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Relationship Obsessive Compulsive Disorder (ROCD) in Iranian culture: Symptoms, causes and consequences

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Abstract

Introduction: Relationship Obsessive-Compulsive Disorder (ROCD) is a debilitating disorder that has many negative effects on couples' lives and new researches are focused on this new theme of OCD. The research question was what were the symptoms, causes, and consequences of the ROCD in a sample of Iranian culture?

Materials and Methods: In the present study, 47 individuals with suspected ROCD were interviewed qualitatively. Also, 10 experts participated to evaluate the categories obtained from qualitative interviews. In-depth Interview, Structured Clinical Interview for DSM-5 Research Version (SCID-5-RV), Relationship Obsessive-Compulsive Inventory (ROCI), and Partner-Related Obsessive-Compulsive Symptoms Inventory (PROCSI) were the tools of the present study. Sample individuals were selected from different universities of Tehran such as Tehran University, Shahid Beheshti, Tarbiat Modares, Shahed, Kharazmi, Amirkabir, Sanati Sharif, and Khajeh Nasir in the period 2018 to 2020 based on theoretical and purposeful sampling. The method of analyzing the data obtained from the qualitative interview of the current research was based on grounded theory with a Glazer approach that the results were collected and coded manually.

Results: The results showed that ROCD was the result of three categories of repetitive thoughts about the characteristics of the spouse, repetitive thoughts about the spouse, and repetitive behaviors about the spouse. The underlying factors included obsessive beliefs, environmental conditions, and other disorders, and the revealing factors included environmental driver situations and thought or mental imagery. The short-term consequences included specific thinking, emotion, and behavior; and the long-term consequences included the effect on one's spouse and symptoms of depression and aggression.

Conclusion: Based on the results, it can be said that according to the DSM-5 framework, ROCD was a type of OCD with a relationship theme.

Keywords: Culture, Relationship obsessive compulsive disorder, Symptom

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Introduction

In the last decade, one form of OCD called Relationship Obsessive-Compulsive Disorder (ROCD) has been investigated in various studies focusing on repeated doubts about the characteristics of the spouse and relationship with him/her and compulsive behaviors in response to these doubts. These relationship doubts may include skepticism about the "correctness" of relationship with spouse, loving him/her, being loved by him/her, betraying the spouse, his/her social competence, emotional intelligence, and other issues that may be associated with compulsive behaviors such as checking on spouse's love, comparing him/her to others, continued reassurance, and more. Relationship obsessions are often seen in the form of thoughts (such as, "Is our relationship

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right?") and images of a relationship with a spouse. Of course, it can also be seen as an impulse (such as the desire to leave a spouse) (1). ROCD symptoms, similar to OCD symptoms, can lead to adverse spouse reactions and are a source of communication conflicts (2). Of course, this disorder is seen in other intimate relationships besides marital relationships, such as parent-child relationships (3).

The cognitive model of OCD (4-7) is one of the most widely used models in explaining obsessive-compulsive symptoms. There is much evidence to support this cognitive model (8,9). According to this model, obsessive-compulsive beliefs include over-importance of thoughts, the importance of controlling one's thoughts, inflated responsibility, overestimation of threat, intolerance for uncertainty, and perfectionism (10-12).

Like those found in other OCD themes, cognitive beliefs and biases may also be found in ROCD (13). However, some dysfunctional cognitions related to OCD may be more pronounced in the relationship theme. The OCD-related beliefs may influence how one interprets disturbing spouse-related thoughts. For example, the overestimation of threat may be seen in the spouse's emotional misinterpretation and exaggeration of perceived deficiencies. In addition, the intolerance for uncertainty may play an essential role in ROCD because it is associated with one of the critical components of the disorder: uncertainty about the "correctness" of the relationship (2).

Doron et al. (1) have shown that dysfunctional beliefs about relationships play a prominent role in the formation and persistence of ROCD. Rachman's model (14,15) suggested that multiple cognitive biases imply catastrophic consequences of thoughts, mental images, and impulses related to the relationship. One of these biases is about beliefs centered on the catastrophic consequences of leaving a spouse, and another relates to the catastrophic consequences of staying in a relationship that is not perfect for the individual. Among different cognitive beliefs, perfectionism and catastrophic beliefs seem to have a more significant impact on the symptoms of ROCD. Perfectionism in focusing on errors and hesitation in performing specific actions, catastrophizing about communication errors, and being alone is the most predictive of the symptoms of ROCD (16).

