but are not limited to, repeated checking of one's own feelings and thoughts towards the partner or the relationship, comparing partner's characteristics or behaviors to others', reassurance seeking, and self-reassurance [11].

ROCD symptoms are often ego-dystonic, in that they contradict the subjective experience of the relationship (e.g., "I love her, but I can't stop questioning my feelings"), or personal values (e.g., "appearance should not be important in selecting a relationship partner"). Such intrusions are perceived as unacceptable and unwanted, and often bring about feelings of guilt and shame regarding their occurrence and/or content [11]. Moreover, since they tend to focus on one's emotions about his current or past relationships, and not on future relationships, relationship-related intrusions are different from general worries, in both content and form [11].

ROCD, relationship satisfaction and sexual satisfaction

ROCD symptoms are particularly detrimental for relationship quality and stability. Repeated monitoring of one's feelings towards a romantic partner or doubting the "rightness" of one's relationship may destabilize emotional bonds, escalate existing relational fears and doubts, and result in increased relationship distress [7, 11]. Moreover, ROCD clients' constant preoccupation with the perceived flaws of their romantic partner may impede idealized perceptions of the relationship and/or partner [8, 11]. Such idealized perceptions are considered as an important predictor of positive relational outcomes, such as greater satisfaction, less conflict, and enhanced relationship stability [12, 13, 14, 15]. Furthermore, like other OCD symptoms, ROCD symptoms might be a source of relationship conflicts, bringing about negative responses from one's romantic partner [7, 8].

Two studies conducted on nonclinical samples have found the expected relationship between ROCD symptoms and poor relationship satisfaction. In one study, relationship-centered OC symptoms were associated with relationship dissatisfaction, even when controlling for common OCD symptoms, mood symptoms, low self-esteem, attachment anxiety and avoidance, and relationship ambivalence [7].

In another study, partner-focused OC symptoms were associated with relationship dissatisfaction, even when controlling for relationship-centered symptoms in addition to all the other controls mentioned above. In fact, both partner-focused and relationship-centered OC symptoms had their own unique statistical contribution to relationship dissatisfaction, suggesting somewhat divergent causal paths [8].

Poor relationship satisfaction, as often experienced by ROCD clients, may easily hamper sexual satisfaction. Although sex may provide grounds for positive relational experiences [e.g., see review by Mikulincer & Shaver, 16], ROCD clients might channel their relational doubts and dissatisfaction into the sexual realm and suffer from conflicting, joyless and disappointing sexual encounters. In line with this view, robust findings show that low relationship satisfaction is often associated with low sexual satisfaction, among men and women, and within different stages of romantic relationships [see review by Sprecher & Cate, 17]. Moreover, sexual satisfaction and related subjective measures of sexuality (e.g., sexual intimacy), were also found to be positively associated with other indicators of relationship quality, including love [18] and commitment [19].

Taken together, these findings suggest that ROCD symptoms are associated with poor relationship satisfaction. Relational doubts and dissatisfaction might intrude on sexual experiences with one's partner, interfere with erotic pleasure and result in low sexual satisfaction. Hence, ROCD symptoms are likely to be indirectly associated with poor sexual satisfaction.

Aims

The aim of the present research was to examine the hypothesis that ROCD symptoms (relationship-centered and partner-focused) would be associated with lower

sexual satisfaction and that this association would be mediated by decreased relationship satisfaction.

Method

Participants

The sample consisted of 157 Israelis from the general population (71 women) who were recruited via *Midgam.com*, an Israeli online survey platform analogous to other survey platforms around the world (e.g., Amazon Mturk). These participants were previously registered to the website and agreed to participate in the study. The use of community participants is in accordance with the common practice in the study of OCD related phenomena [20,21]. Participants' ages ranged from 20 to 65 (*Mdn* = 44). All participants were Jewish (58% secular, 23.6% traditional, and 18.4% religious). They had varying degrees of education. Namely, 10.2% did not complete a highschool education, 62.4% completed either a highschool education or non-academic higher education, and 27.4% had an academic degree. Their socioeconomic status also varied (38.9% below average, 36.3% average, and 24.8% above average). All participants were involved in an intimate relationship during the study. Median relationship length was 181 months. Participants were informed of their rights and completed an online informed consent form in accordance with university IRB standards. They completed the survey in one session (the website allows one entry per participant) and were reimbursed 20 NIS (around \$5) for their efforts.

