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# Development of an Intervention Program Based on the Lived Experiences of Individuals with Relationship Obsessive-Compulsive Disorder in Isfahan and Its Effectiveness on Obsessive Beliefs and Symptoms

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## ABSTRACT

This study aimed to identify the lived experiences of individuals with relationship obsessive-compulsive disorder (ROCD), develop a culturally informed integrative intervention, and evaluate its effectiveness in reducing obsessive symptoms, obsessive beliefs, and relationship beliefs. An exploratory sequential mixed-methods design was employed. In the qualitative phase, 40 individuals diagnosed with ROCD participated in in-depth semi-structured interviews analyzed phenomenologically. The findings informed the development of an eight-session integrative intervention drawing on cognitive-behavioral, acceptance and commitment, compassion-focused, emotion-focused, and attachment-based approaches. In the quantitative phase, 30 eligible participants were randomly assigned to experimental and control groups (15 each) in a quasi-experimental pretest–posttest design. Data were collected using the Yale–Brown Obsessive-Compulsive Scale, Relationship Obsessive-Compulsive Inventory, Partner-Related Obsessive-Compulsive Symptoms Inventory, Obsessive Beliefs Questionnaire, and Relationship Beliefs Inventory. Multivariate and univariate analyses of covariance were conducted. MANCOVA indicated a significant overall intervention effect on the combined dependent variables after controlling for pretest scores (Pillai's trace = 0.182, $F = 5.21$, $p = 0.001$, partial $\eta^2 = 0.274$). ANCOVA results showed significant reductions in obsessive beliefs ($F = 8.10$, $p = 0.006$, partial $\eta^2 = 0.128$), relationship-centered obsessive symptoms ($F = 7.25$, $p = 0.009$, partial $\eta^2 = 0.116$), partner-focused obsessive symptoms ($F = 6.70$, $p = 0.012$, partial $\eta^2 = 0.109$), and relationship beliefs ($F = 5.95$, $p = 0.018$, partial $\eta^2 = 0.098$). The strongest effect was observed for obsessive beliefs, whereas relationship beliefs showed the smallest effect. The lived-experience-based integrative intervention effectively reduced major cognitive and symptomatic dimensions of ROCD and supports the value of culturally adapted, multidimensional treatment programs.

**Keywords:** Relationship obsessive-compulsive disorder; obsessive beliefs; relationship beliefs; lived experience; integrative intervention.

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## Introduction

Obsessive-compulsive disorder is a chronic and frequently disabling psychological condition characterized by intrusive, unwanted, and recurrent thoughts, images, or impulses, together with repetitive

behaviors or mental acts performed to reduce distress or prevent feared outcomes. Although obsessions and compulsions can focus on contamination, checking, symmetry, morality, religion, aggression, or sexuality, contemporary research has increasingly emphasized that obsessive-compulsive symptoms may also become organized around close interpersonal relationships. Relationship obsessive-compulsive disorder (ROCD) refers to a clinically significant pattern in which obsessive doubts, preoccupations, and compulsive responses are centered on an intimate relationship or on the perceived characteristics of a romantic partner. Individuals with this presentation may repeatedly question whether they truly love their partner, whether their partner loves them sufficiently, whether the relationship is "right," or whether the partner possesses the necessary physical, intellectual, moral, social, or emotional qualities. These doubts are not equivalent to ordinary relational uncertainty. Rather, they are intrusive, persistent, distressing, difficult to dismiss, and commonly associated with repetitive reassurance seeking, comparison, checking, emotional monitoring, avoidance, and mental review (1, 2).

The conceptual framework proposed for ROCD distinguishes two closely related symptom dimensions. The first is relationship-centered obsessive-compulsive symptomatology, which involves recurrent doubts about the suitability, authenticity, stability, and future of the relationship. The second is partner-focused obsessive-compulsive symptomatology, which involves persistent preoccupation with perceived flaws or inadequacies in the partner's appearance, intelligence, competence, morality, sociability, or emotional stability. These dimensions may occur independently, but they frequently overlap and reinforce one another. For example, a perceived flaw in the partner may trigger doubts about whether the relationship should continue, while uncertainty about the relationship may intensify scrutiny of the partner's characteristics. Such processes can generate a self-perpetuating cycle in which intrusive doubts increase anxiety, anxiety prompts compulsive analysis or reassurance seeking, and the temporary relief produced by these behaviors strengthens future reliance on them (1, 3, 4).

ROCD can create substantial impairment in both individual and relational functioning. Individuals may spend considerable time reviewing their feelings, comparing their partner with others, monitoring fluctuations in affection, seeking confirmation from friends or family, or testing whether they experience sufficient attraction or emotional certainty. Because these strategies rarely provide lasting reassurance, the person may become increasingly dependent on compulsive checking and more sensitive to ordinary variations in mood, closeness, attraction, or conflict. This process can weaken intimacy, reduce relationship satisfaction, increase interpersonal tension, and place the partner in the difficult position of repeatedly responding to unresolvable questions. Empirical evidence indicates that ROCD symptoms are associated with marked interference, maladaptive beliefs, emotional distress, and difficulties in romantic functioning, supporting the view that these symptoms represent a clinically meaningful manifestation of obsessive-compulsive psychopathology rather than a simple form of indecision or dissatisfaction (2).

One of the central cognitive characteristics of ROCD is the tendency to interpret normal relational ambiguity as evidence of danger, incompatibility, or personal failure. Intimate relationships naturally involve uncertainty, emotional fluctuation, disagreement, and awareness of the partner's imperfections. However, individuals with ROCD may evaluate these ordinary experiences according to rigid standards, such as the belief that genuine love must be constant, complete, effortless, and entirely free from doubt. Under these conditions, even a temporary decrease in positive emotion may be interpreted as proof that the

relationship is fundamentally wrong. Similarly, noticing an imperfection in the partner may be viewed as evidence that the partner is unsuitable or that remaining in the relationship will lead to irreversible regret. These appraisals transform everyday relational experiences into threatening internal events and thereby increase the perceived need for certainty, control, and repeated evaluation (1, 5).