The search for etiological processes related to the formation and persistence of Obsessive-Compulsive (OC) symptoms focused on relationships seems to be of great importance (1,13). On the other hand, culture plays a vital role in explaining explanatory models of disorders, such as beliefs and attitudes related to mental disorders (17) and identifying stimulus, barriers, and patterns of helping individuals (18,19). Culture plays a vital role in the formation of obsessions and compulsions. The results of many years of research indicate that different cultures play an essential role in forming different symptoms of obsession (20). Varied cultural habits distinctly influence the phenomenology and prevalence of obsessions and compulsions by forming different beliefs and attitudes (20,21). For example, Sica et al. (9) compared the mean scores of anxiety, depression, OC symptoms, and OC-related cognitions of Greek, Italian, and American students. Their study showed that overall, American students showed a strong association between OC symptoms and their associated cognitions. This association was moderate among Italian students and weak among Greek students. Thus, the causal role of these cognitions on OC symptoms seems to be moderated by cultural factors (22,23).

In Iran, only the study of Sadeghian et al. (24) has investigated OCD from Iranian culture. This study which aimed to study the semiotics of OCD in patients referred to health centers in Tehran with an emphasis on Iranian culture showed that the overall pattern of semiotic OCD is consistent with the pattern observed in Western culture and some Eastern countries, so that the main features of OCD were relatively independent of cultural variables and the only exception was the content of obsessive-compulsive symptoms in which cultural factors play a significant role. Based on the results of this study, it can be concluded that the role of culture in the evaluation of obsessive-compulsive symptoms seems not to have been much considered. On the one hand, the study considered the prevalence of obsessive-compulsive symptoms to be independent of culture (although superstitious fears were one of the most common obsessions), and on the other hand, the content of obsession about culture was considered. Also, the only tool used to diagnose OCD was the Y-BOCS, and no structured clinical interview was used. Thus, further studies seem to be needed to investigate the role of culture in the prevalence of OCD and other its related features.

Thus, based on the mentioned arrangements, on the one hand, given the research vacuum regarding the study of OCD in Iranian culture, on the other hand, given the importance of examining the concept of ROCD about the adverse effect it has on the affected person and his/ her spouse, the research question was what were the symptoms, causes and consequences of the ROCD in a sample of Iranian culture?

Materials and Methods

In the form of qualitative research based on the grounded theory method with the Glaser approach (25), the present study examined the symptoms and pathological content of individuals with ROCD, along with its associated factors and consequences. The statistical population of the present study included all married students of Tehran who were suspected of ROCD. These students were selected from different faculties and fields of Tehran universities such as Tehran University, Shahid Beheshti, Tarbiat Modares, Shahed, Kharazmi, Amirkabir, Sanati Sharif, and Khajeh Nasir in the period 2018 to 2020. On the other hand, to evaluate the validity of the categories performed by the researcher, all the experts were included in the study population. Considering the qualitative nature of the present study, the sample size was determined based on theoretical sampling and purposeful sampling (26-28). In this study, 47 individuals with suspected ROCD were interviewed qualitatively. Also, ten experts (Ph.D. in clinical psychology or Ph.D. student in clinical psychology) evaluated the categories obtained from qualitative interviews.In the first step of the current study, the Relationship Obsessive-Compulsive Inventory (ROCI) and Partner-Related Obsessive-Compulsive Symptoms Inventory (PROCSI) were first distributed to the married student population using the available sampling method. In the second step, each of the sample subjects whose scores were above one standard deviation (Average ROCI scores: 9/88, the standard deviation of ROCI scores: 8/40; average PROCSI scores: 12/79, the standard deviation of PROCSI scores: 16/03) and had inclusion criteria, to investigate the presence of OCD and then to examine the relationship theme of this disorder (ROCD) were interviewed using the Structured Clinical Interview for DSM-5 Research Version (SCID-5-RV) (29) and literature in the field of ROCD (1,2,13,30,31). Then, if there was OCD with a relationship theme, in-depth interviews were conducted. In-depth interviews with patients were based on theoretical and purposeful sampling. Inclusion criteria were being married (female or male), diagnosis of OCD, diagnosis of ROCD (score above one standard deviation on the ROCI and PROCSI), consent to participate in the study (written consent was obtained from the participants), and at least six months have passed since the marriage of the couple. In addition, not cooperating to end the interview was considered the exclusion criterion. The present study used an available sampling method to select the experts to evaluate the categories obtained from qualitative interviews.