Procedure

The study was administered online using the web-based survey platform *www.midgam.com*. Responses were saved anonymously on the server and downloaded for analysis. All participants completed a battery of questionnaires that

included, in randomized order, the main measures and covariates. All measures were completed in Hebrew using translated versions that have been used extensively in prior research [e.g., 7, 8]

Main measures

Relationship-centered symptoms were assessed via the Relationship Obsessive-Compulsive Inventory [ROCI; 7], a self-report measure of obsessions and compulsions centered on one's romantic relationship. The scale includes 12 items covering three relational dimensions: feelings towards one's partner (e.g., "I continuously reassess whether I really love my partner"), perception of one's partner's feelings (e.g., "I continuously doubt my partner's love for me"), and appraisal of the "rightness" of the relationship (e.g., "I check and recheck whether my relationship feels right"). Participants rated the extent to which such thoughts and behaviors described their experiences in their intimate relationships on a scale ranging from 0 ("not at all") to 4 ("very much"). Previous studies have shown that the ROCI subscales can be regarded as three correlated factors or as part of a single higher-order factor [6]. Moreover, the ROCI total score was found to be related to various measures of relational and personal dysfunction, as well as to measures of OCD symptoms and OCD-related beliefs [6]. Thus, a total score was created by averaging all 12 items (Cronbach's $\alpha = .92$).

Partner-focused symptoms were assessed via the Partner-Focused Obsessive-Compulsive Inventory [PROCSI; 8], a 24-item self-report measure of obsessions and compulsions centered on one's partner's perceived flaws. These may include appearance flaws (e.g., "every time I'm reminded of my partner I think about the flaw in his/her appearance"), character flaws (e.g., "I am constantly bothered by doubts about my partner's morality level"), psychological flaws (e.g., "I keep examining

whether my partner acts in a strange manner"), and intellectual flaws (e.g., "the thought that my partner is not intelligent enough bothers me greatly"). Participants rated the extent to which such thoughts and behaviors describe their experiences in their relationships on a scale ranging from 0 (*not at all*) to 4 (*very much*). Previous studies have shown that the PROCSI subscales can be regarded as six correlated factors or as part of a single higher-order factor [8]. Moreover, the PROCSI total score was found to be related to various measures of relational and personal dysfunction, as well as to measures of OCD symptoms and OCD-related beliefs [8]. Thus, a total score was created by averaging all 24 items (Cronbach's $\alpha = .95$).

Relationship satisfaction was assessed via the Relationship Assessment Scale [22]. This scale consists of 7 items rated on a 7-point Likert scale (e.g., "In general, how satisfied are you with your relationship?"). A total score was created by averaging all 7 items (Cronbach's $\alpha = .92$).

Sexual satisfaction was assessed via the 3-item sexual satisfaction subscale of the Israeli Sexual Behavior Inventory [ISBI; 23]. Participants rated on a 5-point Likert scale the extent to which each item was self-descriptive (e.g., "I feel satisfied with my sexual life"). A total score was created by averaging these items (Cronbach's $\alpha = .83$).

Covariates

Current depression symptoms were assessed via the 7-item depression subscale of the short Depression Anxiety Stress Scales [DASS; 24], a self-report questionnaire listing depression, anxiety, and stress symptoms. Participants rated how often each particular symptom was experienced in the past week on a 4-point scale. A total score was created by averaging the items (Cronbach's $\alpha = .89$).

General worries were assessed via the Penn State Worry Questionnaire [PSWQ; 25], a 16-item self-report scale (e.g., "My worries overwhelm me"). Participants rated

the degree to which each item is typical of them on a 5-point scale. A total score was created by averaging the items (Cronbach's $\alpha = .92$).

OCD symptoms were assessed via the Revised Obsessive-Compulsive Inventory [OCI-R; 26], an 18-item self-report questionnaire assessing OCD symptoms. Participants rated the degree to which they were bothered by OCD symptoms in the past month on a 5-point scale. A total score was created by averaging the items (Cronbach's $\alpha = .92$).

Attachment orientations were assessed via the Experience in Close Relationships Scale [ECR; 27], a 36-item self-report scale tapping variations in attachment anxiety (e.g., "I worry about being abandoned") and avoidance (e.g., "I get uncomfortable when people want to be very close"). Participants rated the extent to which each item described their feelings in close relationships on a 7-point scale. Total scores for anxiety (Cronbach's $\alpha = .92$) and avoidance (Cronbach's $\alpha = .86$) were created by averaging the items of each subscale.