Perfectionism is particularly relevant to this process. Individuals who hold excessively demanding standards for themselves, their partners, or intimate relationships may experience heightened distress when reality fails to conform to idealized expectations. Romantic perfectionism may involve the assumption that the correct partner should satisfy all emotional, physical, social, and personal expectations or that a successful relationship should be consistently harmonious. Recent findings suggest that obsessive doubts about romantic relationships are meaningfully associated with perfectionistic tendencies and broader personality characteristics. These associations have also been examined across diverse sexual orientations, indicating that ROCD-related doubts are not confined to heterosexual relationships and should be understood within a broader framework of individual differences, personality traits, minority-related experiences, and culturally shaped relational expectations (6). Personality traits, fear of guilt, and the duration of the relationship may further shape the severity and content of ROCD symptoms. In particular, individuals who experience an exaggerated fear of making a morally wrong relational decision may feel compelled to achieve impossible certainty before committing to or continuing a relationship (5).

The feared-self perspective provides another useful explanation for the persistence of relationship obsessions. From this perspective, intrusive thoughts become especially threatening when they appear to reveal an unacceptable possibility about the self. A person may fear being unloving, deceptive, irresponsible, disloyal, superficial, or incapable of making a correct relational choice. Consequently, the obsession is not limited to whether the partner is appropriate; it may also concern what the presence of doubt means about the individual's moral identity or personal worth. Research examining feared-self processes has shown that these concerns are related to relationship obsessions, sexual-orientation obsessions, and general obsessive-compulsive symptoms. This suggests that the severity of intrusive relational doubts may partly depend on the extent to which individuals interpret them as evidence of a feared identity rather than as transient mental events (7).

Attachment-related vulnerabilities also appear to contribute to the development and maintenance of ROCD. Insecurely attached individuals may experience greater sensitivity to rejection, abandonment, emotional distance, or loss of autonomy. Anxiously attached individuals may repeatedly seek reassurance regarding the partner's love and commitment, whereas avoidantly attached individuals may interpret closeness, dependence, or emotional vulnerability as threatening. These attachment patterns can interact with obsessive beliefs and increase the tendency to monitor the relationship for signs of danger. Iranian research has indicated that difficulties in emotion regulation and experiential avoidance may mediate the association between attachment styles and the severity of ROCD symptoms. In other words, insecure attachment may increase vulnerability to distressing relational experiences, but the intensity of symptoms may depend partly on whether individuals can regulate difficult emotions and remain in contact with uncertainty without attempting to suppress or escape it (8, 9).

Emotion regulation difficulties are especially important because ROCD is often sustained by an inability or unwillingness to tolerate anxiety, doubt, guilt, sadness, jealousy, or emotional ambivalence. Individuals

may regard these internal experiences as intolerable and attempt to eliminate them through reassurance, rumination, avoidance, comparison, or mental neutralization. Experiential avoidance provides short-term relief but prevents corrective learning. When individuals repeatedly escape from uncertainty rather than remaining in contact with it, they do not learn that intrusive doubts can diminish without compulsive action or that a meaningful relationship can continue despite emotional variability. This mechanism helps explain why interventions that focus solely on the factual content of relationship doubts may be insufficient. Treatment may also need to address the person's relationship with internal experiences, including willingness to experience uncertainty, acceptance of emotional discomfort, and the capacity to observe thoughts without treating them as commands or objective truths (8-11).

Metacognitive processes represent a related mechanism. Individuals with ROCD may believe that doubts must be analyzed until certainty is reached, that intrusive thoughts are inherently meaningful, or that continuous monitoring will prevent a disastrous relational decision. Such beliefs encourage prolonged rumination and attentional fixation. Metacognitive therapy attempts to modify the beliefs that sustain repetitive thinking rather than debating every individual obsession. Evidence from Iranian studies suggests that metacognitive therapy can reduce ROCD symptoms and experiential avoidance, indicating that changing beliefs about the necessity, controllability, and significance of obsessive thinking may weaken the cycle of doubt and compulsive response (10, 11). Nevertheless, the persistence of relational beliefs, attachment insecurities, emotional avoidance, and interpersonal patterns implies that a broader integrative treatment may be needed for some individuals.

The social and cultural context in which romantic relationships are formed can influence both the content and consequences of ROCD symptoms. Cultural expectations regarding marriage, partner selection, family approval, gender roles, divorce, loyalty, and emotional expression may determine which doubts become especially threatening. In settings where marriage is viewed as a major personal, familial, and social commitment, uncertainty about the spouse or the relationship may be experienced as a threat not only to personal happiness but also to family stability, social identity, and moral responsibility. Iranian researchers have therefore emphasized the importance of culturally appropriate assessment. The development and psychometric evaluation of an Iranian measure of relationship obsessive-compulsive symptoms reflects the need to capture symptom expressions that are meaningful within the local cultural context (12, 13). These efforts are important because instruments developed in one cultural setting may not fully represent the language, values, relational expectations, or reassurance patterns observed in another.

The harms associated with ROCD may be particularly pronounced among married women, whose experiences can be shaped by social expectations, relational power structures, caregiving responsibilities, economic dependence, and concerns about stigma or marital disruption. Emerging qualitative evidence has begun to identify the psychological, relational, and social harms experienced by married women with ROCD, underscoring the need to examine the disorder through lived experience rather than relying exclusively on standardized symptom measures (14). A phenomenological understanding can reveal how individuals interpret their symptoms, how obsessive doubts affect daily marital life, which events trigger symptom escalation, what barriers prevent treatment seeking, and which personal or family resources support adaptation. Such information is particularly valuable for designing culturally responsive interventions that address the actual experiences of affected individuals.

