Assessment and Treatment of Relationship-Related OCD Symptoms (ROCD): A Modular Approach

Guy Doron

Interdisciplinary Center (IDC) Herzliya

Danny Derby

Cognetica – The Israeli Center for Cognitive Behavioral Therapy

In press in: *Handbook of Obsessive-Compulsive Disorder Across the Lifespan*, edited by J. Abramowitz, D. McKay, & E. Storch, Hoboken, NJ: Wiley.

Lilly[1] , a 30-year old woman, in her third year of medical residency, living with her current partner for the last year, seeks treatment for what she calls ROCD. She describes her problem: "I've been in a relationship for the last two years and my partner (Rob) has recently asked me to marry him. I am not sure about what to do. I love Rob; I think he is great. However, I imagined being in love differently. I thought that I would be thinking about my partner all the time; I would be euphoric, "living in the clouds". It is not at all like that. Every time I notice that I don't think of him constantly or that I am irritated, stressed or uneasy in his company, I start doubting whether he is the right one for me and whether I am in the right relationship. Recently, I've also begun thinking that he may not be interesting or intelligent enough for me. I know it is not true. Rob has a PhD; he is witty and easy going, but I can't stop thinking about whether this is the right relationship for me. I check what I feel for him all the time, how I feel when I am with him, whether he is smart enough. I know I love him, but these doubts haunt me. I find it hard to concentrate on my studies and it really affects my mood".

Lilly suffers from what is commonly referred to as Relationship Obsessive Compulsive Disorder (ROCD) — obsessive-compulsive symptoms that center on close or intimate relationships, an OCD presentation that has been receiving increasing research and clinical attention (Doron, Derby, Szepsenwol, & Talmor, 2012a, 2012b; Doron, Derby, Szepsenwol, 2014a). Relationship obsessions may occur in various types of close relationships such as parent-child, relationship with a supervisor and even relationship with one's God. Current research, however, has

[1] Lilly's details and characteristics are fictional, and dialogues are representative examples of sessions with different clients.

mainly focused on ROCD in the context of romantic relationships. In this chapter, we therefore refer to ROCD within romantic relationships.

One common presentation of ROCD involves doubts and preoccupations centered on the perceived suitability of the relationship itself (e.g., the strength of one's feelings towards their partner, the "rightness" of the relationship) and on the perceived nature of one's partner's feelings towards oneself. This presentation has been referred to as *relationship-centered* OC symptoms (Doron, Derby et al., 2012a). Relationship obsessive compulsive disorder may also involve disabling preoccupation with perceived deficits of the relationship partner (e.g., not being intelligent enough). Such symptoms have been referred to as *partner-focused* OC symptoms (Doron, Derby et al., 2012b). Although similar in some ways to what has been referred to in the literature as Body Dysmorphic Disorder by Proxy (i.e., obsessional focus on perceived physical flaws in others; see Josephson & Hollander, 1997; Greenberg et al., 2013), partner-focused OC symptoms refer to obsessional preoccupation with a wider variety of the partner's "flawed" characteristics (e.g., morality, sociability, success; Doron, Derby et al., 2014a).

ROCD symptoms have been linked with significant personal (e.g., mood, anxiety, other OCD symptoms; Doron, Derby et al., 2012a; 2012b) and dyadic difficulties (e.g., relationship and sexual dissatisfaction; Doron, Derby et al., 2012a; 2012b; Doron, Mizrahi, Szepsenwol, & Derby, 2014). For instance, results from a recent study comparing OCD, ROCD and community controls indicated similar levels of interference in functioning, distress, resistance attempts and degree of perceived control in both clinical groups (Doron, Derby, Szepsenwol, Nahaloni & Moulding, 2014b).

ROCD related intrusions often come in the form of thoughts such as "Is he the right one?" or "She is not beautiful" and images such as visualization of the face of the relationship partner or of an awkward moment associated with the partner. ROCD intrusions can also occur in the form of urges; for instance, the urge to leave one's current partner. Such intrusions are generally ego-dystonic, as they contradict the individual's personal values (e.g., "appearance should not be important in selecting a relationship partner") and/or subjective experience of the relationship (e.g., "I know I love her, but I can't stop questioning my feelings"). Hence, they are perceived as unacceptable and unwanted, and often bring about feelings of guilt and shame regarding their occurrence and/or content.

ROCD may also involve a wide range of compulsive behaviors and other maladaptive responses (see Table 1). Examples may include reassurance seeking, repeated checking of one's own feelings, comparisons of one's partner's characteristics with those of other potential partners, and avoidance behaviors. Neutralizing behaviors may include visualizing being happy together and sustaining a positive thought about the partner. These compulsive behaviors are aimed at alleviating the significant distress caused by the unwanted intrusions (Doron, Derby et al., 2014a).

-Insert Table 1 about here-

Development and Maintenance Mechanisms in ROCD

In this section, we present a summary of our ROCD model and supporting research (for a more extensive review see Doron, Derby et al., 2014a). Cognitive-behavioral theories of OCD assert that most individuals experience a range of intrusive doubts, thoughts, urges, and images (Rachman & de Silva, 1978; Radomsky, Alcolado, et al., 2014). In OCD and related disorders, the misappraisal and mismanagement of such intrusions lead to their escalation into obsessions (OCCWG,

2005; Storch et al., 2008). Consistent with this, Doron, Derby, and Szepsenwol (2014a) have suggested several mechanisms that perpetuate a vicious cycle of increased attention and reactivity to relationship-related concerns, the mismanagement of such intrusions and their escalation into relationship-related obsessions. These include particular self-vulnerabilities, OCD-related and relationship-related unhelpful beliefs, attachment insecurities, compulsive behaviors and dysfunctional commitment processes.

Self-vulnerabilities in ROCD: According to Doron and Kyrios (2005), pre-existing vulnerabilities in specific self-domains such as morality increase attention and vigilance to events related to these domains. Individuals whose self-esteem is highly dependent upon the relationship domain, for instance, may be hypervigilant to any slight relationship concern (e.g., feeling of boredom) as it has significant implications for their own feelings of worth (Doron, Szepsenwol, Karp, & Gal, 2013). Similarly, individuals perceiving their partner's deficiencies or flaws as reflecting on their own worth (i.e., partner-value contingent self-worth) are expected to be more sensitive to thoughts or events pertaining to their partner's qualities and characteristics (Doron, Derby et al., 2014a).

