

# “Why do I obsess about my child’s flaws?”: Assessing the role of parental self-vulnerabilities in parent–child relationship obsessive compulsive disorder (ROCD) symptoms

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## Abstract

**Objective:** Relationship obsessive compulsive disorder (ROCD) is a manifestation of obsessive compulsive disorder (OCD) that refers to obsessions, doubts, and compulsive behaviours focusing on one's relationship and relationship partner. ROCD symptoms occur in various types of relationships including parent–child dyads, involving obsessional preoccupations with the perceived flaws of one's child (parent–child ROCD symptoms). Such preoccupations have been shown to be associated with decreased mood and significant parental distress. We examined the double self-vulnerability hypothesis—that the co-occurrence of parental contingency of self in specific domains (i.e., intelligence and appearance) and child-value contingent self-worth would be associated with increased parent–child ROCD symptoms.

**Method:** A total of 175 parents participated in the study and completed self-report questionnaires to assess ROCD and depressive symptoms and parental self-contingencies. We used linear regression with simple slope analyses to estimate interaction effects.

**Results:** Parents whose self-worth were strongly dependent on their child's perceived value showed higher parent–child ROCD symptoms, particularly when co-occurring with parental intelligence and appearance self-contingencies. These findings were maintained when controlling for depression symptoms, parental age, and gender.

**Conclusions:** Results supported the double self-vulnerability hypothesis suggesting that parents with child-value and domain-relevant self-vulnerabilities might be susceptible to child-related obsessions. More research is needed to further explore susceptibility of vulnerable parents to the development and maintenance of parent–child ROCD symptoms.

## KEYWORDS

OCD, parent–child ROCD symptoms, parenting, relationships, ROCD

## 1 | INTRODUCTION

Relationship obsessive compulsive disorder (ROCD) is an impairing form of obsessive compulsive disorder (OCD) comprising of obsessive compulsive (OC) symptoms that focus on close relationships (Doron, Derby, Szepsenwol, Nahaloni, & Moulding, 2016; Melli, Bulli, Doron, & Carraresi, 2018; Trak & Inozu, 2019). Within romantic relationships, ROCD symptoms often involve disabling obsessional doubts regarding the relationship itself and/or obsessional preoccupation with the partner's perceived flaws (Doron, Derby, & Szepsenwol, 2014). Within the parent-child dyad, ROCD symptoms manifest as parental excessive preoccupation with children's perceived flaws (Doron, Derby, & Szepsenwol, 2017). Such parent-child ROCD symptoms have been shown to uniquely contribute to parental depression, OCD symptoms, distress, and to be relatively common (Doron et al., 2017). In this study, we aimed to examine processes contributing to the development and maintenance of parent-child ROCD symptoms. Consistent with previous finding linking OCD (Aardema et al., 2018; García-Soriano, Clark, Belloch, del Palacio, & Castañeiras, 2012) and ROCD symptoms (Doron & Szepsenwol, 2015; Doron, Szepsenwol, Karp, & Gal, 2013) with thematically relevant self-vulnerabilities, we assessed whether parent-child ROCD symptoms are associated with parental self-vulnerabilities.

### 1.1 | ROCD symptoms

Research has identified two related, but conceptually distinct ROCD symptom presentations (Szepsenwol, Shahar, & Doron, 2016). The first presentation, relationship-centred ROCD symptoms, comprises extreme doubts and preoccupation pertaining to the relationship experience itself including one's feelings towards the relationship partner, the partner's feelings towards oneself, and the "rightness" of the relationship (Doron et al., 2013; Doron, Derby, Szepsenwol, & Talmor, 2012b). The second presentation, partner-focused symptoms, concerns extreme preoccupation with the perceived flaws of the relationship partner including the partner's personality attributes, physical appearance or social skills (Doron, Derby, Szepsenwol, & Talmor, 2012a; Szepsenwol et al., 2016).