ROCD-like processes may also occur in relationships beyond romantic partnerships. Research on parent–child ROCD has shown that parents may become obsessively preoccupied with perceived flaws in their children and that these symptoms may be linked to vulnerabilities in the parental self. This work broadens the conceptual scope of ROCD and demonstrates that obsessive-compulsive processes can become attached to highly valued relational domains whenever the individual's identity, responsibility, or self-worth is strongly invested in the relationship (15). The relevance of self-vulnerability across relational contexts suggests that effective intervention should address not only symptom reduction but also fragile self-evaluations, conditional self-worth, perfectionistic standards, and the tendency to define personal adequacy through the perceived quality of close relationships.

Existing intervention research provides promising evidence but remains limited. Cognitive-behavioral principles, including exposure, response prevention, cognitive restructuring, and the reduction of reassurance seeking, are central to the treatment of obsessive-compulsive symptoms. However, ROCD often includes interpersonal and emotional processes that require adaptation of standard protocols. Digital and couple-oriented interventions have begun to address this need. A randomized controlled trial of a cognitive-behavioral mobile application demonstrated that targeted exercises could strengthen couples' resilience to ROCD symptoms, suggesting that interventions may benefit both the symptomatic individual and the relational system (16). Similarly, training programs designed to strengthen lasting connection, family developmental functioning, and relational flexibility may help couples respond more adaptively to obsessive doubts and repetitive reassurance cycles (17). These findings support the inclusion of relationship skills, emotional communication, and couple resilience alongside conventional obsessive-compulsive treatment strategies.

Systematic reviews indicate that the scientific literature on ROCD has expanded, but substantial conceptual, methodological, and clinical gaps remain. Much of the research has been cross-sectional, focused on symptom correlates, or conducted in nonclinical samples. Treatment studies remain relatively few, and there is limited evidence concerning interventions developed directly from the lived experiences of diagnosed individuals. Moreover, available studies suggest that ROCD is associated with a complex network of maladaptive beliefs, perfectionism, attachment insecurity, feared-self concerns, experiential avoidance, emotion regulation difficulties, reassurance seeking, interpersonal dysfunction, and culturally shaped relationship expectations (3, 4). A single-theory intervention may therefore fail to address the full range of mechanisms involved.

An integrative approach may offer a more comprehensive response to this complexity. Cognitive-behavioral techniques can challenge catastrophic interpretations and reduce compulsive checking and reassurance seeking. Acceptance- and mindfulness-based strategies can help individuals tolerate doubt and disengage from efforts to suppress or neutralize intrusive thoughts. Compassion-focused methods may reduce shame, harsh self-criticism, and perfectionistic self-evaluation. Emotion-focused strategies can improve the recognition, acceptance, and communication of difficult emotions. Attachment-based interventions can address insecurity, fear of rejection, and maladaptive relational expectations. When these components are informed by the lived experiences of individuals within a specific cultural context, the resulting intervention may achieve greater relevance, acceptability, and clinical utility than a standardized protocol transferred without adaptation.

Despite increasing recognition of ROCD, there remains a need for research that first clarifies how affected individuals experience the disorder and then translates those findings into an empirically evaluated treatment package. Such a design can connect phenomenological knowledge with clinical intervention development. It can also identify predisposing, precipitating, perpetuating, and protective factors that may not be adequately captured by conventional diagnostic frameworks. In the Iranian context, this need is especially important because relational norms, family involvement, marital expectations, and culturally specific beliefs may shape symptom expression and treatment response. Although Iranian studies have contributed to measurement development, attachment-based explanations, metacognitive treatment, and couple-focused training, an intervention systematically developed from the lived experiences of individuals with ROCD and evaluated across obsessive symptoms, obsessive beliefs, and relationship beliefs remains necessary (12, 13, 17).

Accordingly, the present study aimed to identify the lived experiences of individuals with relationship obsessive-compulsive disorder in Isfahan, develop an integrative intervention program based on those experiences, and evaluate its effectiveness in reducing relationship-centered symptoms, partner-focused symptoms, obsessive beliefs, and dysfunctional relationship beliefs.

## Methods and Materials

### *Study Design and Participants*

The study used an exploratory sequential mixed-methods design comprising an initial qualitative phase followed by a quantitative intervention phase. The qualitative phase adopted a phenomenological approach to describe and interpret the lived experiences of individuals with relationship obsessive-compulsive disorder (ROCD), with particular attention to the symptoms of the disorder and the factors contributing to its development and persistence. The study population consisted of married men and women who had attended counseling centers in Isfahan during 2023–2025 with complaints related to obsessive symptoms. During the initial screening stage, 412 clients completed measures assessing relationship-centered and partner-focused obsessive-compulsive symptoms. The screening results identified 213 individuals as potentially eligible for a diagnostic interview. Eighty-one individuals could not be contacted because they had not provided adequate contact information, and 132 were subsequently contacted. Of these, 41 agreed to participate in the in-depth interview process. Their clinical status was evaluated using a structured clinical interview based on the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Forty participants met the diagnostic criteria for ROCD, whereas one individual displayed related symptoms but did not satisfy the complete diagnostic criteria. Therefore, the final qualitative sample consisted of 40 participants selected through purposive sampling. Interviews continued until data saturation was achieved. Each participant attended one or two interview sessions, with each session lasting approximately 45–60 minutes. The qualitative sample included 22 women and 18 men, with a mean age of 34.6 years and an age range of 23–52 years. Their mean duration of marriage was 7.8 years, while the mean duration of ROCD was 4.3 years. Based on the qualitative findings, an eight-session integrative treatment program was developed by combining cognitive-behavioral, acceptance and commitment, compassion-focused, emotion-focused, and attachment-based therapeutic principles. In the quantitative phase, a quasi-experimental pretest–posttest design with an experimental group and a control group was implemented.