Research instrument

A) The Structured Clinical Interview for DSM-5 Research Version (SCID-5-RV): The SCID-5 is a semi-structured interview that provides diagnoses based on DSM-5. It is a semi-structured interview because its implementation requires the interviewer's clinical judgment of the interviewee's responses, and therefore the interviewer must have clinical knowledge and experience in psychopathology. The SCID-5 has been compiled in several versions, including SCID-5-CV (Clinical Version), SCID-5-CT (Clinician Trials), SCID-5-RV (Research Version), SCID-5-PD (Personality Disorders), and SCID-5-AMPD (Alternative Model for Personality Disorders) (29). In Iran, the validity and reliability of the SCID-5-RV and SCID-5-CV are currently being studied in the form of a research project (30-33). The main focus of this study, given the need for accurate diagnosis of OCD, was the SCID-5-RV.

The method of analyzing the data obtained from the qualitative interview of the present study was based on the grounded theory with the Glaser approach. The data analysis method in grounded theory is based on coding and categorization. In Glaser's approach (25), we see two coding steps. In the first stage, pure coding (or vertical) occurs, which is dependent on the data, and we see the process of comparison, focusing on the data, making it more abstract, and the emergence of frameworks; and in the second stage coding, known as theoretical coding, the refinement of extracted categories that integrate into the nuclear category is addressed (34). One of the essential methods of this approach is selective

coding. In selective coding, takes the findings of the previous coding steps, selects the main category, systematically relates it to other categories, proves those relationships, and identifies the categories that need further improvement and development. In this case, attention to the relationships between categories is based on their characteristics and dimensions. The first step in selective coding is to describe the storyline. The second step is to relate the complementary categories around the main category using a model. In the next step, each category must be related to its dimensions. The fourth step is to validate those relationships using data. The last step is to complete the categories that need to be modified or expanded. Finally, the grounded theory may end with propositions or theorems that illuminate the relationships between the axial coding pattern (25). The results of this study were collected and coded manually. After categorizing qualitative interview data, their reliability was considered that in this regard, the coder's agreement was investigated using the coder's agreement coefficient formula. The ethical aspects of this study, including the confidentiality of the information obtained from the interviews of the sample, were given priority, especially given the communication problems of the couple. This research was approved by the ethics committee of Shahed University. The method of data analysis from the qualitative interview of the present study was based on a grounded theory with a glazer approach that the results were collected and coded manually.

Results

In this section, we present the results of a qualitative interview with a sample of ROCD in two parts. In the first part, the concept of ROCD, its influencing factors, and consequences are extracted and categorized, and in the second part, the reliability and validity of the qualitative interview data are evaluated.Part I: Results derived from symptoms, influencing factors, and consequences of ROCD.In the current study, we interviewed people who scored high on the ROCI and PROCSI. According to reviews, 48 respondents scored above one standard deviation on both scales. Notably, 102 respondents indicated scores above one standard deviation on one of the scales (PROCSI or ROCI) and 41 respondents had scores above one standard deviation in another of those scales, and 46 respondents scored above average on both scales. In total, 237 of the 459 interviewees were eligible for initial screening for ROCD symptoms. Of these, 99 did not include information on the questionnaire for subsequent calls (such as email or phone number). Finally, the remaining 138 individuals were contacted, of which 47 agreed to be interviewed. They participated in one or two 45-60 minute interview sessions(s). At the interview session, based on Doron's view that people with ROCD always have OCD symptoms and a specific ROCD theme, the SCID-5 is first administered to diagnose OCD, and in fact, the symptoms of OCD and its differential aspects were examined. Then, a qualitative interview was conducted to examine the symptoms, causes, and consequences of ROCD. The mean age of these 47 patients was 27.08 years, 31.42% of them were male, and 68.58% were female. Also, 48.57% were master's students, 25.71% were Ph.D. students, and 28.57% were undergraduate students. The average length of marriage was four years and 18 months. Many of these people studied at the University of Tehran (70.23%), and many studied humanities (80.12%). Their fields of study were: accounting 24.2%, law 20.52%, management 35.40%, basic sciences (such as chemistry and physics) 8.28%, medicine 3.5%, technical engineering (such as petroleum engineering, chemical engineering, etc.) 8.1%. They were all employed and childless. Finally, 5 of these 47 patients did not show clinical symptoms of OCD, nine were diagnosed with ROCD, and the remaining 33 showed symptoms of ROCD and did not have complete symptoms of the disorder, based on the diagnostic features of existing literature in the field of ROCD (1,2,13,30,31). For theoretical saturation (35) except for nine individuals with ROCD, data from a qualitative interview with 33 individuals who showed symptoms of ROCD were also considered. After collecting information from the interviewees, their symptom content was classified into two general categories of repetitive thoughts and behaviors. Then, the category of repetitive thoughts was classified into two general categories: repetitive thoughts about the spouse's characteristics and repetitive thoughts about the relationship with the spouse. Table 1 shows the categorization of a sample of content derived from symptoms of ROCD.