Like in other OCD symptom dimensions, a wide variety of compulsive behaviours may be associated with ROCD symptoms. These may include repeated comparisons with potential alternative partners, monitoring one's feelings, neutralising, obsessive analysing, and reassurance seeking (Doron, Derby, & Szepsenwol, 2014). ROCD symptoms have been associated with significant personal

### Key Points

1. Parent-child ROCD symptoms are associated with parental self-vulnerabilities.
2. Double parental self-vulnerability is associated with increased ROCD symptoms.
3. Vulnerable parents may be sensitive to particular child-related intrusions.

and relational distress and disability (Doron, Derby, et al., 2016; Doron, Mizrahi, Szepsenwol, & Derby, 2014). For instance, Doron, Derby, et al. (2016) compared individuals diagnosed with OCD, ROCD, and community controls, and found similar levels of impairment and distress in the ROCD and OCD clinical groups. Thus, ROCD symptoms might cause severe personal and dyadic distress and impaired functioning in various aspects of one's life (Doron, Derby, & Szepsenwol, 2014).

### 1.2 | Parent-child ROCD symptoms

Although parenthood is considered one of the most rewarding and empowering tasks of adulthood, the parenting experience often includes various negative emotions, such as doubt, worry, stress, fear, anxiety, and insecurity (Dix, 1991; Koeske & Koeske, 1990). Naturally, parents strive to protect their children from negative experience. Parental fears, however, may stem from their own previous experiences, particularly distressing ones (Cooper & Nickerson, 2013). Parental attempts to avoid potential sources of future harm, therefore, may unintentionally lead to the over-identification of perceived deficiencies in their children's personality characteristics, skills, and physical features (Doron et al., 2017). For instance, a father may start being preoccupied with his child's social skills fearing his son would be bullied, as he was during his childhood years. Similarly, parents who want their child to be particularly successful may be over-concerned with their child's intelligence. In some cases, everyday parental concerns may develop into severe parental preoccupation regarding their child's perceived physical, personality, or behavioural flaws (Doron et al., 2017).

Parents with parent-child ROCD symptoms often experience unwanted intrusions including thoughts ("Is my child socially competent?"), images (e.g., of specific facial features), or urges (e.g., to intervene in a social interaction) associated with their child's presumed flaws (Doron et al., 2017). These intrusive experiences may defy the parental values (e.g., "I should never criticise my

child) and/or subjective experience (e.g., “s/he has many friends, why can’t I stop being preoccupied with her social skills”), and lead to parental guilt and shame (Doron et al., 2017). Parent–child ROCD symptoms also involve compulsions, including repeated comparisons of the child to other children, including siblings, checking of the child’s behaviours, and reassurance seeking regarding the child’s competencies and perceived flaws (Doron et al., 2017).

Previous findings suggest that parent–child ROCD symptoms may be relatively common and may have a significant impact on parental well-being and the parental experience (Doron et al., 2017). For instance, in a recent online study of 350 parents from the USA, 9.5% of parents reported spending at least 1–3 hr a day being preoccupied with the perceived flaws in their eldest child’s appearance, personality, or aptitude. Furthermore, 4.1% of parents reported interference following such preoccupation and as much as 11.6% reported at least moderate distress associated with such obsessions (Doron et al., 2017). Moreover, findings from this study suggested that scores on the parent–child version of the Partner-Related Obsessive Compulsive Symptoms Inventory (PROCSI-PC) (Doron, Derby, et al., 2012b) were associated with parental depression and anxiety over and above parental OCD symptoms, and were associated with parental stress over and above parental depression, OCD symptoms, and age (Doron et al., 2017). These findings are consistent with previous descriptions of disability and distress associated with parent–child ROCD symptoms within the physical appearance domain (body dysmorphic disorder by proxy; American Psychiatric Association (APA), 2013; Bakhla, Prakriti, & Kumar, 2012; Bouman & Gofers, 2016; Greenberg, Mothi, & Wilhelm, 2016).