Thirty eligible participants were selected and randomly assigned to the experimental and control groups, with 15 participants in each group. The principal inclusion criteria were being married, having been married for at least six months, meeting the clinical and questionnaire-based criteria for ROCD, obtaining scores greater than one standard deviation above the relevant means on the relationship-centered and partner-focused symptom measures, and providing informed consent to participate. The experimental group received the eight-session intervention, whereas the control group did not receive the intervention during the study period.

### *Data Collection*

Qualitative data were collected through in-depth semi-structured interviews developed to elicit participants' perceptions and lived experiences of ROCD. The interviews explored intrusive and repetitive thoughts about the intimate relationship, obsessive concerns about the partner's characteristics, compulsive or reassurance-seeking behaviors, and the individual, interpersonal, familial, biological, and sociocultural factors associated with the onset and continuation of symptoms. All interviews were conducted in one or two sessions, audio-recorded with the participants' permission, transcribed in full, and prepared for phenomenological analysis. The Structured Clinical Interview for DSM-5 Disorders was used during the diagnostic assessment to determine whether the participants met the relevant clinical criteria. Quantitative data were collected at the pretest and posttest stages using five standardized instruments. The Yale–Brown Obsessive-Compulsive Scale was administered to assess the severity of general obsessive thoughts and compulsive behaviors. The Relationship Obsessive-Compulsive Inventory was used to measure relationship-centered obsessive-compulsive symptoms, including recurrent doubts regarding the participant's feelings toward the spouse, the spouse's feelings toward the participant, and the perceived correctness or suitability of the relationship. The Partner-Related Obsessive-Compulsive Symptoms Inventory measured partner-focused preoccupations concerning characteristics such as physical appearance, sociability, morality, emotional stability, intelligence, and competence. The Obsessive Beliefs Questionnaire was used to assess dysfunctional cognitive beliefs associated with obsessive-compulsive symptomatology, while the Relationship Beliefs Inventory evaluated maladaptive assumptions and rigid beliefs regarding intimate relationships. These instruments were administered under comparable conditions to both groups before and after the intervention. The findings derived from the qualitative interviews were also reviewed by psychology specialists to assess the conceptual relevance and content validity of the extracted themes and the resulting intervention protocol. The reported content validity indices were .96 for the main themes and .95 for the subthemes, while inter-coder agreement was reported as .98, indicating a high level of consistency in the qualitative coding process.

### *Data Analysis*

The qualitative interviews were analyzed using a phenomenological thematic process focused on identifying recurring meanings, common experiences, and shared patterns across participants' accounts. Following verbatim transcription, the researchers repeatedly reviewed the interview material to achieve immersion in the data, identified meaningful statements and preliminary codes, compared codes across interviews, and organized conceptually related codes into subthemes and overarching themes. The analysis

generated themes concerning relationship-centered obsessive thoughts, partner-focused obsessive thoughts, and repetitive or compulsive behaviors. It also identified predisposing, precipitating, perpetuating, and protective factors associated with ROCD. To strengthen the trustworthiness of the qualitative findings, the study applied the criteria of credibility, dependability, transferability, and confirmability. Two independent coders contributed to the coding process, and agreement was evaluated using percentage agreement and Cohen's kappa-related procedures. Peer review, expert evaluation, detailed documentation of analytic decisions, direct participant quotations, and an audit trail were also employed to enhance the transparency and dependability of the analysis. The themes were subsequently evaluated by specialists through content-validity procedures, and the confirmed qualitative findings formed the empirical foundation for developing the integrative intervention program. In the quantitative phase, inferential analyses were conducted after controlling for participants' pretest scores. Multivariate analysis of covariance was first used to examine the overall effect of the intervention on the combined dependent variables, including relationship-centered obsessive symptoms, partner-focused obsessive symptoms, obsessive beliefs, and relationship beliefs. After a significant multivariate effect was obtained, separate univariate analyses of covariance were performed for each dependent variable. Additional multivariate and univariate covariance analyses were conducted for the subscales of relationship-centered and partner-focused obsessive symptoms. Adjusted posttest means were compared between the experimental and control groups, and statistical significance was evaluated using F statistics and associated probability values. Partial eta squared was reported as an index of effect size to estimate the proportion of posttest variance attributable to the intervention after controlling for baseline differences.

## Findings and Results

The qualitative phase included 40 married individuals diagnosed with relationship obsessive-compulsive disorder, comprising 22 women (55%) and 18 men (45%). Participants ranged in age from 23 to 52 years, with a mean age of 34.6 years. Regarding educational attainment, 2 participants (5%) had completed middle school, 14 (35%) held a high school diploma, 18 (45%) held a bachelor's degree, 4 (10%) held a master's degree, and 2 (5%) held a doctoral degree. The mean duration of marriage was 7.8 years, ranging from 6 months to 22 years. Eighteen participants (45%) had no children, 12 (30%) had one child, 6 (15%) had two children, 3 (7.5%) had three children, and 1 (2.5%) had four children. The mean duration of ROCD symptoms was 4.3 years, ranging from 6 months to 15 years. In terms of employment, 22 participants (55%) were employed and 18 (45%) were unemployed or homemakers. Moreover, 24 participants (60%) had previously received pharmacological or psychotherapeutic treatment, whereas 16 (40%) were seeking treatment for the first time. In the quantitative phase, 30 eligible individuals were assigned to the experimental and control groups, with 15 participants in each group.