Table 1. Categorization related to a sample of interviewees' symptoms

N	An example of statements	First level category		Second level category	
1	"My spouse is not mature"	Mature behavior	Mature behavior	Recurring thoughts about spouse characteristics	ROCD
2	"My spouse is misconduct towards my parents"	Mature behavior in specific situations			
3	"If my spouse does not take a bath and is late in prayer, it will have a bad result "	Commitment to religion	Religion		
4	"Are we religiously similar?"	Religious differences			
5	"I have a difference of opinion with my spouse and it affects the baby "	Influencing religious differences			
6	"My spouse is a bad role model for my child "	Modeling for the child	Parenting		
7	"My spouse hurts my baby"	Incompatible parenting			
8	"My spouse will betray me "	Non-person-centered betrayal	Betrayal		
9	"My spouse loves my sister more"	Person-centered betrayal			
10	"My spouse's body smells bad "	Customs of grooming	Customs of grooming		
11	"My spouse has AIDS and she/he infects me"	Disease spread	Disease		
12	"Does the food my spouse eats cause her/his illness or not?"	Non-spread of disease			
13	"My spouse has no emotional stability"	Emotional instability	Emotional instability		
14	"My spouse's feelings are not very strong "	show emotions			
15	"My spouse disregards me"	To get attention			
16	"Does my spouse understand me?"	To be understood			
17	"My spouse's social connection is weak"	Verbal and nonverbal communication	Social skill		
18	"Does my spouse have a good expression?"	Verbal communication			
19	"My spouse is lying"	Honesty	Honesty and reliability		
20	"My spouse is not trustworthy"	Reliability			
21	"My spouse 's job skills are poor	No tagging	Inadequacy in the job		
22	Others abuse my spouse (in her/his job), my spouse is naive	Tagging			
23	My spouse is not very tall	Spouse's height	Unattractiveness		
24	My spouse is not very pretty	Spouse's face			
25	My spouse doesn't have a high IQ	IQ	Cognitive ability		
26	My spouse is not making the most of her/his abilities	Lack of optimal use of cognitive ability			
27	My spouse is not an independent person	Independence of practice	Independence of practice		
28	Our relationship is not perfect	Perfectionism	Perfectionism in communication	Recurring thoughts about relationship with spouse	
29	Our relationship is not exactly what I was looking for	Comparison of the relation with perfectionist notions			
30	My spouse no longer loves me, she/he gets cold from me	Fear of being rejected	Fear of being rejected		
31	I have a mother's order for my spouse and he doesn't like me as a wife	Fear of being rejected in detail			
32	I love her/him?	Spouse rejection	Spouse rejection		
33	Our emotional connection is not very strong	Emotional strife	Emotional strife		
34	I neutralize it with the opposite idea, for example my spouse has abilities that are much better than me	Neutralizing thoughts with the help of reverse thoughts	Neutralize thoughts with the help of other thoughts		
35	Feeling guilty of slandering my spouse and then mentioning Estaghferolah	Neutralizing thoughts with the help of religious rituals			
36	Talking to others calms down	Talking to others	Neutralizing thoughts with the help of behavior	Neutralizing thoughts	Repetitive behavior about spouse
37	I try to reduce these thoughts by talking to my spouse	Talking to spouse			
38	I ask myself to make sure he/she loves me	Checks and assurance behaviors			
39	By talking to others, I try to compensate for my spouse's behavior	Compensatory behaviors			
40	I distract myself to be comfortable with these thoughts	Distraction			
41	I go into the room and I don't talk to her/him	Avoid spouse	Avoidance behaviors to avoid exposure to thoughts		
42	Avoiding people to avoid judgment	Avoid others			
43	Cancel travel	Avoid fun			
44	I don't do anything special because I can't do it	Passivity	Passive behaviors in the face of thoughts		