### 1.3 | Self-vulnerability and parent–child ROCD symptoms

According to cognitive-behavioural accounts of OCD, most individuals experience a range of unwanted intrusive experiences (i.e., thoughts, urges, and images; Rachman & de Silva, 1978). The misinterpretation of common intrusions based on maladaptive beliefs (e.g., inflated responsibility, and importance of thoughts) and the mismanagement of these intrusions, results in OC symptoms (Obsessive Compulsive Cognitions Working Group, 1997; Salkovskis, 1985).

Accumulating research suggests that pre-existing self-vulnerabilities might contribute to the development of specific obsessional content (Aardema & O’Connor, 2007; García-Soriano et al., 2012). For example, thoughts and events that challenge highly valued self-domains

(e.g., the moral self-domain) may threaten a person’s sense of self-worth in this domain, intensifying the activation cognitions and behavioural tendencies intended to reduce such perceived threat (Doron & Kyrios, 2005; Doron, Sar-El, & Mikulincer, 2012). However, maladaptive coping responses such as thought suppression or reassurance seeking may further increase the occurrence of unwanted intrusions and cognitions (e.g., “I’m immoral”, “I’m unworthy”; Doron & Szepsenwol, 2015). In this way, common aversive experiences may activate overwhelmingly negative evaluations in sensitive self-domains (Doron, Kyrios, & Moulding, 2007) that together with the activation of other dysfunctional cognitions (e.g., inflated responsibility, and threat overestimation), can result in the development of obsessions and compulsions (Doron, Kyrios, & Moulding, 2007; Doron, Kyrios, Moulding, Nedeljkovic, & Bhar, 2007; Doron, Moulding, Kyrios, & Nedeljkovic, 2008).

Consistent with this proposal, research has demonstrated that information threatening one’s moral self-perceptions leads to increased activation of OCD-related maladaptive beliefs (e.g., perfectionism; Abramovitch, Doron, Sar-El, & Altenburger, 2013). In addition, OCD symptoms have been associated with vulnerabilities in relevant self-domains (Doron, Sar-El, & Mikulincer, 2012; García-Soriano et al., 2012). For example, the co-occurrence of relationship contingent self-worth and attachment anxiety (i.e., double relationship-vulnerability) has been shown to be associated with relationship-centred behavioural tendencies using correlational and experimental designs (Doron et al., 2013).

Partner-focused ROCD symptoms were also associated with self-esteem contingencies. For instance, Doron and Szepsenwol (2015) have demonstrated that compared with two other control groups, a significant decrease in self-esteem following priming of ROCD-like intrusions (i.e., unfavourable comparisons with alternative partners) was shown only in participants with high levels of pre-existing partner-focused ROCD symptoms. Interestingly, intrusions comparing one’s partner favourably to others did not have a similar positive effect on self-esteem. Doron and Szepsenwol (2015) concluded that partner-value self-sensitivity is a potential perpetuating mechanism involved in partner-focused OC phenomena. Previous studies have linked domain-specific self-vulnerability with theme-related OCD symptoms (Doron et al., 2013; Doron, Sar-El, & Mikulincer, 2012). We propose that increased vigilance towards a particular theme (e.g., physical appearance) would intensify one’s detection of unwanted theme-related events and intrusive thoughts concerning both self (e.g., “I am ugly”) and others (“S/he does not look good”). Like in other OC symptoms, pre-existing maladaptive cognitions

(e.g., perfectionism; Melli et al., 2018) would then be triggered, resulting in a dysfunctional management of such intrusions (e.g., thought suppression) and perpetuating the obsessive cycle.

Consistent with findings relating to partner-focused ROCD symptoms (Doron & Szepeswol, 2015), we further suggest that susceptibility to parent-child ROCD symptoms may be associated with an additional self-vulnerability: child-value contingent self-worth (CVCSW) (Doron et al., 2017). This self-vulnerability can be defined as parents' over-reliance on the perceived value of their child as a source of self-worth (Doron et al., 2017; Trak & Inozu, 2019). CVCSW, therefore, is the extent to which the perceived failures or flaws of the child affect parents' own self-worth.