**Table 1. Complete Qualitative Findings Concerning the Symptoms and Associated Factors of Relationship Obsessive-Compulsive Disorder**

| Domain | Main Theme | Subthemes | Description |
|---|---|---|---|
| ROCD symptoms | Recurrent thoughts about the spouse's characteristics | Intelligence, professional competence, morality, physical characteristics, hygiene habits, interpersonal relationships, sexual functioning, and emotional stability | Participants experienced intrusive and repetitive thoughts concerning the spouse's adequacy, appearance, morality, personality, and other personal characteristics. These thoughts led to persistent doubt, repeated evaluation, comparison, and excessive monitoring of the partner. |

| | | | |
|---|---|---|---|
| ROCD symptoms | Recurrent thoughts about the relationship with the spouse | Perceived affection from the spouse, affection toward the spouse, and correctness of the relationship | Participants reported recurrent doubts about the quality of the relationship, whether the spouse truly loved them, whether they genuinely loved the spouse, and whether continuing the marriage was the correct decision. These doubts produced persistent psychological tension even when no objective relational problem was evident. |
| ROCD symptoms | Repetitive behaviors | Neutralization of obsessive thoughts, compulsive comparison, repeated checking, reassurance seeking, and avoidance | Participants engaged in controlling, checking, reassurance-seeking, neutralizing, or avoidant behaviors to reduce anxiety caused by obsessive thoughts. Although these behaviors provided temporary relief, they reinforced obsessive doubts and maintained the cycle of anxiety and compulsion. |
| Factors associated with ROCD | Predisposing factors | Biological factors and environmental factors | Earlier experiences and biological or individual structures increased vulnerability to ROCD. These factors included genetic or temperamental susceptibility, anxiety proneness, perfectionistic tendencies, exposure to obsessive behavioral models, and childhood environments characterized by criticism or excessively high expectations. |
| Factors associated with ROCD | Precipitating factors | Individual factors, interpersonal factors, and environmental-social factors | Specific experiences or turning points activated latent obsessive vulnerability. These included rigid childhood standards, changes in the spouse's behavior, ambiguity in emotional expression, interpersonal conflict, migration-related pressures, sudden lifestyle changes, and exposure to idealized portrayals of intimate relationships in social media. |
| Factors associated with ROCD | Perpetuating factors | Obsessive beliefs, relationship beliefs, nonacceptance of unpleasant emotions, deficiencies in the behavioral repertoire, self-related processes, limited mindfulness, biophysiological conditions, quality of social relationships, and treatment-limiting factors | Dysfunctional cognitive, emotional, behavioral, and interpersonal mechanisms maintained the obsessive cycle. Participants interpreted intrusive thoughts as meaningful, believed that genuine love should be free from doubt, attempted to suppress distressing emotions, lacked effective communication and conflict-management skills, based their self-worth on relationship quality, became cognitively fused with obsessive thoughts, experienced symptom escalation during fatigue or sleep deprivation, lacked adequate social support, and sometimes feared that recovery would diminish the depth of their love. |
| Factors associated with ROCD | Protective factors | Family support and resources, treatment accessibility and quality, and self-care activities | Personal and interpersonal resources helped participants manage their symptoms and improve their quality of life. Supportive family relationships, access to appropriate psychological treatment, confidence in the quality of therapeutic services, and engagement in self-care practices reduced vulnerability and strengthened resilience against obsessive relational concerns. |

The phenomenological analysis identified three interconnected manifestations of ROCD: recurrent partner-focused thoughts, recurrent relationship-centered thoughts, and repetitive or compulsive behaviors. Partner-focused obsessions involved persistent evaluation of the spouse's intelligence, appearance, morality, competence, social behavior, hygiene, sexuality, and emotional stability. Relationship-centered obsessions primarily concerned the authenticity of the participants' feelings, the spouse's affection, and the correctness or viability of the marriage. In response to these intrusive thoughts, participants engaged in compulsive comparison, repeated checking, reassurance seeking, thought neutralization, and avoidance. These behaviors temporarily reduced distress but ultimately reinforced obsessive uncertainty. The analysis also identified four broad categories of factors associated with the disorder. Predisposing factors created an underlying vulnerability, precipitating factors activated symptoms, and perpetuating factors maintained the cycle through maladaptive beliefs, emotional avoidance, skill deficits, limited mindfulness, physical exhaustion, social isolation, and barriers to treatment. In contrast, family support, access to effective

treatment, and self-care functioned as protective resources. The credibility of these findings was supported by an inter-coder agreement coefficient of .98 and content validity indices of .96 for the main themes and .95 for the subthemes.

**Table 2. Adjusted Posttest Means of the Study Variables by Group**

| Variable | Experimental Group Adjusted Mean | Control Group Adjusted Mean | Adjusted Mean Difference |
|---|---|---|---|
| Obsessive beliefs | 3.10 | 4.05 | −0.95 |
| Relationship-centered obsessive symptoms | 2.35 | 3.00 | −0.65 |
| Partner-focused obsessive symptoms | 2.75 | 3.20 | −0.45 |
| Relationship beliefs | 2.68 | 3.22 | −0.54 |

After adjustment for baseline scores, the experimental group obtained lower posttest means than the control group on all four outcomes. The largest adjusted difference was observed for obsessive beliefs, for which the experimental group mean was 3.10 compared with 4.05 in the control group, corresponding to a difference of 0.95 points. The adjusted mean for relationship-centered obsessive symptoms was 2.35 in the experimental group and 3.00 in the control group, producing a difference of 0.65 points. For partner-focused obsessive symptoms, the corresponding adjusted means were 2.75 and 3.20, respectively, with a difference of 0.45 points. Finally, the adjusted mean for relationship beliefs was 2.68 in the experimental group and 3.22 in the control group, representing a difference of 0.54 points. Thus, the descriptive pattern consistently favored the experimental group and indicated lower levels of obsessive and dysfunctional relational cognitions following the intervention. Raw pretest and posttest means and standard deviations were not reported in the supplied manuscript; therefore, only the model-adjusted means available in the source are presented.