Results

Zero-order correlations between relationship-centered OC symptoms, partner-focused OC symptoms, relationship satisfaction and sexual satisfaction are presented in Table 1. Consistent with prior research [7, 8], ROCI and PROCSI scores were positively correlated. In addition, both scores were negatively correlated with relationship and sexual satisfaction. As expected, relationship and sexual satisfaction were positively correlated.

Further analysis of the data was conducted in three steps. First, the unique relationships between relationship-centered and partner-focused OC symptoms and sexual satisfaction were assessed through multiple regression analysis. As expected, ROCI and PROCSI scores (Tolerance = .76) were uniquely and negatively associated

with sexual satisfaction ($\beta = -.25, p < .01$ & $\beta = -.24, p < .01$ for ROCI and PROCSI respectively). These effects remained significant ($\beta = -.30, p < .01$ & $\beta = -.26, p < .01$ for ROCI and PROCSI respectively) even when controlling for attachment anxiety and avoidance, depression, general worries, and common OCD symptoms within a hierarchical regression analysis. ROCI and PROCSI scores, entered in the second step, explained 12.5% of the variance in sexual satisfaction over and above the covariates.

Second, mediation was assessed through structural equation modeling (path analysis)¹. A hypothesized model in which relationship satisfaction fully mediates the relationship between relationship-centered and partner-focused OC symptoms and sexual satisfaction was compared to a null model that allowed direct paths from both relationship-centered and partner-focused OC symptoms to sexual satisfaction (see Figure 1). As expected, both direct paths were nonsignificant. Moreover, constraining these paths to 0 in the hypothesized full-mediation model had no significant effect on goodness of fit ($\Delta X^2_{(2)} = 4.46, ns$), indicating that relationship satisfaction fully accounts for the relationship between relationship-centered and partner-focused OC symptoms and sexual satisfaction. Fit indices for this model, reported in Figure 1, generally indicated good fit (CFI, NFI, & TLI $> .95$, SRMR $< .05$). The root mean square error of approximation (RMSEA) was outside the range commonly regarded as indicating close fit (RMSEA $< .05$), but the close fit hypothesis was not rejected ($p = .20$).

Finally, an alternative model in which sexual satisfaction fully mediates the relationship between relationship-centered and partner-focused OC symptoms and relationship satisfaction was examined. This model was significantly inferior to a null model that allowed direct paths from relationship-centered and partner-focused OC

symptoms to relationship satisfaction ($\Delta X^2_{(2)} = 51.87, p < .001$), indicating that sexual satisfaction does not account for the associations between relationship-centered and partner-focused OC symptoms and relationship satisfaction.

Discussion

Taken as a whole, the findings were in line with our prediction. Both forms of ROCD symptoms were uniquely associated with poor sexual satisfaction. These relationships were accounted for by relationship satisfaction, suggesting that ROCD symptoms contribute to poor relationship satisfaction that leads to poor sexual satisfaction. ROCD symptoms involve repeated doubting and checking of one's feelings towards the partner and/or the relationship. Such continuous doubting may seriously undermine core relationship processes (e.g., intimacy, commitment) and directly destabilize emotional bonds. Negative emotions (e.g., stress, sadness) and behaviors (e.g., criticism, avoidance) associated with decreased relationship satisfaction might interfere with erotic pleasure during sexual acts and with experiencing gratifying and joyful sexual encounters [28].

Although the data was consistent with the hypothesized mediation model, it is important to note that our design was cross-sectional and correlational, and therefore one cannot derive any causal inferences from the findings. Moreover, because sex often serves as a means of evaluating the suitability and compatibility of a romantic partner [29], ROCD client's subjective experience of low sexual satisfaction may in turn promote relationship-related doubts and fears, maintaining a cycle of doubts and low satisfaction. Sex may also lead to heightened monitoring of physical attraction and levels of emotional closeness toward one's partner [30], which might interfere with achieving such states [30, 31, 32], further perpetuating uncertainty and ROCD-related compulsive behaviors. Hence, the relationship between ROCD symptoms and

sexual dysfunction is likely to be bidirectional and self-reinforcing. Future research such as daily diary repeated measurements of ROCD symptoms, using a variety of sexual and relationship satisfaction measures [33, 34] may help elucidate the bidirectional dynamics between these variables.