Consistent with this, recent findings indicate that self-esteem which is highly dependent on the relational domain (i.e., relationship contingent self-esteem) and attachment anxiety jointly contribute (i.e., double-relationship vulnerability) to increased ROCD behavioral tendencies (Doron et al., 2013). Likewise, self-esteem levels in individuals with high partner-focused obsessions have been found to be more susceptible to thoughts threatening positive views of their partner (e.g., s/he is not "as good" as others), relative to individuals with low partner-focused symptoms (Doron & Szepsenwol, 2014). Thus, particular self-sensitivities may increase attention and

vigilance towards unwanted relationship-related intrusions thereby perpetuating the ROCD cycle.

Maladaptive beliefs in ROCD: In OCD-related disorders, maladaptive beliefs such as intolerance of uncertainty, importance of thoughts and their control, and inflated responsibility increase the likelihood of catastrophic appraisals of intrusions (OCCWG, 2005; Storch et al., 2008). In ROCD, such maladaptive beliefs may play a similar role. For instance, attributing importance to thoughts and their control may increase unhelpful interpretations of the occurrence of commonly occurring relationship doubts. Similarly, difficulty with uncertainty may increase distress and maladaptive management of inherently elusive internal states such as love and passion. Indeed, findings suggest that ROCD symptoms are associated with OC-related beliefs in clinical and non-clinical samples (Doron, et al., 2012a; 2012b; Doron, Derby et al., 2014b).

Beliefs regarding the potential negative consequences of relationships and unrealistic perceptions regarding the relationship experience may be particularly relevant to the development and maintenance of relational OCD. For instance, beliefs regarding the harmfulness of staying in a relationship one has doubts about or acute fears of discontinuing an existing relationship may provoke relationship related "catastrophic scripts". Such scripts often include fears of being forever trapped in an unsatisfying and distressing relationship that one was not initially sure about. Other scripts include fears of missing The One and regretting it forever.

Extreme romantic beliefs including unrealistic perceptions of what love should be, feel and look like may also contribute to the misinterpretation of relationship events. ROCD clients often describe beliefs such as "If I am not euphoric when I am with her, it is not true love" or "If I do not think about her all the time, s/he is not the

one". Such beliefs, particularly when coinciding with a pre-existing fear of experiencing regret (e.g., "The feeling after making a wrong decision is intolerable for me") or fear of future regret (i.e., "I won't be able to cope with the thought that I have made a wrong decision"), frequently increase distress following relationship events pertaining to partner or relationship suitability.

Consistent with these suggestions, ROCD symptoms have been linked with relationship-related maladaptive beliefs. For instance, in a recent study using the relationship catastrophization scale (RECATS; Doron, Derby et al., 2014b), ROCD clients showed higher levels of relationship maladaptive beliefs than OCD clients and community controls (Doron, Derby et al., 2014b). Initial findings from our ongoing research using our Extreme Love Belief scale (EXL) and Fear of Regret scale (FOR) suggest increased ROCD symptoms are associated with higher endorsement of such beliefs.

Attachment insecurities and ROCD: According to Doron, Moulding, Nedeljkovic, Kyrios, Mikulincer and Sar-El (2012), for most people, the distress caused by maladaptive interpretation of intrusions results in the activation of distress-regulation strategies that restore emotional calmness. In ROCD, however, attachment insecurity, particularly attachment anxiety, has been suggested to hinder such adaptive emotional regulations strategies (Doron et al., 2013). According to attachment theory (Bowlby, 1982; Mikulincer & Shaver, 2007), interpersonal interactions with protective others (“attachment figures”) early in life are internalized in the form of mental representations of self and others (“internal working models”). Interactions with attachment figures that are available and supportive in times of need foster the development of both a sense of attachment security and positive internal working models of self and others. Attachment security is undermined, however, when

attachment figures are rejecting or unavailable in times of need, leading to the formation of negative representations of self and others (Mikulincer & Shaver, 2007).

Attachment orientations can be organized around two orthogonal dimensions, representing the two insecure attachment patterns of anxiety and avoidance (Brennan, Clark, & Shaver, 1998; reviewed by Mikulincer & Shaver, 2007). The first dimension, attachment anxiety, reflects the degree to which an individual worries that a significant other will not be available or adequately responsive in times of need, and the extent to which the individual adopts “hyperactivating” attachment strategies (i.e., insistent attempts to obtain care, support, and love from relationship partners) as a means of regulating distress and coping with threats and stressors. The second dimension, attachment avoidance, reflects the extent to which a person distrusts a relationship partner's good will and strives to maintain autonomy and emotional distance from him or her. An avoidantly attached individual relies on "deactivating" strategies, such as denial of attachment needs and suppression of attachment-related thoughts and emotions. Individuals who score low on both dimensions are said to hold a stable sense of attachment security (Mikulincer & Shaver, 2007).

According to Doron, Derby et al., (2014a), anxiously attached individuals' hypervigilance toward real or imagined relationship threats may make them especially vulnerable to intrusive thoughts that challenge self-perceptions in the relational domain. Moreover, their reliance on hyperactivating strategies may predispose such individuals to compulsive reassurance seeking and checking behaviors, particularly in the context of intimate relationships. Further, anxiously attached individuals tend to react to such negative relationship experiences with the activation of maladaptive beliefs and hyper-activating attachment-relevant fears (Mikulincer & Shaver, 2003).

Indeed, previous findings have linked attachment insecurities with maladaptive beliefs and ROCD symptoms (Doron et al., 2012a; Doron et al., 2012b). For instance, subtle hints of incompetence in the relational self-domain (i.e., mildly negative feedback regarding the capacity to maintain long-term intimate relationships) were found to lead to increased ROCD tendencies mainly among individuals high in both attachment anxiety and relationship-contingent self-worth (Doron et al., 2013).