**Table 3. Univariate ANCOVA Results for the Effects of the Intervention on the Primary Outcomes**

| Dependent Variable | Experimental Group Adjusted Mean | Control Group Adjusted Mean | F | df1 | df2 | p | Partial $\eta^2$ |
|---|---|---|---|---|---|---|---|
| Obsessive beliefs | 3.10 | 4.05 | 8.10 | 1 | 55 | .006 | .128 |
| Relationship-centered obsessive symptoms | 2.35 | 3.00 | 7.25 | 1 | 55 | .009 | .116 |
| Partner-focused obsessive symptoms | 2.75 | 3.20 | 6.70 | 1 | 55 | .012 | .109 |
| Relationship beliefs | 2.68 | 3.22 | 5.95 | 1 | 55 | .018 | .098 |

Before examining the individual dependent variables, the multivariate analysis of covariance showed a statistically significant overall difference between the experimental and control groups after adjustment for pretest scores, Pillai's trace = .182, $F(4, 55) = 5.21$, $p = .001$, partial $\eta^2 = .274$. The other multivariate statistics supported the same conclusion, including Wilks' lambda = .818, $F(4, 55) = 5.12$, $p = .001$, partial $\eta^2 = .271$; Hotelling's trace = .223, $F(4, 55) = 5.34$, $p = .001$, partial $\eta^2 = .279$; and Roy's largest root = .137, $F(4, 55) = 6.45$, $p = .001$, partial $\eta^2 = .319$. The subsequent univariate ANCOVAs demonstrated that the intervention had a statistically significant effect on every primary outcome. The strongest individual effect was found for obsessive beliefs, $F(1, 55) = 8.10$, $p = .006$, partial $\eta^2 = .128$. A significant intervention effect was also found for relationship-centered obsessive symptoms, $F(1, 55) = 7.25$, $p = .009$, partial $\eta^2 = .116$, followed by partner-focused obsessive symptoms, $F(1, 55) = 6.70$, $p = .012$, partial $\eta^2 = .109$. Relationship beliefs also decreased significantly, $F(1, 55) = 5.95$, $p = .018$, partial $\eta^2 = .098$, although this outcome had

the smallest effect size. Collectively, these results indicate that the lived-experience-based integrative intervention significantly reduced obsessive beliefs, relationship-centered symptoms, partner-focused symptoms, and dysfunctional relationship beliefs after baseline differences were statistically controlled.

## Discussion and Conclusion

The present study was conducted to identify the lived experiences of individuals with relationship obsessive-compulsive disorder (ROCD), formulate an intervention grounded in those experiences, and evaluate its effectiveness in reducing relationship-centered symptoms, partner-focused symptoms, obsessive beliefs, and dysfunctional relationship beliefs. The qualitative findings indicated that the participants' experiences could be organized into three principal symptom domains: recurrent obsessive thoughts concerning the relationship, recurrent obsessive thoughts concerning the partner's characteristics, and repetitive behaviors performed to reduce distress or obtain certainty. In addition, four broad groups of associated factors were identified, namely predisposing, precipitating, perpetuating, and protective factors. Based on these findings, an eight-session integrative intervention incorporating cognitive-behavioral, acceptance and commitment, compassion-focused, emotion-focused, and attachment-based components was developed. The quantitative findings demonstrated that the intervention produced a statistically significant overall effect on the combined dependent variables after controlling for pretest scores. Significant improvements were found in obsessive beliefs, relationship-centered obsessive symptoms, partner-focused obsessive symptoms, and relationship beliefs. The largest effect was observed for obsessive beliefs, whereas the smallest effect was found for relationship beliefs.

The qualitative finding that ROCD symptoms were expressed through both relationship-centered and partner-focused obsessions is consistent with the established conceptual framework of the disorder. Participants described persistent doubts about whether they truly loved their spouses, whether their spouses loved them adequately, and whether the relationship was correct or worth continuing. They also reported intrusive preoccupations with the spouse's appearance, intelligence, morality, competence, sociability, hygiene, sexual functioning, and emotional stability. This pattern closely corresponds to the distinction between relationship-centered and partner-focused symptom dimensions proposed in foundational ROCD research (1, 2). The coexistence of these symptom dimensions suggests that individuals do not merely evaluate the relationship as a whole or the partner in isolation. Rather, doubts in one domain appear to activate and intensify doubts in the other. A perceived weakness in the partner may be interpreted as evidence that the relationship is unsuitable, while uncertainty about the relationship may lead the individual to scrutinize the partner more closely for flaws. This reciprocal process can progressively increase distress and impair both individual and relational functioning.

The repetitive behaviors identified in the interviews included checking, reassurance seeking, comparison, avoidance, and attempts to neutralize intrusive thoughts. These behaviors were intended to reduce anxiety, but participants reported that relief was temporary and that the behaviors ultimately intensified their need for certainty. This finding supports cognitive-behavioral models in which compulsions are understood as negatively reinforced strategies that reduce distress in the short term but prevent corrective learning and maintain obsessive concerns over time. Previous research has similarly shown that ROCD is associated with repeated monitoring of feelings, comparison of the partner with others, questioning friends and family,

reviewing past interactions, and avoiding situations that trigger doubt (2-4). The present qualitative findings extend this literature by showing how these behaviors are experienced within married life in the Iranian cultural context, where decisions about marital continuity may carry substantial personal, familial, and social meaning.