## 1.4 | The current study

The co-occurrence of two parental self-contingencies was expected to increase vulnerability to parent-child ROCD symptoms: specific self-domain contingency (e.g., the extent to which they consider the physical appearance domain relevant to their self-worth) and child-value self-contingency (the extent to which they consider their child's characteristics relevant to their own self-worth) (Doron et al., 2013). This *double self-vulnerability* would increase parents' detection and maladaptive responses to child-related events in domains relating to their parents' vulnerable self-domain. We, therefore, hypothesised that high levels of parental CVCSW would be associated with increased parent-child ROCD symptoms, particularly for parents with self-contingency in specific domain (e.g., physical appearance or intelligence).

## 2 | METHODS

### 2.1 | Participants

One hundred and eighty Israeli parents were recruited through internet forums. Five participants were excluded due to inconsistent demographic information, leaving 175 participants, aged 31 to 66 ( $M = 42.05$ ,  $SD = 7.46$ ). More than half of the sample were females ( $N = 102$ , 58.3%). The age of participants' first born child ranged from 2 to 28 ( $M = 13.07$ ,  $SD = 7.07$ ). Participants completed the survey in one session and did not receive payment or benefit upon participating. They were informed of their rights and completed an online informed consent form. The present study was approved by the IDC Herzliya Institutional Review Board.

### 2.2 | Materials and procedure

The study was administered online using the web-based survey platform [www.qualtrics.com](http://www.qualtrics.com). Participants were recruited from parenting internet forums and invitations to participate in a parenting study posted on Facebook. Responses were saved anonymously and downloaded for the purpose of analysis. All of the participants were requested to complete self-report questionnaires detailed in the following. We randomised the order of the questionnaires across the participants. In order to avoid the confounding influence of birth order, participants were asked to refer only to their first born child as the subject of interest in all questionnaires (Doron et al., 2017).

The *Single-Item Self-Esteem scale* (SISE; Robins, Hendin, & Trzesniewski, 2001) required participants to rate their level of agreement with the sentence "I have a high self-esteem" on a 9-point scale, ranging from 1 (*not very true of me*) to 9 (*very true of me*). The SISE has been found to have high reliability and strong validity (Robins et al., 2001). We used the SISE as control in our analyses.

The *Depression Anxiety Stress Scales* (DASS, Antony, Bieling, Cox, Enns, & Swinson, 1998) is a self-report questionnaire listing three subscales of negative emotional symptoms including depression, anxiety, and stress. In the current study, participants were asked to address only the seven depression items that were rated on a scale ranging from 0 (*did not apply to me at all*) to 3 (*applied to me very much*). A depression measure was created from these seven items. In past studies the depression subscale of the DASS-21 demonstrated high internal consistency (Cronbach's  $\alpha = .88$ ) (Henry & Crawford, 2005). Cronbach's alpha of the depression index was .76. We used the depression subscale as control in the current study.

The CVCSW is an eight-item questionnaire assessing CVCSW. The CVCSW is an adapted version of the of the partner-value contingent self-worth scale (Doron, Derby, et al., 2016). In the CVCSW, participants rated how much they find their child's perceived flaws or achievements relevant to their self-worth in a positive (e.g., "The more my children are perceived positively, the higher my self-esteem") or in a negative way (e.g., "If my children do not succeed in something, I feel less of a success"), on a scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Confirmatory factor analysis (CFA) conducted on a separate sample of 237 community participants (68% female,  $M$  parent age = 39.5,  $SD = 7.93$ ,  $M$  child age = 15,  $SD = 3.31$ ) supported a two factor model (negative and positive contingencies) of the CVCSW (CFI = 0.97, RMSEA = 0.09, SRMR = 0.04). The two factors were composed of four items each and were highly correlated ( $r = 0.80$  between mean factor scores). They demonstrated



high internal consistency (Cronbach's alphas over 0.80). For this study, we used the negative subscale of the CVCSW (i.e., the CVCSW-N). This is in line with previous research that demonstrated that individuals with increased levels of partner-focused OC symptoms were specifically vulnerable to *negative* intrusions of their partner, and were not affected by positive intrusions (Doron & Szepeswol, 2015). Cronbach's alpha of the negative subscale was .84.