As shown in Table 1, ROCD is the result of three categories of repetitive thoughts about the spouse's characteristics, repetitive thoughts about the spouse, and repetitive behaviors about the spouse. In categories of repetitive thoughts about spouse characteristics, infidelity and emotional intelligence were the most prevalent among the interviewees and grooming customs, sickness, and independence were the least prevalent. Among the repetitive thoughts about the relationship with the spouse, perfectionism in the relationship and the fear of rejection were the most prevalent among the interviewees' content. Also, as shown in the Table, in categories of the repetitive behavior of the spouse, after the repetitive thoughts about the

spouse or his characteristics, neutralizing them with the help of other thoughts (especially the opposite thoughts) and with the help of behavior (mainly talking to a spouse, distracting and checking) were the most prevalent among interviewees. Also, neutralizing thoughts with the help of religious rituals and avoiding recreation had a minor frequency among the interviewees. Table 2 shows the categorization of factors affecting the formation of ROCD.

Table 2. Categorize the causes of the interviewees' symptoms

N	An example of statements	First level category		Second level category	
1	When my spouse is online he/she must be in touch with someone else	The importance of thinking	Obsessive beliefs	Contextual factors	Effective factors
2	My spouse will betray me	Thought control			
3	If I leave my spouse and travel, my spouse 's emotional vacuum will be compensated by another woman/men	High responsibility			
4	Don't call my spouse while I'm away, means cooling off of me	Overestimating the threat			
5	Our relationship is not as ideal as I would like	Perfectionist beliefs			
6	My father betrayed my mother	Family conditions of individual	Environmental conditions		
7	My spouse has already betrayed me once	Spouse conditions of individual			
8	I have a lot of cultural differences with my spouse	Cultural differences			
9	Precision in the works has caused to go very slowly	Other obsessions	Disorders or symptoms of other disorders		
10	I'm very worried about the future	Anxiety			
11	I'm bored	Depression			
12	When I fight with my spouse over an issue	Fights with spouse			
13	When I'm home alone and have nothing to do	being alone			
14	When we are at family parties and comparing my spouse's behavior to my sister's spouse	Participate in special environments	Environmental conditions	Representative factors	
15	When my spouse talks to the office clerk who has a lot of makeup	Talking spouse of the opposite sex			
16	My spouse disregards me	Thought	Mental conflict		
17	Images of comparing my spouse to people I used to love	Phantasm			

As can be seen in Table 2, it can be said that the factors affecting the ROCD include both underlying and revealing factors. The underlying factors include obsessive beliefs, environmental conditions, and other disorders, revealing factors including environmental driver situations and thought or mental imagery. Table 3 shows the categorization of outcomes for ROCD.

Table 3. Categorize the consequences of the interviewee's symptoms

N	An example of statements	First level category		Second level category	
1	I can't do anything else that day	Dysfunction	Behavior	Short-term consequences	Consequences
2	I think how can I continue with my spouse?	Mental rumination	Thoughts		
3	I like to not think about my spouse and our issues, so I go to my parents' house, then I feel better	Not engaging in thought			
4	I blame myself for not marrying a more successful person academically and professionally	Anger focused on himself	Emotion		
5	I fight with my spouse	Anger focused on another			
6	My spouse's nerves have faded from asking if she/he likes me all the time	The effect of one's reaction on his/her spouse	Long-term consequences		
7	I became a bored person from that energetic person who did whatever he/she wanted	Symptoms of depression			
8	I get nervous	Aggression			

As shown in Table 3, the consequences of ROCD include short-term and long-term consequences. The short-term consequences include specific thinking, emotion, and behavior, and the long-term consequences include the effect on one's spouse and symptoms of depression and aggression.

Part II: Assessing the reliability and credibility of qualitative interview data

To further evaluate the reliability of the data, using the Content Validity Index (CVI), the content of each of the extracted categories from the content of the interviews with individuals was evaluated by experts (n = 10). To evaluate the CVI of the subcategories and the main categories, four options ("totally relevant to the content", "relevant to the content but requiring review", "it needs to be modified to include content", "is not relevant to the content"), were used. As a result, the Scale- level Content Validity Index/Averaging (S-CVI/Ave) was 0.96 for the main categories and 0.95 for the subcategories. As such, they were higher than 0.79 (acceptable score for CVI) (36), and it can be said that from the point of view of experts, the intended content for the main categories and the subcategories is appropriate with the content of ROCD and the sample expressions obtained from interviewing couples.