Compulsive behaviors and ROCD symptoms: Like in other OCD presentations, compulsive behaviors play a curial role in the maintenance of ROCD symptoms. ROCD related compulsive behaviors include a wide variety of strategies aimed to reduce distress following the negative interpretations of relationship-related intrusions. These may include self-criticism (e.g., I am stupid to think like that, so the thought is not important), increased monitoring of internal states (e.g., scanning the body for feelings), reassurance seeking behaviors (e.g., seeking reassurance that the relationship is going right), comparisons (e.g., Are we as happy as they are?) and neutralizing (e.g., recalling positive experiences with the partner). Importantly, such strategies paradoxically increase pre-existing vulnerabilities, maintain maladaptive beliefs and self-perpetuate. For instance, critical self-talk may increase self-vulnerabilities by reducing feelings of self-worth and self-confidence. Repeated recollection of positive relational situations or feelings (i.e., neutralizing) may prevent the assimilation of new information regarding one's ability to cope with uncertainty or regret. Compulsive monitoring of internal states is likely to self-perpetuate by decreasing accessibility to such states. Thus, identification and reduction of compulsive behaviors is crucial for successful therapeutic interventions.

Relational commitment and ROCD: According to Rusbult, Martz and Agnew (1998) one's intention to preserve an existing relationship (i.e., commitment)

is highly influenced by relationship satisfaction, the perceived quality of potential alternatives and one's investment in the current relationship. These three commitment components, however, significantly impact, and are impacted by ROCD symptoms. ROCD doubts, for instance, often reduce relational satisfaction. Lower relational satisfaction, however, may also increase relationship doubts. Indeed, ROCD symptoms have been linked with lower relationship satisfaction (Doron et al., 2012a; 2012b).

ROCD: Assessment and treatment

Often clients and therapists are unaware of ROCD and related phenomena, and tend to mistake ROCD symptoms for "life dilemmas" or dyadic difficulties. Conversely, worries and doubts regarding relationships are common, particularly during relationship conflict and may indeed reflect problematic couple interactions. Further, ROCD-like behaviors may occur during the normal course of a developing relationship, mainly during the flirting and dating stages or prior to relational commitment. Diagnosing ROCD, therefore, may be a complicated endeavor.

Like other OCD symptoms, relationship-related OC symptoms require psychological intervention when causing significant distress and when incapacitating. Relational obsessions tend to begin in the early stages of a relationship and exacerbate as the relationship progresses or reaches decision points (e.g., cohabitation, marriage). Clinicians should keep in mind that such relationship obsessions persist regardless of relationship conflict. When suspecting ROCD, initial evaluation should include a clinical interview to ascertain the diagnosis of OCD and coexisting disorders or medical conditions.

A thorough history would include the presenting problem(s), background of the problem(s), and personal history, with specific emphasis on relational history,

family history and family environment. It is of the utmost importance to gain a clear understanding of the nature, pattern, and duration of the client's symptoms within the current relationship context and in previous relationships. Therapists should collect detailed information about triggers of obsessions, their frequency and duration, the expected feared outcome or worry about the obsessions, and the responses to these intrusions. Responses include emotions (e.g., anxiety, guilt), overt compulsions (e.g., checking, comparing, reassurance seeking), covert compulsions (e.g., thought suppression, monitoring of internal states, self-reassurance), and avoidance or safety behaviors.

To ascertain diagnosis of OCD and/or related conditions, it is strongly recommended to use structured interviews, such as the Mini International Neuropsychiatric Interview (MINI; Sheehan et., 1998) or the SCID (First, Spitzer, Gibbon, & Williams, 2012). Additional instruments should be used to quantify OCD symptoms (e.g., Obsessive-Compulsive Inventory-Revised, Foa et al., 2002; Yale Brown Obsessive Compulsive Scale, Goodman et al., 1989), mood (depression, anxiety; Depression, Anxiety and Stress Scale; Levibond & Lovibond, 1995), body dysmorphic symptoms (e.g., DCQ; Oosthuizen, Lambert, & Castle, 1998) and other symptoms identified in the clinical interview.

In the following sections of this chapter, we suggest assessment and intervention procedures that follow the theoretical model presented earlier. We use Lilly's case to exemplify these procedures. Importantly, each client shows different patterns of vulnerability and maintenance factors. The aim of the initial assessment, therefore, is to provide idiosyncratic case conceptualization that will allow a modular client-tailored treatment-interventions focused on client-specific susceptibilities (see Table 2, for suggested assessment tools of ROCD).

-Insert Table 2 about here-

The proposed intervention for ROCD follows cognitive behavioral therapy for OCD. Treatment includes assessment and information gathering, psycho-education and case formulation, identification and challenge of core ROCD maintaining mechanisms and relapse prevention. We used cognitive-behavioral technics such as cognitive reconstruction, behavioral experiments and Exposure and Response Prevention (ERP), as well as experiential interventions such as Imagery Rescripting to challenge dysfunctional self-perceptions, maladaptive beliefs, attachment-related fears and commitment related behaviors.

Psycho-education and case formulation: The psycho-education and case formulation component sets the tone of treatment and covers the cognitive model of ROCD with client-specific hypothesized maintenance mechanisms. It is important to provide the client with the rationale for the therapeutic process and discuss the course of therapy. In Lilly's case, following the clinical interview, the therapist summarized her reasons for attending therapy, and discussed the course of therapy. Lilly was haunted by fears relating to her relationship. She was unable to decide what was to be done? Was she the problem? Did her difficulties reflect "real" issues relating to the partner or to the relationship? She spent over three hours per day thinking about her relationship decisions. She also described a variety of behaviors she performed in response to these doubts (e.g., reassurance seeking, checking information on the web).

Further probing led Lilly to realize, however, that the way she was trying to resolve her problem (i.e., repetitive thinking and related behaviors) may not have been very useful. On the contrary, over time she had become increasingly preoccupied, confused, distressed and anxious. Discussing her troubled state and the impact it had on her ability to reach an informed conclusion, Lilly agreed to postpone her decision

regarding the relationship for six months or until the obsessions were sufficiently reduced. The therapist and Lilly agreed that just as a thick fog tends to diminish our ability to see afar, obsessional thinking decreases our capacity to judge our relational experience.