The PROCSI-PC (Doron et al., 2017) was adapted from the PROCSI (Doron, Sar-El, & Mikulincer, 2012) to the parent-child relationship context. In this 28-item measure, participants rate the extent to which they experience parent-child ROCD symptoms in six domains, including physical appearance, intelligence, morality, sociability, emotional stability, and competence. Ratings were made on a scale ranging from 0 (*not at all*) to 4 (*very much*) (Doron et al., 2017). In this study, the Hebrew original and validated version (Doron et al., 2017) was used. The four items of each of the physical appearance and intelligence domains were averaged separately to create the PROCSI-PC-A and the PROCSI-PC-I measures, respectively. In previous studies, the six subscales demonstrated high internal consistencies of Cronbach's alphas ranging from .75 to .89 (Doron et al., 2017). The Cronbach's alphas of the physical appearance and the intelligence subscales were .90 and .78, respectively.

The *Contingencies of Self-Worth Scale* (CSWS; Crocker, Luhtanen, Cooper, & Bouvrette, 2003) is a 35-item self-report questionnaire that required participants to rate the level to which they consider seven specific domains as relevant to their self-worth: appearance, others' approval, competition, academic competence, family support, god's love, and virtue. For the purpose of this study, participants were asked to address the five original items associated with appearance (e.g., "My self-esteem is influenced by how attractive I think my face or facial features are."). Participants were also requested to address five additional items in which we have made minor adaptations from academic competence to intelligence (e.g., "My self-esteem is influenced by my intelligence."). The items were rated on a scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The CSWS indexes have been found to have high test-retest reliability and internal consistencies with Cronbach's alphas ranging from .82 to .96 (Crocker et al., 2003). In the adapted intelligence subscale, we chose to exclude one of the reversed items due to its extremely low and negative correlation with the other items. After doing so, Cronbach's alphas for the intelligence and the appearance subscales in study 1 were .86 and .82, respectively. The items of each of the physical appearance and the intelligence subscales were averaged separately to create the ACSW and the ICSW measures, respectively.

## 2.2.1 | Statistical analysis

In order to characterise the associations between the study variables, we first examined their zero-order correlations. Next, we sought to examine whether the interaction between parental contingent self-worth in specific domains (intelligence and appearance) and CVCSW is associated with increased parent-child ROCD symptoms (PROCSI-PC-I). We conducted two separate regression analyses. In the first regression analysis, the predictor (Intelligence contingent self-worth), the moderator (CVCSW) and their interaction were simultaneously entered as predictor variables. The dependent variable was the PROCSI-PC-I. In the second regression model, the predictor (appearance contingent self-worth), the moderator (CVCSW), and their interaction were simultaneously entered as predictor variables. The dependent variable was PROCSI-PC-A. In both models, the predictors were standardised prior to the analysis in order to reduce multicollinearity and aid in interpretation. Interaction analyses were performed using SPSS.21 with the PROCESS macro (Hayes, 2012).

## 3 | RESULTS

Table 1 presents the correlations between the study variables. The intelligence and appearance subscales of the CSWS demonstrated a small to moderate correlation with the PROCSI-PC-I and with the PROCSI-PC-A. The CVCSW showed moderate correlations with the PROCSI-PC-I and with the PROCSI-PC-A subscales score. Preliminary analysis also demonstrated that depression, the parent's gender, and the parent's age were significantly correlated with PROCI-PC-I score (Table 1).