Discussion

Based on the results, the interviewees were diagnosed with OCD with a relationship theme according to the DSM-5 criteria (37). In other words, this disorder contained repetitive, annoying, and disturbing obsessions (thoughts, impulses, or images) or compulsive behaviors (repetitive and excessive subjective behaviors or actions) (38). As Bloch et al. (39) and Williams et al. (40) believed that obsessions might manifest in different forms, we also saw another theme of OCD that has recently been the focus of attention in the current study. In a review study by Bloch et al. (39), 21 studies with a sample size of 5,124 people with OCD were used, and the questionnaires of these studies were the Yale-Brown Obsessive-Compulsive Scale (YBOCS). This study showed different forms of obsession (such as order and symmetry, disturbing thoughts such as aggression, sexual, religious, and physical obsessions) that, in line with the current study, showed a variety of signs and symptoms of obsession. The study by Williams et al. (40), which used a sample size of 201 OCD patients and the YBOCS, showed that "pure obsession" is usually absent and a search for confidence in people with OCD.

Important in the acquisition of the present study results was to consider the role of culture in the formation of content and causes of ROCD. In this respect, the results of studies conducted in Japan in 2001 can be cited. These studies have shown that although the main themes of symptoms of OCD are similar across the world, historical, cultural, and religious contexts can influence the specific content and frequency of obsessive-compulsive symptoms (41). The findings of the current study in semiotics showed that the doubt and skepticism of the interviewees constitute the basis of their obsession. In this regard, the results of the current study were in line with the results of Doron et al., (2) In this regard, Sadock et al. (40) acknowledged that morbid doubt is the second most common pattern of OCD and thus the importance of morbid doubt in the ROCD model can be considered.

One of the current study results was the obsession with infidelity in the participants. There have been many studies of infidelity (41-44). The increase in these investigations is due to the negative consequences of infidelity (45). The results of the study by Rokach and Philibert-Lignières (46) showed that the consequences of infidelity, such as depression, decreased social support, and self-esteem, are related to one's sense of loneliness. Infidelity can quickly lead to distress for couples and the dissolution of their relationships (47,48). A study by De Smet et al. (48) showed that of the 194 couples who experienced infidelity, about one-fifth committed at least one unwanted chase during the past two weeks. Being a woman, having low education, and low social status increased the number of behaviors committed.

Also, clinical experience has shown that individuals with ROCD who exhibit spouse-centered OC symptoms often pay particular attention to replacing other individuals with their spouses, and in their minds, constantly compare these alternatives to their spouse. When accompanied by decreased marital satisfaction, increasing attention to these alternatives will likely lead to a decrease in marital commitment (49) and will increase one's doubts about the relationship with the spouse (2). In the current study, another obsessive-compulsive theme of couples was the

doubt about the spouse's emotional intelligence (such as understanding, empathy, emotion, etc.). However, once a person's insight into his/her emotions increases and his/her mood is understood correctly, it is not without benefit to his/her spouse (50). Indeed, research results showed that emotional awareness plays an essential role in marital satisfaction (51). The results of the study by Lavalekar et al. (52) on 316 couples aged 25 to 65 years using the Marital Satisfaction Scale (MSS) and the Exploring Emotional Abilities Scale (EEA) showed that there is a significant and positive relationship between emotional intelligence and marital satisfaction. Another issue that emerged in the semantic results of the current study was the relatively high degree of obsession associated with the perfectionism of the interviewed couples. Burns (53,54) believed that perfectionism had a devastating effect on marital life. Trends of perfectionism may lead to a mental occupation about the "rightness" of the relationship. One's trends of perfectionism may be found in mental occupations of the ideal spouse's personality or appearance. Beliefs about mandatory control of negative thoughts may lead to suppression of doubts and negative thoughts about the spouse and relationship with her/him, which leads to an increase in the occurrence of such thoughts (2).