Lilly did not want her partner to be involved in the therapy process. In other cases, however, one should consider involving the partner in the therapeutic process. In such cases, the partner's symptom accommodation should be assessed, ROCD psycho-education should be provided, and strategies for reducing dyadic influences suggested.

Symptom evaluation and monitoring: Assessing the severity and focus of ROCD symptoms is important for the formulation of client specific interventions. Monitoring of obsessions and compulsions also assist the client in managing the reduction of compulsions and avoidance behaviors. In her initial assessment session, Lilly described being distressed by obsessional thoughts regarding the relationship and her partner. The therapist used the Relationship Obsessive Compulsive Inventory (ROCI; Doron et al., 2012a) to assess her levels of relationship-centered symptoms. The ROCI is used to evaluate individuals' ROCD symptoms in three dimensions; one's feelings towards one's partner, the "rightness" of the relationship and the perceived nature of the partner's feelings towards oneself. Indeed, Lilly showed elevated scores on items such as "I continuously doubt my love for my partner" and "I check and recheck whether my relationship feels "right". Lilly's relationship-centered symptoms seemed to be focused on her feelings towards her partner and the rightness of the relationship, rather than her partner's feelings towards her.

The therapist then asked Lilly to complete the Partner Related Obsessive Compulsive Symptoms Inventory (PROCSI; Doron et al., 2012b). The PROCSI was

designed to measure obsessions (i.e., preoccupations and doubts) and neutralizing behaviors (i.e., checking) focused on the perceived flaws of one's relationship partner in six character domains: physical appearance, sociability, morality, emotional stability, intelligence, and competence. Lilly's strong adherence to items such as "I am constantly questioning whether my partner is deep and intelligent enough" echoed her severe preoccupation with her partner's intelligence and complexity.

Self-monitoring sheets were then used to identify Lilly's triggers and compulsive behaviors (see Table 1, for examples of ROCD maladaptive behaviors). Lilly's triggers were numerous. Some triggers she tried to avoid (e.g., meeting with certain friends, going to romantic movies, watching romantic comedies on television). It was harder for her to deal with other triggers such doubts "popping" into her head. Lilly described monitoring her feelings and attraction towards her partner numerous times a day. She also observed how "witty" he was in the company of friends, and compared his reactions to others (to assess his "depth"). Lilly's compulsive behaviors included sitting for hours, searching on Google for information such as "what to do when your partner is not smart enough" or "how do you know when your partner is right one" and lengthy participation on internet based relationship forums. She asked her friends for reassurance regarding the "normality" of her worries and the qualities of her partner.

Although she now realized that her response to triggers (e.g., monitoring, comparing, searching on the web) might not be useful in the long term, she still felt somewhat reluctant to cease performing them. The therapist, therefore, suggested a behavioral experiment − Lilly was to increase her web searching for information about relationships every second day (i.e., search for at least an hour). On the other days, she was to decrease these behaviors. During the week of the experiment, Lilly

had to monitor her overall well-being, intensity of doubts, clarity of emotions and overall satisfaction with the relationship. The following session, Lilly reported becoming increasingly aware of the negative effects of her searching on the web. Searching actually made her feel worse, caused her to doubt herself more and amplified her confusion. Based on this understanding, Lilly and the therapist agreed on identifying additional unhelpful responses (e.g., self-reassurance) and using similar behavioral experiments to evaluate them. They would then think of ways to reduce such unhelpful behaviors.

In order to get a better understanding of her obsessional cycle, Lilly and the therapist examined the chain of events linking triggers to responses. They found that a triggering event (e.g., a couple kissing) often brought about an intrusion (e.g., "they look euphoric" or "we don't look this happy") that was followed by thoughts about the intrusion (e.g., "Rob, therefore, is not the ONE"). Thoughts about the intrusions or the meaning we give to intrusive thoughts, Lilly acknowledged, made her feel very anxious and guilty (emotional response) and she immediately responded by telling herself "We are very happy. He is smart and I love him". Following several such examples, they determined that Lilly's unhelpful responses were driven, at least to some extent, by her need to reduce anxiety, provoked by the meaning she gave to intrusions.

ROCD and maladaptive beliefs: The therapist explained that maladaptive beliefs might lead to negative and even catastrophic interpretations of commonly occurring intrusive thoughts. Such interpretations often lead to dysfunctional responses that maintain, or even increase, the distress associated with the intrusions. The therapist then asked Lilly to complete several questionnaires assessing her most prominent maladaptive beliefs. She showed high scores on the Extreme Love Beliefs

scale (EXL; see Table 1), Importance of Thoughts scale of the Obsessive Beliefs Questionnaire-Short (OBQ-S; Moulding et al., 2011), the overestimation of the consequences of being in the wrong relationship subscale of the Relationship Catastrophization Scale (RECATS; see Table 1) and the Fear of Regret scale (FOR; see Table 1).

Lilly's obsessive peaks often followed thoughts relating to daily events contradicting her beliefs about how she should feel (e,g., euphoric, relaxed, without any negative feelings), think (e.g., constantly thinking about the partner, having no critical thoughts) and act (e.g., never look at other men) in the "right" relationship. Such relational events, therefore, would be interpreted as signs that she might not be "truly in love" with her partner and that her partner was not the Right One. The therapist and Lilly, therefore, decided to start by focusing on Lilly's extreme love beliefs.

High scores on items such as " If the relationship is not completely harmonious, it is unlikely to be 'true love'" and "It is not 'true' love, if you do not feel good all the time" on the EXL resonated Lilly's extreme love expectations. Lilly was, therefore, asked to note her beliefs regarding how one should feel, think and behave during relationships. Lilly then took it upon herself to survey her friends regarding their relational views. Contrary to her expectation, most respondents of the survey did not show extreme relational beliefs. More importantly, responses from the friends she viewed as having a "perfect" relationship considered emotional fluctuations and negative emotions a natural part of romantic relationships. They reported regularly experiencing different degrees of negative (e.g., anger, frustration and apathy) and positive emotions (e.g., affection, attraction and tenderness) during their relationship. They also recalled having a wide range of thoughts including doubts regarding their

relationship and criticism of their partner. Importantly, these friends also described a less stringent interpretation of their own behaviors (e.g., looking at other men is not harmful). The therapist then asked Lilly to consider scenarios whereby her extreme relational beliefs (e.g., of continuously thinking about one's partner) were to materialize. What would she expect the impact of such scenarios to have on her social, work, and family functioning and on the relationship itself? On second thought, Lilly declared, such relational expectations might be neither realistic nor desirable.