### 3.1 | Moderation analysis

#### 3.1.1 | Intelligence

In order to control for the effect of depression, parental age, and parental gender on the PROCSI-PC-I (Table 1), they were entered as covariates in the regression analysis. The regression model was significant ( $F_{[6, 166]} = 19.55$ ,  $p < .001$ ,  $R^2 = 0.41$ ). The analysis revealed a significant main effect for CVCSW ( $\beta = 0.46$ ,  $t = 5.06$ ,  $p < .001$ ), indicating that parents' increased dependency on the child's perceived value is associated with an increased tendency to obsess about their child's flaws in the intelligence domain. The main effect of intelligence contingent self-worth on the PROCSI-PC-I was not significant ( $\beta = 0.04$ ,  $t = 0.63$ ,  $p = ns$ ). These results, however,

**TABLE 1** Correlations between the study variables ( $N = 175$ )

	PROCSI-PC-A	PROCSI-PC-I	CVCSW-N	ACSW	ICSW	SISE	Dep	Parent's age
PROCSI-PC-A								
PROCSI-PC-I	0.45***							
CVCSW-N	0.41***	0.54***						
ACSW	0.30***	0.25**	0.50***					
ICSW	0.29***	0.20**	0.49***	0.48***				
SISE	0.03	-0.08	-0.13	-0.12	0.10			
Dep	0.06	0.21**	0.23**	0.19*	0.20**	-0.44***		
Parent's age	-0.06	-0.29***	-0.20**	-0.30***	-0.21**	-0.01	-0.09	
Parent's gender	-0.01	-0.20**	0.07	-0.17*	-0.10	0.03	-0.09	0.10

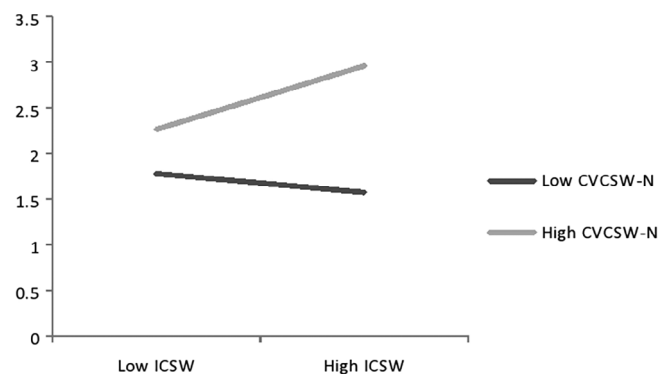
Note: ACSW, physical appearance subscale of the Contingencies of Self-Worth scale; CVCSW-N, negative subscale of the Child-Value Contingent Self-Worth; Dep, DASS-21 depression scale; ICSW, intelligence subscale of Contingencies of Self-Worth scale; PROCSI-PC-A, physical appearance subscale of the Parent-Child-Related Obsessive Compulsive Inventory; PROCSI-PC-I, Parent-Child-Related Obsessive Compulsive Inventory—Intelligence subscale; SISE, Single-Item Self-Esteem scale.

\* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$ .

were qualified by a significant two-way interaction that emerged between parental intelligence contingent self-worth and parental child-value self-contingency in predicting the PROCSI-PC-I score ( $F_{[1,166]} = 8.56$ ,  $p < .01$ ,  $R^2 = 0.03$ ; see Figure 1). Analysis of simple slopes demonstrated that among parents with high child-value self-contingency (i.e.,  $+1 SD$ ), the association between intelligence contingent self-worth and the PROCSI-PC-I was significant ( $b = .35$ ,  $t = 2.59$ ,  $p < .05$ ). In contrast, for parents who did not view their child's perceived value as relevant to their own self-worth (i.e.,  $-1 SD$ ), the association between intelligence contingent self-worth and the PROCSI-PC-I was not significant ( $b = -0.10$ ,  $t = -1.00$ ,  $p = ns$ ; Figure 1).