The identified predisposing factors included temperamental anxiety, perfectionism, genetic or familial vulnerability, strict childhood environments, and exposure to obsessive behavioral models. These findings align with evidence indicating that perfectionistic standards and personality characteristics are associated with romantic obsessive doubts. Individuals who hold rigid expectations regarding love, compatibility, attractiveness, morality, or relational success may become highly sensitive to ordinary imperfections in the partner or fluctuations in emotional closeness. Recent research has shown that romantic relationship obsessive doubts are related to perfectionism and broader personality traits across both heterosexual and sexual-minority populations (6). Similarly, fear of guilt and selected personality characteristics have been linked to ROCD symptoms, particularly when individuals believe that choosing the wrong partner or continuing an imperfect relationship would represent a serious moral or personal failure (5). Thus, perfectionistic and responsibility-related vulnerabilities may create a cognitive context in which normal uncertainty is interpreted as intolerable or dangerous.

The precipitating factors identified in the present study included changes in the spouse's behavior, ambiguity in the expression of affection, conflict, migration-related pressures, lifestyle changes, and exposure to idealized images of relationships through social media. These findings suggest that ROCD symptoms may become activated when internal vulnerabilities interact with relational or environmental stressors. A person with rigid beliefs about love and compatibility may remain relatively stable until a disagreement, emotional distance, change in routine, or comparison with another couple challenges the perceived certainty of the relationship. At that point, the individual may begin to monitor feelings, analyze the spouse's behavior, and seek reassurance. This interpretation is compatible with the conceptual model proposed by Doron and colleagues, in which attachment insecurity, maladaptive beliefs, and self-vulnerabilities interact with relationship-related triggers to produce obsessive preoccupation (1). The role of environmental comparison is also clinically important because idealized relational representations may strengthen the false belief that healthy relationships should be consistently harmonious, passionate, and free from doubt.

The perpetuating factors found in this study were broad and multidimensional. They included obsessive beliefs, dysfunctional relationship beliefs, nonacceptance of unpleasant emotions, deficiencies in communication and conflict-management skills, self-worth contingent on relationship quality, limited mindfulness, physical exhaustion, poor social support, and barriers to treatment. This pattern supports the assumption that ROCD is not maintained by a single mechanism. Instead, cognitive, emotional, behavioral, interpersonal, and contextual processes appear to interact. The role of insecure attachment, emotion-regulation difficulties, and experiential avoidance has been documented in Iranian research, which has shown that difficulties in regulating emotion and avoiding unpleasant internal experiences mediate the relationship between attachment styles and ROCD symptom severity (8, 9). When individuals cannot tolerate anxiety, ambivalence, jealousy, disappointment, or guilt, they may resort to checking, rumination, or

reassurance seeking. These strategies reduce discomfort temporarily but strengthen the belief that uncertainty cannot be endured.

The role of self-related processes in the qualitative findings is also consistent with the feared-self perspective. Some participants interpreted relational doubt as evidence that they were disloyal, incapable of love, morally deficient, or unable to make correct decisions. Previous research has demonstrated that feared-self concerns are associated with relationship obsessions, sexual-orientation obsessions, and general obsessive-compulsive symptoms (7). From this perspective, the distress associated with an intrusive thought depends not only on its content but also on what the individual believes the thought reveals about the self. A fleeting perception that the partner is unattractive, for example, may become highly threatening when interpreted as proof that the individual is superficial or does not truly love the partner. Treatment must therefore address both the obsessional content and the identity-based meanings attached to it.

The qualitative identification of protective factors, including family support, access to high-quality treatment, and self-care, adds an important strength-oriented dimension to the findings. Most ROCD research has concentrated on symptoms and vulnerabilities, while fewer studies have examined the resources that help individuals manage intrusive doubts. Supportive relationships may reduce excessive dependence on the spouse as the sole source of emotional security, while effective treatment may provide alternative strategies for responding to uncertainty. Self-care practices may also reduce the physiological and emotional exhaustion that participants described as intensifying their symptoms. These findings are relevant to intervention planning because they suggest that treatment should not focus exclusively on eliminating symptoms; it should also strengthen external support, self-regulation, daily functioning, and adaptive relational resources.

The quantitative results confirmed the effectiveness of the lived-experience-based intervention. The significant multivariate effect indicated that the intervention produced improvement across the combined outcome variables rather than influencing only one isolated domain. This broad pattern is theoretically consistent with the integrative design of the program. Cognitive-behavioral components likely reduced maladaptive interpretations, compulsive reassurance seeking, checking, and comparison. Acceptance- and mindfulness-based techniques may have increased participants' willingness to experience uncertainty and observe intrusive thoughts without immediate reaction. Compassion-focused methods may have reduced shame, self-criticism, and perfectionistic evaluation, while emotion-focused and attachment-based components may have improved the recognition and communication of emotional needs. The combination of these approaches appears particularly appropriate for ROCD because the disorder involves both classical obsessive-compulsive mechanisms and deeper relational vulnerabilities.

The strongest intervention effect was observed for obsessive beliefs. This result suggests that the program was particularly effective in modifying beliefs concerning the significance of thoughts, the need for certainty, responsibility for preventing relational mistakes, and the assumption that doubt must be resolved before action can be taken. This finding is consistent with metacognitive treatment studies showing that interventions targeting beliefs about thinking and experiential avoidance can reduce ROCD symptoms (10, 11). It is also compatible with cognitive models proposing that intrusive thoughts become clinically significant when they are interpreted catastrophically. By challenging the need for absolute certainty and

helping participants regard thoughts as mental events rather than facts, the intervention may have weakened the cognitive foundation of the obsessive-compulsive cycle.