Lilly and the therapist decided to summarize these conclusions on a card or what they called a CBT-note. On one side of the card, Lilly wrote beliefs: "If the relationship is not completely harmonious, it is unlikely to be 'true love'" or "If you don't continuously think about your partner, he is not the ONE". Challenging these beliefs, on the other side of the card she wrote: "Does a completely harmonious relationship exist? Are feelings constant? Do I really want to think about my partner all the time? What would the impact of that be?"

Lilly believed that having doubts regarding the relationship might suggest that this relationship was not right for her. She therefore constantly attempted to suppress her thoughts, contradict them (using reassurance), and recall situations where she was sure about her partner. Challenging Lilly's beliefs regarding the importance and control of thoughts, the therapist proposed an alternative interpretation – Lilly's attempts to control her thoughts and doubts increased their frequency and associated distress. In order to test this hypothesis, the therapist and Lilly undertook the Pink Elephant behavioral experiment (see Bennett-Levy et al., 2004 for detailed description). As expected, trying "not to think" about a pink elephant made the thoughts more noticeable and frequent. Lilly and the therapist agreed to write another

CBT-note to summarize this conclusion. On one side of this note Lilly wrote: "If I have doubts, there is a problem with the relationship or my partner is not the one". On the other side of the card she wrote: "My mishandling of intrusions may increase doubts −Pink Elephant".

For the next several sessions, Lilly and the therapist used a variety of exposure and response prevention (ERP) exercises in order to break the link between her maladaptive appraisals and unhelpful responses. For instance, Lilly was asked to repeatedly trigger her doubts and preoccupations by having sentences such as "I don't feel euphoric"; "I have doubts" as frequent reminders on her phone. She was then to avoid using unhelpful responses (e.g., searching on the web for answers or use self-reassurance), but rather experience how the anxiety dissipated after a while.

Although somewhat reduced, Lilly's reaction to relationship doubts seemed to persist. Fear of regret was identified as an additional maintaining factor of the distress following relationship doubts. Indeed, Lilly endorsed items such as "I find the feelings after I make a wrong decision hard to tolerate" and "The thought that I may have made a better choice is distressing to me" on the FOR scale (see Table 1). The therapist and Lilly, therefore, decided to work on attenuating Lilly's fear of regret and the experience of regret. Initially, Lilly and the therapist built an exposure hierarchy of regret exposures whereby she was asked to purposely make wrong choices in everyday decisions (e.g., about shoes, food, movies, and books). This led Lilly to slightly revise her expectations of not being able to cope with the experience of regret.

Lilly's fear of regret, however, often expressed itself in "catastrophic relational scripts" − abstract mental images of hypothetical worst case scenarios of making the wrong relational decision and the distress associated with them. She feared that remaining with Rob was the "wrong" relational choice that would lead her to a

miserable life. Conversely, she dreaded leaving Rob as she might later realize she missed the "love of her life". Thus, Lilly was faced with "catastrophic relational scripts" irrespective of her relational decision. Moreover, Lilly felt that these catastrophic relational scripts were beyond her control, that they were automatic.

As a first step, the therapist introduced to Lilly the Identify, Delay And Respond (I DARE) technique. Once identifying her relational intrusion, Lilly was taught to wait ten seconds and only then (if she chose) start the elaboration of her scripts. During these ten seconds, she was asked to consider whether she was interested in articulating (again) to herself the possible negative consequences of a wrong relational decision. Lilly quickly learned that such ruminations were deliberate actions under her control and that she could choose whether to initiate them. She also felt she could apply this method to many of her other maladaptive interpretations of intrusions.

Getting more control over the formation of catastrophic scripts was useful for Lilly's sense of competency and self-efficacy. Overcoming fear of regret, however, had to involve "facing" her catastrophic scripts. To better understand and deal with these scripts, Lilly and the therapist decided on repeated and systematic imagined exposure. Exposure for Lilly included writing (and then reading) these catastrophic scripts in as much emotional detail as possible, in the first person, and in the present tense. Lilly wrote the following script: All I have is my work. My personal life is a mess. I live with Rob, but I do not want to be with him. I don't want to spend time with him. I thought he was not intelligent enough, but this is far worse. I can't talk to Rob, I find him so dull. It is like we are having the same conversations again and again. I go to work and complain to my friends about him. I feel trapped. I have the children at home, but I do not want to come home and have to face him. I am ashamed

to socialize with others while with him. I want out of this horrible relationship, but I can't leave because of the children. I ask myself "How did I marry this man?" I feel sorry for myself and I regret every moment I am in this relationship. I think to myself that "this was a terrible mistake".

These exposure exercises followed by a discussion of the meanings and emotions associated with them (i.e., emotional processing) helped diminish Lilly's fears by facilitating the incorporation of new information regarding her role as an agent in her own life (i.e., the course of relationships is not predetermined), her capabilities (e.g., tolerating uncertainty and negative emotions) and the skills she felt she needed to improve (e.g., assertiveness). "Now", Lilly announced, "I feel more confident that I can reduce the chances of such situations occurring and I feel strong enough to cope with them if they do".

ROCD related self-vulnerabilities: Lilly attributed extreme importance to the success of her romantic relationships. She described being attuned and emotionally responsive to most relational events. Indeed, self-vulnerability in the relationship domain increases attention and hypervigilance to relationship-related occurrences. To evaluate this potential susceptibility, the therapist used the Relationship Contingent Self-Esteem questionnaire (RCSE; Knee et al., 2008). The RCSE assesses the extent to which one’s self-regard is dependent on the nature, process, and outcome of one’s relationship. Lilly showed very high scores on items such as "An important measure of my self-worth is how successful my relationship is" and "I feel better about myself when it seems like my partner and I are emotionally connected", suggesting high contingency in this self-domain.