### 3.1.2 | Physical appearance

The regression model that examined the interaction effect between appearance contingent self-worth and CVCSW was significant, explaining 21.07% of the variance in the PROCSI-PC-A score ( $F_{[3, 171]} = 15.21$ ,  $p < .001$ ,  $R^2 = 0.21$ ). The analysis revealed a main effect for the CVCSW ( $\beta = 0.31$ ,  $t = 3.74$ ,  $p < .001$ ) indicating that parents with higher dependency on the child-value to their self-worth exhibit increased obsessions about their child's flaws in the physical appearance domain compared to parents with lower dependency on the child-value as relevant to their self-worth. The main effect of parental appearance contingent self-worth on the PROCSI-PC-A was not significant ( $\beta = 0.09$ ,  $t = 1.18$ ,  $p = ns$ ). These results were qualified by a significant interaction effect between appearance contingent self-worth and the CVCSW in predicting the PROCSI-PC-A

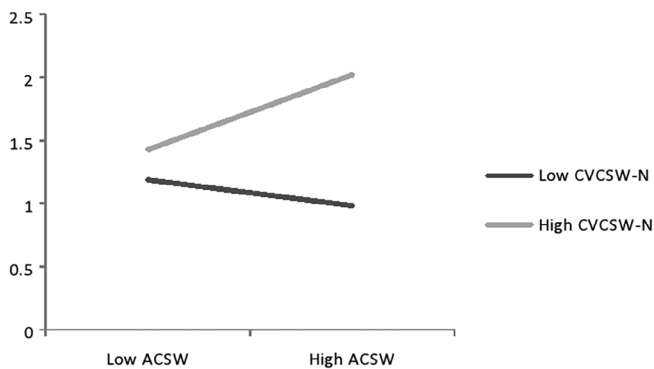


**FIGURE 1** Estimated values of Parent-Child-Related Obsessive Compulsive Inventory—intelligence subscale as a function of intelligence contingent self-worth and child-value self-worth

( $F_{[1,171]} = 8.77$ ,  $p < .01$ ,  $R^2 = 0.04$ ; see Figure 2). Simple slope analysis indicated that for parents with high ratings of CVCSW, the association between appearance contingent self-worth and the PROCSI-PC-A was significant ( $\beta = 0.29$ ,  $t = 2.63$ ,  $p < .01$ ). On the other hand, for individuals with low ratings of CVCSW, the association between appearance contingent self-worth the PROCSI-PC-A was not significant ( $\beta = -0.10$ ,  $t = -1.02$ ,  $p = ns$ ).

## 4 | DISCUSSION

Relationship obsessive-compulsive disorder is an understudied and disabling form of OCD (Melli et al., 2018). The goal of the current research was to extend previous research regarding ROCD and to attempt to explore



**FIGURE 2** Estimated values of the Parent–Child-Related Obsessive Compulsive Inventory—appearance subscale as a function of appearance contingent self-worth and child-value self-worth

possible mechanisms underlying ROCD symptoms in the context of parent–child relationships. Consistent with our double self-vulnerability hypothesis, we found that coinciding parental contingent self-worth in specific domains and CVCSW were associated with increased parent–child ROCD symptoms. Specifically, intelligence and physical appearance concerns were linked with higher parent–child ROCD symptoms particularly for parents whose self-worth was highly dependent on their child's perceived flaws or accomplishments.

These results are consistent with models that implicate self-vulnerabilities in OCD (Doron et al., 2007; García-Soriano et al., 2012; Moulding, Doron, Kyrios, & Nedeljkovic, 2008) and ROCD (Doron et al., 2013; Doron, Derby, et al., 2016; Doron & Szepsenwol, 2015). In addition, our findings further suggest that parental self-vulnerabilities may increase attention to intrusions related to specific parental self-domains and that child-value self-contingencies may further increase and direct such attention to one's child. The combined effect of these two vulnerabilities might exacerbate parent child ROCD symptoms. Indeed, we found that the ROCD symptoms in the context of parent–child relationship were elevated only when the score of both self-vulnerabilities were high.