Also, another semantic result showed that doubt about loving a spouse or being loved by him/her is another of the themes of relationship obsession of couples with a relatively high frequency. Many studies have examined couples ' attachment styles about intimate relationships that indicate a loving spouse or being loved by him/her. For example, research results suggest that people with anxiety attachment to "highly active" strategies, such as repeated and sustained attempts to acquire love from the spouse, may increase the likelihood of reassurance and checking behaviors in them (1,13). Finally, in adulthood, these attachment images are transmitted to the spouse and may trigger the obsessive cycle and ineffective coping strategies (1,13). In addition to the raised issues, the current study results indicated that the most common behaviors followed by the mentioned obsessions were neutralizing obsessive thoughts with the help of inverse thoughts, distracting, talking to others, and checking. The purpose of these behaviors was to reduce the anxiety due to obsessive thoughts. Wells and Mathews (55) have identified five strategies for thought control which included: re-evaluation (i.e., analyzing and interpreting the meaning of disturbing thoughts), self-punishment (getting angry from self for having such thoughts), social control (i.e., expressing thoughts and talking with others), worry (focusing on the possible consequences of negative thoughts), and distracting attention (or deliberately diverting attention to other thoughts). Abramowitz et al. (56), who used 28 adult patients with OCD in their study, showed that OCD uses reappraisal, punishment, social control, and worry strategies more than non-obsessive individuals. The results of the current study, in line with Wells and Mathews (55), showed that social control (talking to others), evaluation (such as neutralizing obsessive thought with another reverse thought), and, of course, distraction were among the behaviors that were most often used to reduce obsessive-compulsive anxiety. Also, the current study results showed that checking behavior was another type of behavior that was followed by patients' obsessive doubts and had a relatively high frequency. In fact, consistent with Rachman's (57) view, in OCD, repetitive checking behavior results in a reduced risk of perceived injury. The compulsive checking behavior, followed by obsessive doubts, has been studied by other researchers. For example, Muller and Roberts (58) and Tolin et al. (59), who in their study distributed self-report questionnaires of OCD symptoms, obsessive beliefs as well as anxiety and depression scales to 562 undergraduate students, showed that dysfunctional beliefs about memory and uncertainty lead to the continuation of compulsive checking behavior.

Another result of the current study was the causes of ROCD. The present study is in line with the results of the study by De Oliveira (60) and Wilson and Chambless (61), who showed that distorted beliefs and catastrophic thoughts play an essential role in the formation and persistence of obsessive-compulsive symptoms. Also, the present study results were consistent with the results of McHugh O'Leary (10) on the important role of beliefs about excessive responsibility in the cognitive model of OCD. In the present study, one of the other factors observed in the etiology of ROCD was the role of past experiences. Among these experiences was a history of infidelity, rape, and troubled family history. Carpenter and Cheung Chung (62), assessed 82 patients with

OCD and 92 normal people and Childhood Trauma Questionnaire (CTQ-R), Yale-Brown Obsessive-Compulsive Scale (YBOCS), and the Experiences in Close Relationships Scale (ECR) were run on them, showing that results also showed that there is a relationship between childhood trauma and OCD. However, it is not a direct relationship; one's past experiences play a role in forming OCD. Also, the opposing family environment during childhood, especially the ongoing stresses and conflicts, can be one of the underlying factors of ROCD (2).In addition, comorbidity with other obsessive-compulsive spectrum disorders and obsessive-compulsive personality disorder were other factors in the etiology of ROCD in the current study. In this regard, the present study results were in line with the study of Givi and Hassan Abi (63), which aimed to determine the presence of obsessive-compulsive personality disorder in patients with OCD referring to psychiatric clinics in 2004-2005. In the study, it was shown that 34 (29.53%) of patients had an obsessive-compulsive personality disorder and OCD at the same time.

Another result of the present study was the consequences of ROCD. As the current study results showed, symptoms of depression are one of the consequences of this disorder. The depressive disorder often has comorbidity with OCD, and about one-third of patients with OCD also have a major depressive disorder, and suicide risk is present in all patients with OCD (37). Consistent with the current study, Doron et al. (1,13) showed that relationship-focused OC symptoms, even though controlling for OCD symptoms, confusion in relationship, low self-esteem, and anxiety and avoidance attachment, had a significant relationship with depression. In addition, as the current study results showed, another consequence of ROCD was increased anger and aggression in the affected individual. Some studies have shown anger attacks in depression, anxiety disorders, eating disorders, and OCD (64-70). For example, Whiteside and Abramowitz (71) showed a relationship between anger and OCD symptoms in 131 college students. On the other hand, increased relationship conflicts and spousal aggression were another consequence of ROCD in the present study. Some studies have studied the individual and relationship consequences of ROCD. The ROCD symptoms can have a significant impact on marital satisfaction. Repeated doubt about the spouse or relationship with her/him can seriously damage the core of the marital relationship and directly affect the relationship's durability. Conversely, positive perceptions towards the spouse and relationship with her/him play a role in the continuity of intimate and successful communication (72,73). Individuals with ROCD have problems maintaining a positive perception towards the spouse or relationship with them/her and may even lack such perception; as such, they have low marital satisfaction (2). One of the most critical limitations of the current study was the mere use of the sample of students. In this regard, it can be said that the generalization of the results of a qualitative interview to other segments of society should be made with caution. Also, the researcher's implementation of all stages of this study is another limitation of the current study.