The significant reduction in relationship-centered obsessive symptoms indicates that participants became less preoccupied with whether they loved their spouses sufficiently, whether the spouse's love was adequate, and whether the relationship was correct. This improvement may have resulted from exposure to uncertainty, reduction of reassurance seeking, cognitive restructuring of unrealistic relationship standards, and acceptance of normal emotional fluctuation. The finding aligns with previous research showing that cognitive-behavioral interventions can reduce ROCD-related distress and improve resilience within couples. A randomized controlled trial demonstrated that a CBT-based mobile application strengthened couples' resilience to ROCD symptoms, indicating that structured cognitive-behavioral exercises can improve responses to obsessive doubts within the relational system (16). The present findings extend that evidence by showing that a broader, culturally informed, face-to-face intervention can produce significant improvement in clinically relevant relationship-centered symptoms.

Partner-focused obsessive symptoms also decreased significantly following the intervention. Participants became less preoccupied with perceived deficiencies in the spouse's appearance, intelligence, morality, competence, social behavior, and emotional stability. This change may reflect reduced perfectionistic scrutiny and a greater capacity to tolerate the partner's ordinary limitations. Previous research has indicated that ROCD symptoms are linked to maladaptive beliefs and interference in relationship functioning (2). The present intervention may have helped participants differentiate between realistic concerns and obsessional evaluation, reduce compulsive comparison, and develop a more flexible understanding of compatibility. The significance of self-vulnerability in relational obsessions is also supported by research on parent–child ROCD, which showed that obsessive focus on another person's flaws may be connected to vulnerabilities in the individual's own self-concept (15). Accordingly, reducing partner-focused symptoms may require not only changing perceptions of the partner but also strengthening self-worth and reducing the need to derive personal security from the other person's perceived perfection.

The intervention also significantly reduced dysfunctional relationship beliefs, although this variable showed the smallest effect size. This finding may indicate that deeply rooted beliefs about love, marriage, compatibility, conflict, and partner selection are more resistant to change than symptom-level cognitions. Such beliefs are often acquired through family models, cultural narratives, social expectations, and long-standing personal experiences. They may therefore require a longer treatment period and repeated relational experiences before substantial restructuring occurs. The smaller effect does not imply that the intervention was ineffective; rather, it suggests a stage-like process in which more accessible obsessive beliefs and compulsive responses change before deeper relational schemas are fully modified. Programs designed to improve family functioning and relational flexibility may be especially relevant to this longer-term process (17).

The culturally grounded nature of the intervention is another important aspect of the findings. Iranian studies have demonstrated the need for culturally appropriate assessment of ROCD and have developed instruments reflecting the language and relational experiences of Iranian participants (12, 13). The present study extended this cultural approach from assessment to treatment development. By deriving intervention content from participants' lived experiences, the program was able to address culturally meaningful concerns

such as marital permanence, family expectations, social judgment, idealized beliefs about love, and the fear that reducing obsessive sensitivity might weaken commitment. Qualitative evidence concerning the harms experienced by married women with ROCD further supports the importance of examining the disorder within the social and marital context in which it occurs (14). Overall, the findings suggest that interventions may be more acceptable and clinically relevant when they integrate established therapeutic principles with locally identified experiences and needs.

The present study had several limitations. The participants were recruited from counseling centers in Isfahan, which may limit the transferability of the findings to individuals who do not seek treatment, unmarried individuals, people from other regions, or those with different cultural and socioeconomic backgrounds. The quantitative sample was relatively small, and the quasi-experimental pretest–posttest design did not include a long-term follow-up assessment. Reliance on self-report questionnaires may also have introduced response bias, social desirability, or inaccurate symptom reporting. In addition, the intervention integrated several therapeutic approaches, making it difficult to determine which specific components were most responsible for the observed improvements. The control group did not receive an active comparison treatment, and therapist effects, treatment fidelity, medication use, and comorbid psychological conditions may not have been fully controlled.

Future studies should evaluate the intervention in larger and more diverse samples recruited from multiple cities and clinical settings. Randomized controlled trials with active comparison groups and follow-up assessments at several time points are needed to determine the durability of treatment effects. Researchers should examine whether changes in experiential avoidance, intolerance of uncertainty, emotion regulation, attachment insecurity, mindfulness, self-compassion, or reassurance seeking mediate treatment outcomes. Component analyses could clarify the relative contribution of cognitive-behavioral, acceptance-based, compassion-focused, emotion-focused, and attachment-based techniques. Further research should also investigate differences according to gender, duration of marriage, symptom severity, treatment history, comorbidity, and cultural background. Dyadic studies involving both partners may provide a more complete understanding of how the intervention affects relationship functioning and partner responses.

Mental health professionals should routinely assess both relationship-centered and partner-focused obsessive symptoms when clients present with persistent marital doubt, repetitive reassurance seeking, excessive partner comparison, or chronic uncertainty about emotional feelings. Clinicians should distinguish ROCD from ordinary relationship dissatisfaction and avoid providing repeated reassurance that may reinforce compulsive patterns. Treatment should combine the reduction of checking and reassurance seeking with work on maladaptive beliefs, emotional acceptance, communication skills, attachment needs, self-compassion, and tolerance of uncertainty. Psychoeducation should also be provided to spouses and family members so that they can respond supportively without participating in compulsive reassurance cycles. Culturally appropriate examples, language, and relational expectations should be incorporated into treatment, and booster sessions may be useful for consolidating changes in deeper relationship beliefs.

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## Authors' Contributions

All authors equally contributed to this study.

## Declaration of Interest

The authors of this article declared no conflict of interest.

## Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

## Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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