Our findings are consistent with previous research linking self-vulnerabilities to OC symptoms (e.g., Aardema et al., 2018; García-Soriano et al., 2012). According to Doron and Kyrios (2005), pre-existing vulnerabilities in specific self-domains increase attention and vigilance to events related to these domains. Parents that perceive their child's deficiencies or flaws as reflecting on their own worth, might be extra sensitive to thoughts or events that challenge their child's value. For these parents, day to day child-related interactions like watching a television gameshow together or conversing at a family dinner, may

trigger thoughts such as “my child is not as intelligent as his peers, I'm a bad parent, I'm worthless” or “my child's behaviours reflect on me as a person”. Indeed, prior findings suggest that even subtle challenges to self-perceptions in sensitive self-domains may increase behavioural tendencies and cognitive biases associated with OCD (Abramovitch et al., 2013; Doron et al., 2013; Doron, Sar-El, & Mikulincer, 2012).

Narcissistic traits have also been associated with partner-focused ROCD symptoms and associated self-vulnerabilities (i.e., partner-value self-contingencies; Caccico, Melli, Bulli, Gelli, Micheli, & Doron, 2019; Melli et al., 2018). Parental narcissistic trait may, therefore, underlie both partner-focused and child-value self-contingencies constituting a general vulnerability to ROCD symptoms. Further research may benefit from assessing such links.

Although consistent with our proposed model, our study has some limitations. First, this study was based on a nonclinical cohort. However, the use of nonclinical populations within OCD research is a common practice. Studies of OCD have found that OCD symptoms and OC-related beliefs are better conceptualised as continuous and dimensional rather than categorical (Haslam, Williams, Kyrios, McKay, & Taylor, 2005). Nevertheless, individuals with ROCD may differ from nonclinical participants in symptom severity and the degree of impairment. Furthermore, our measure assessing child-contingent self-worth contingencies was tested using CFA without being previously assessed using exploratory factor analysis (EFA). Although CFA was done in order to test our hypothesis regarding the structure of the scale, using EFA followed by CFA would have allowed to first extract the factor structure from the data and then test it.

Our research points to parents with child-value and domain-relevant self-vulnerabilities as being more susceptible to child-related obsessive doubts and concerns. Future research would benefit from examining this model in a clinical sample. Furthermore, the correlational design of our study precludes any causal inferences. Future studies should examine the double self-vulnerability hypothesis (i.e., the combined effect of child contingent and domain-relevant vulnerabilities) in longitudinal and in experimental designs. This would contribute to the understanding of vulnerabilities that might play a role in the aetiology and maintenance of parent–child ROCD symptoms.

Consistent with cognitive behavioural interventions for OCD, parents presenting with parent–child ROCD symptoms might benefit from the use of cognitive techniques and behavioural experiments to challenge these associations (Doron & Derby, 2017). Examples may include perspective taking (e.g., “Do you judge your friends

based on their child's value?") or testing of catastrophic expectations regarding the impact of the child's characteristics on oneself (e.g., "I can't accept my child's physical flaws"; "I can't tolerate the embarrassment caused by my child's ignorance") using planned exposure exercises. Homework tasks relating to ROCD beliefs and self-vulnerabilities could include training with evidenced based mobile applications specifically designed for such tasks (e.g., GG relationship doubts [GGRO]; Roncero, Belloch, & Doron, 2018, 2019). Parents' child-value contingencies should be explored, such that the client understands the link between perceptions of the child's behaviours and characteristics, and one's own feelings of self-worth. The clinician is to help the client in identifying this effect and focus on strengthening parents' sense of competency in parenthood.

In conclusion, to our knowledge this research is one of the first attempts to explore possible mechanisms underlying ROCD symptoms in the context of a parent-child relationship, and therefore is valuable for the emerging research field of ROCD. Taking into account potential limitations, our results may have significant theoretical and clinical implications, which, we hope, will enable a better understanding of the factors that influence parents' thoughts and concerns regarding their child's true or imagined flaws, and might assist therapists to diagnose and administer suitable treatments and intervention programs.

## CONFLICT OF INTEREST

None

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