Lilly's self-esteem was also very much influenced by the way she viewed Rob's attributes and the way she believed others perceived him. Lilly was particularly

sensitive to Rob's level of intelligence and "complexity". This self-esteem contingency was evident in her high scores on items such as "My partner's flaws reflect on me" and " My self-esteem suffers when my partner fails" on the partner-value contingent self-worth scale (PVCSW). This recently developed measure (currently undergoing psychometric validation) assesses the extent that perceived failures or flaws of the partner impact on one's own self-esteem.

Lilly and her therapist examined and challenged the links between her feelings of self-worth and perceived relational failures. They identified the rules of competence she applied to this self-domain (e.g., How is one expected to act in relationships? How would you expect a good relationship to be?) and examined the boundary of this domain (e.g., To what extent do romantic relationships have to dominate one's life). Lilly and her therapist also explored other sources of self-worth (e.g., professional, academic, social, creative and artistic) and she was encouraged to reconnect to activities neglected since the beginning of the current relationship.

The therapist and Lilly then tried to understand her reactions to Rob's perceived deficiencies, particularly in the intellectual domain. Lilly described becoming increasingly perfectionistic and attuned to criticism of her own intelligence following several incidents in her childhood and early adulthood. During these distressing and shame provoking incidents, Lilly felt that others had underestimated her intelligence and competence. Her preoccupation with her partner's intelligence, she realized, was partly due to her own sensitivity and increased monitoring in this domain. The therapist and Lilly went on to explore her perception of Rob. Lilly discovered what she already knew − although Rob had a tendency to make a "fool" of himself, she did not perceive him as less intelligent than her. The therapist and Lilly decided to add another CBT-note. On one side of the card Lilly wrote unwanted

thoughts relating to her partner's value: "He is not intelligent"; "People judge me based on my partner". On the other side of the same card, Lilly noted reminder phrases of what she felt were important insights from her discussions with the therapist: "That is his sense of humor", "I am sensitive and hypervigilent to criticism in this domain" and questions that challenged her current beliefs: "Am I acting from my own sensitivities?", "Do I judge my friends based on their partners?". Lilly was asked to go over all her CBT-notes regularly, preferably in the morning, but not following intrusion and obsessive spikes (e.g., for self-reassurance). These daily reminders reduced Lilly's tendency to over-monitor her partner's behavior and to engage in maladaptive reactions to intrusions (e.g., over-analyzing, compulsive doubts and catastrophizing scripts).

Identifying and challenging Lilly's self-sensitivities and their impact helped Lilly cope with her reactivity to relational events. Increased attention to particular intrusions, however, does not inevitably lead to anxiety, distress and other negative responses. We all have intrusive thoughts and we all pay attention to some intrusions more than to others. Attachment insecurities may hinder adaptive coping with unwanted intrusions.

ROCD and attachment insecurities: Lilly described an intense apprehension of being trapped in a relationship that was not suitable for her. This anxiety was echoed in her strong adherence to items such as " I believe that making the wrong romantic choice is often a terrible thing" and " I believe that being in the wrong relationship almost always leads to a wasted life" on the RECATS (see Table 1). Lilly's fear of being in the "wrong" relationship, however, seemed to be fueled by dread that her partner would not be available or adequately responsive in times of need (i.e., attachment anxiety). Indeed, Lilly strongly endorsed items such as " I worry

that romantic partners won't care about me as much as I care about them" and " I get frustrated when my partner is not around as much as I would like" on the anxiety scale of the Experience of Close Relationship scale (see Table 1).

Lilly's early life experiences had been dominated by frequent parental conflict. More specifically, her parents had shown mutual disrespect and, at times, even contempt during her childhood years. They had criticized each other in public and at home, often abusing each other verbally. During these frequent episodes, Lilly recalled hoping her parents would get divorced, feeling frightened, alone and helpless. At the same time, these incidents were associated with intense fear of her parent's separating and her mother abandoning them.

Lilly's memories of her parents' relationship seemed to fuel her attachment insecurities and catastrophic perception of relationships. One incident seemed to particularly stand out for her, encapsulating the meaning of these early experiences − her mother repeatedly calling her father a "nobody" and a "loser" and stating that she would have left already had it not been for the children. Her father had done nothing and had just stared at the opposite wall. The therapist, therefore, decided to use Imagery Rescripting (Holmes, Arntz, & Smucker, 2007) in order to provide Lilly with a more realistic (e.g., "Some people are more predictable than others", "One can end a relationship he is not happy with") and less toxic (e.g., "I do not have to be like my parents") appraisal of these experiences.

In the imagery rescripting session, Lilly was instructed to bring up the memory of this specific incident. She was then asked to describe in detail what was occurring (in present tense and first person perspective) and elaborate on her thoughts, feelings, sensations and needs. Lilly, imagining herself as a child, expressed a strong sense of injustice about her mother's behavior towards her father whom she viewed as

kind hearted. She was distressed at the unpredictability of her mother's outbursts, thinking: "Not again. This time she is going to leave. This is terrible. Why don't they break up? Why do they have to continue like this? I feel tense all over; everything is loud; I want to hide and I know I will never get married!" Lilly was then asked to enter the imagery as her own adult self and tell her mother what she felt and needed. Lilly entered the imagery, confronted her mother, and told her how her behavior had made "little Lilly" feel and what she needed. She asked her mother to "stop exploding" and to promise she would never abandon her. She also asked her mother to be more respectful towards her father "because he is my father and a kind man".

During the debriefing, Lily described feeling empowered when she confronted her mother, sheltered by her older self. She also described the attenuation of her anxiety of being abandoned and of being unprotected. Encouraged by the effects of this exercise, Lilly wanted to use imagery rescripting to express her needs to her father. In the following session, therefore, Lilly entered the imagery and told her father she needed him to be "stronger", more active in her life and show her that he could protect her and her mother.