An additional limitation of the current study is the use of an analogue cohort consisting of unselected community participants recruited online. Evidence suggests research with analogue samples is highly relevant for understanding OC-related symptoms and cognitions [20]. Further, previous findings support comparability of paper and internet administration assessing such OC phenomena [35] and respondents completing online surveys (e.g., MTurk) have been found to produce high quality data [36]. Nevertheless, clinical samples may differ in the severity of OCD symptom-related impairment [37]. Replicating these findings among ROCD patients would, therefore, support the generalizability of our findings. Such research may also benefit from using interview based methods that assess a wider variety of ROCD related impairments.

Limitations notwithstanding and pending replication of the results, our findings may have important clinical implications. To our knowledge, this is the first study exploring links between ROCD symptoms and sexual satisfaction. Such an investigation may enhance awareness of, and clinical attention to, ROCD symptoms when dealing with sexual and relational difficulties. In cases where ROCD symptoms are the main cause of sexual and relational difficulties [see 10, for discussion of assessment and interventions procedures], such symptoms may be better dealt with prior to marital and sexual interventions, preferably in individual therapy settings. When ROCD symptoms are secondary to marital or sexual issues, drawing attention to the role of ROCD symptoms in the dynamic of such issues may be useful. For

instance, reducing continuous monitoring of one's sexual arousal before (or during) sexual encounters, may increase sexual satisfaction and reduce relationship doubts.

Conclusions

Relationship-centered and partner-focused ROCD symptoms are uniquely associated with low relationship and sexual satisfaction. While further research is needed into the causal structure of the relationship between ROCD symptoms and sexual impairment, marital and sexual therapists might consider assessing ROCD symptoms as an underlying vulnerability factor for relational and sexual problems.

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Notes

1. The mediation analysis was also conducted with a traditional regression approach, and yielded the same results.

Table 1

Means, Standard Deviations, Cronbach's Alphas, and Correlations between Study Variables

	1	2	3	4
1. Relationship-centered OC symptoms (ROCI)	.92			
2. Partner-focused OC symptoms (PROCSI)	.49***	.96		
3. Relationship satisfaction (RAS)	-.59***	-.49***	.92	
4. Sexual satisfaction (ISBI)	-.37***	-.36***	.51***	.83
M	0.81	0.72	5.57	3.84
SD	0.81	0.72	1.37	0.96

Note. Cronbach's alphas are displayed on the diagonal.

*** $p < .001$

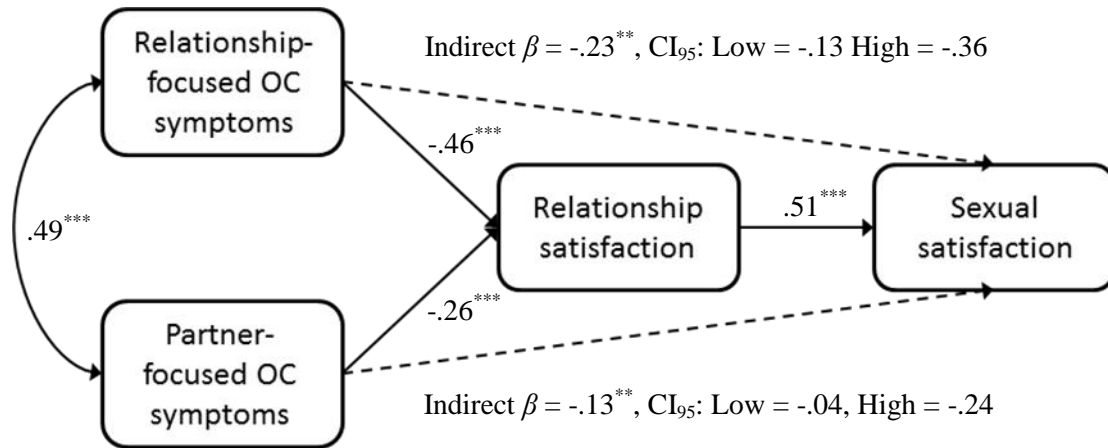


Figure 1. Relationship satisfaction fully mediates the associations between relationship-focused and partner-focused OC symptoms and sexual satisfaction. Direct paths (dashed) are constrained to 0. Significance and 95% confidence intervals for indirect effects estimated through bootstrapping (bias-corrected; N = 1000). Model $\chi^2_{(2)} = 4.46, ns$; NFI = .974, CFI = .985, TLI = .956, RMSEA = .089, SRMR = .043.

** $p < .01$ *** $p < .001$