The imagery rescripting sessions attenuated Lilly's core fears by enabling more adaptive appraisals of early experiences. Lilly was now able to see how being exposed to parental conflict contributed to her fear of being trapped in a failed relationship. These exercises also allowed Lilly to better recognize how different she was from her mother in terms of emotional regulation skills and personality attributes. Although her critical voice was similar to her mother's, she was very different from her. Rob, Lilly also realized, was very different from her father – her was assertive and gave her a feeling of security. Finally, Lilly's fears of not being able to get out of a "bad" relationship were attenuated by learning to identify when "things go wrong"

in the relationship and how to express her needs assertively (but not aggressively) when they do.

ROCD and relational commitment: Relational commitment is an important aspect of intimate relationships (Rusbult, 1998). ROCD symptoms may impact directly on commitment related processes by increasing preoccupation with potential alternative partners and indirectly by decreasing relationship satisfaction and relational investment.

Lilly still showed some sensitivity to potential alternative partners. The therapist and Lilly therefore decided on some ERP exercises for her to deal with the compulsion to check on potential partners on the web (e.g., Facebook photos and statuses, Tweets, and others). For instance, Lilly was to go over her Facebook feed, recognize potential partners (i.e., looked good or shared interesting statuses), but avoid further checking. Initially, this exercise proved difficult for Lilly as she believed she would not be able to resist the strong urge check and "to know" a little more about the person. With time, however, these behavioral exercises challenged this belief. The urge to check subsided and Lilly could more easily look at other potential partners and her Facebook feed without fear.

Lilly's level of investment in the relationship was low. She had feared that initiating fun activities such as going out to a bar, going to the movies or even having sex would give Rob the wrong impression that she was ready to commit. More quality time with Rob, she feared, might also lead to a clearer understanding that he was not the One. Moreover, such activities often triggered intrusive thought and compulsive behaviors (e.g., over-monitoring of her feelings and comparing). This apparent lack of investment in the relationship and reduced sexual activity had led to relational conflict and had reduced relationship satisfaction for both Lilly and Rob. The therapist

suggested testing an alternative strategy. Now that Lilly's ROCD symptoms and cognitions were significantly attenuated, interaction with Rob would allow her to experience the relationship more fully and make more informed decisions about the future of the relationship.

Lilly's increased level of investment in the relationship and associated time spent with Rob was a positive experience for both of them. Lilly and the therapist then went on to examine which qualities and characteristics Lilly believed to be essential for a potential partner, and which were less important. Lilly was happy to discover that Rob had many of the crucial qualities, although not all of the desired characteristics. Lilly decided that she was willing to accept and mourn the lack of these desired characteristics. She felt that she wanted Rob and loved him.

At the end of therapy, some clients choose to pursue the current relationship others end up breaking up. Successful treatment would substantially reduce ROCD symptoms and cognitions and promote relational decisions based on factors related to the quality of the relationship including mutual trust, feelings of closeness, communication, similar values and relational expectations.

Concluding remarks

In this chapter, we have presented an integrative, modular, CBT approach to the treatment of ROCD. We used the character of Lilly in order to exemplify assessment and interventions strategies we found useful in our dealings with ROCD within romantic relationships. ROCD symptoms, however, may occur in a variety of relational contexts including parent-child and individual-God relationships. Future research would benefit from exploring similar processes in such relational context, adjusting and refining the model accordingly. This new body of literature would also benefit from using larger clinical samples and the examination of different clinical

groups. This would facilitate the identification of specific factors associated with ROCD symptoms. Longitudinal designs and more experimental manipulations would help establish causal between the hypothesized processes in the proposed ROCD model.

In our experience, a client-tailored modular approach is useful with ROCD clients. The goal of therapy is to reduce ROCD such that the client is able to reach an informed decision regarding his/her relationship. Back to Lilly…as therapy progressed, Lilly's sensitivities shifted and her extreme views about love and relationships weakened. Triggers became less frequent and distressing; her catastrophizing scripts were reduced and her relational fears significantly attenuated. When therapy neared its end, Lilly was able to make the decision to marry Rob. Although Lilly still deals with obsessive spikes every now and then, she manages them well. Lilly is happy and is pleased with her relational choice.

References

Bennett-Levy, J., Butler, G., Fennell, M., Hackmann, A., Mueller, M., & Westbrook, D. (Eds.). (2004). Oxford guide to behavioural experiments in cognitive therapy. Oxford: Oxford University Press.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation: Anxiety and anger*. New York: Basic Books.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46-76). New York: Guilford Press.

Doron, G., & Kyrios, M. (2005). Obsessive compulsive disorder: A review of possible specific internal representations within a broader cognitive theory. *Clinical Psychology Review, 25*, 415-432.

Doron, G., Sar-El, D., & Mikulincer, M. (2012). Threats to moral self-perceptions trigger obsessive compulsive contamination-related behavioral tendencies. *Journal of Behavior Therapy and Experimental Psychiatry, 43*, 884-890.

Doron, G., Derby, D., Szepsenwol. O., & Talmor. D. (2012a). Tainted Love: Exploring relationship-centered obsessive compulsive symptoms in two non-clinical cohorts. *Journal of Obsessive-Compulsive and Related Disorders, 1*, 16-24.

Doron, G., Derby, D., Szepsenwol. O., & Talmor. D. (2012b). Flaws and all: Exploring partner-focused obsessive-compulsive symptoms. *Journal of Obsessive-Compulsive and Related Disorders, 1,* 234-243.

Doron, G., Derby, D., & Szepsenwol. O. (2014a). Relationship obsessive compulsive disorder (ROCD): A conceptual framework. *Journal of Obsessive-Compulsive and Related Disorders,* 3, 169-180.

Doron, G., Szepsenwol. O., Karp. E., & Gal. N. (2013). Obsessing about intimate-relationships: Testing the double relationship-vulnerability hypothesis. *Journal of Behavior Therapy and Experimental Psychiatry,* 44, 433-440.

Doron, G., Mizrahi, M., Szepsenwol, O., & Derby, D. (2014). Right or flawed: relationships, obsessions and sexual satisfaction. *Journal of Sexual Medicine, 11, 2218-2224*

Doron, G., & Szepsenwol, O. (2014). Partner-focused obsessions and self perceptions: An experimental investigation. Under review

Doron, G., Derby, D., Szepsenwol. O., Nahaloni. E, & Moulding. R. (2014b). Relationship obsessive-compulsive disorder (ROCD): Symptoms and maladaptive beliefs in clinical cohorts. Under review.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. (2012). Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Clinician Version, Administration Booklet. American Psychiatric Pub.

Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., et al. (2002). The Obsessive–Compulsive Inventory: Development and validation of a short version. *Psychological Assessment,* 14, 485–496.

Foa, E. B., Huppert, J. D., & Cahill, S. P. (2006). *Emotional processing theory: an update*. In: B. O. Rothbaum (Ed.), *Pathological anxiety: emotional processing in etiology and treatment* (pp. 3–24). New York, NY: Guilford Press.

Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., Heninger, G. R., & Charney, D. S. (1989). The Yale-Brown obsessive compulsive scale: I. Development, use, and reliability. *Archives of General Psychiatry*, 46(11), 1006-1011.

Holmes, E. A., Arntz, A., & Smucker, M. R. (2007). Imagery rescripting in cognitive behaviour therapy: Images, treatment techniques and outcomes. *Journal of*

Behavior Therapy and Experimental Psychiatry, 38(4), 297-305.

Knee, C. R., Canevello, A., Bush, A. L., & Cook, A. (2008). Relationship-contingent self-esteem and the ups and downs of romantic relationships. *Journal of Personality and Social Psychology, 95,* 608-627.

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33*(3), 335-343.

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change.* New York: Guilford Press.

Moulding, R., Anglim, J., Nedeljkovic, M., Doron, G., Kyrios, M., & Ayalon, A. (2011). The Obsessive Beliefs Questionnaire (OBQ): Examination in non-clinical samples and development of a short version, *Assessment*, 18, 357-374.

Obsessive Compulsive Cognitions Working Group (2005). Psychometric validation of the Obsessive Beliefs Questionnaire: Factor analyses and testing of a brief version. *Behaviour Research and Therapy, 43*, 1527-1542.

Oosthuizen, P., Lambert, T., & Castle, D. J. (1998). Dysmorphic concern: prevalence and associations with clinical variables. *Australian and New Zealand Journal of Psychiatry*, 32(1), 129-132.

Rachman, S., & de Silva, P. (1978). Abnormal and normal obsessions. *Behaviour Research and Therapy, 16,* 233-248.

Radomsky, A. S., Alcolado, M. G., et al., (2014). Part 1. You can run but you can't hide: Intrusive thoughts on six continents. *Journal of Obsessive- Compulsive and Related Disorders, 3, 269-279.*

Rusbult, C. E., Martz, J. M., & Agnew, C. R. (1998). The investment model scale: Measuring commitment level, satisfaction level, quality of alternatives, and

investment size. *Personal Relationships, 5*, 357-391.

Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E et al., (1998). The Mini-International Neuropsychiatric Interview (MINI): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry*, 59, 22-33.

Storch, E. A., Abramowitz, J. S., & Goodman, W. K. (2008). Where does obsessive compulsive disorder belong in DSM-V?. *Depression and Anxiety*, 25, 226–247.

Table 1: Examples of ROCD related compulsions and maladaptive responses

Compulsions and maladaptive responses	Examples
Checking	Looking for information about relationships or about partner qualities on the internet/internet forum (e.g., "I am not sure about my feelings"; "not sure my partner is smart enough") or testing of the partner's behaviors (e.g., Did I think about my partner enough? Does my partner answer questions intelligently? Does my partner react properly in social situations?).
Monitoring (internal states)	Monitoring for current feelings (e.g., What am I feeling right now? Am I attracted to my partner?), their strength and their extent (e.g., Is this feeling "right" or "strong" enough?).
Neutralizing	Holding the opposite thought in mind, recalling situations where expectations were met, elaborating and reanalyzing the potential negative consequences of making the wrong decision (catastrophic scripts).
Comparison	Comparing qualities of the partner to other potential partners (e.g., colleagues, partners of her friends, acquaintances or an internal image of ideal partner) or feelings towards past partners.
Reassurance	Consulting with friends, family, therapists and even fortune tellers and psychics.
Self-criticism	Degrading self-talk (e.g., "I am selfish", "I am unappreciative", "I am stupid for thinking like this").
Avoidance	Avoiding social situations (e.g., meeting with certain friends) or particular leisure activities (e.g., going to romantic movies, watching romantic comedies on television).

Table 2: Suggested tools for assessment of ROCD symptoms and related phenomena (see http://rocd.net/helpful-measures, for full questionnaires)

Domain	Questionnaire	Item Examples
Symptoms		
Relationship-centered	Relationship obsessive compulsive inventory (ROCI; Doron et al., 2012a)	"I check and recheck whether my relationship feels 'right'".
Partner-focused	Partner related obsessive compulsive symptoms inventory (PROCSI; Doron et al., 2012b)	"When I am with my partner I find it hard to ignore her physical flaws".
Self		
Relationship contingencies	Relationship contingent self-esteem (RCSW; Knee et al., 2008)	"My feelings of self-worth are based on how well things are going in my relationship".
Partner value contingency*	Partner-value contingent self-esteem (PVCSW)	"When others perceive my partner negatively, I feel like I am perceived in the same way".
Beliefs		
Catastrophic relationship beliefs	Relationship catastrophization scale (RECATS; Doron, Derby et al., 2014b)	"For me, being in an imperfect relationship is like betraying myself".
Extreme love beliefs*	Extreme love beliefs scale (EXL)	"If the relationship is not completely harmonious, it is unlikely to be “true love”.
Fear of regret*	Fear of anticipated regret (FOR)	"I avoid decisions because I fear the feelings that may follow".
Attachment insecurities		
	Experience of close relationships (ECR; Brennan, 1998)	"I find that my partners don’t want to get as close as I would like".
Commitment		
	The investment model scale (Rusbult et al., 1998)	"I want our relationship to last for a very long time".

* Currently undergoing psychometric validation