Conclusion

It can be said that in Iranian culture, infidelity, emotional intelligence and perfectionism obsessions, and obsessions about loving a spouse or being loved by a spouse are most prevalent among people with Relationship Obsessive-Compulsive Disorder (ROCD). Also, in the present study, several factors were found in the formation of this disorder, including dysfunctional beliefs such as catastrophic thought, importance, control of thoughts, etc., that were confirmed by previous research. Also, in the present study, in analyzing this disorder, we came to understand the role of past experiences and other disorders that further researches are needed on this issue.

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References

1. Doron G, Szepsenwol O, Derby D, Nahaloni E. [Relationship-related obsessive-compulsive phenomena: The case of relationship-centered and partner-focused obsessive compulsive symptoms]. Psicoterapia Cognitivae Comportamentale 2012; 1: 71-82. (Italian)

2. Doron G, Derby DS, Szepsenwol O. Relationship obsessive compulsive disorder (ROCD): A conceptual framework. J Obsessive Compuls Relat Disord 2014; 3: 169-80.

3. Doron G, Derby D, Szepsenwol O. "I can't stop thinking about my child's flaws": An investigation of parental preoccupation with their children's perceived flaws. J Obsessive Compuls Relat Disord 2017; 14: 106-11.
4. Frost RO, Steketee G. Cognitive approaches to obsessions and compulsions: Theory, assessment, and treatment. United Kingdom: Oxford; 2002.
5. Salkovskis PM. Obsessional-compulsive problems: A cognitive-behavioral analysis. Behav Res Ther 1985; 23: 571-83.
6. Salkovskis PM. Cognitive-behavioural factors and the persistence of intrusive thoughts in obsessional problems. Behav Res Ther 1989; 27: 677-82.
7. Salkovskis PM. Cognitive-behavioral approaches to the understanding of obsessional problems. In: Rapee RM. (editor). Current controversies in the anxiety disorders. New York: Guilford; 1996: 103-34.
8. Taylor S. Cognition in obsessive-compulsive disorder. In: Frost RO, Steketee G. (editors). Cognitive approaches to obsessions and compulsions: Theory, assessment, and treatment. United Kingdom: Oxford; 2002: 1-12.
9. Sica C, Taylor S, Arrindell WA, Sanavio E. A cross-cultural test of the cognitive theory of obsessions and compulsions: A comparison of Greek, Italian, and American individuals—a preliminary study. Cognit Ther Res 2006; 30: 585-97.
10. McHugh O'Leary EM. Cognitive appraisal model of obsessive compulsive disorder (OCD): Recent advances. N Z Clin Psychologist 2007; 17: 2-8.
11. Clark DA. Cognitive-behavioural therapy for OCD. New York: Guilford; 2004.
12. Obsessive Compulsive Cognitions Working Group (OCCWG). Cognitive assessment of obsessive-compulsive disorder. Behav Res Ther1997; 35: 667-81.
13. Doron G, Talmor D, Szepsenwol O, Derby DS. [Relationship-centered obsessive compulsive phenomena]. Psicoterapia Cognitiva e Comportamentale 2012; 18: 79-90. (Italian)
14. Rachman SJ. A cognitive theory of obsessions. Behav Res Ther 1997; 35: 793-802.
15. Rachman SJ. A cognitive theory of obsessions: Elaborations. Behav Res Ther 1998; 36: 385-401.
16. Melli G, Bulli F, Doron G, Carraresi C. Maladaptive beliefs in relationship obsessive compulsive disorder (ROCD): Replication and extension in a clinical sample. J Obsessive Compuls Relat Disord 2018; 18: 47-53.
17. Kleinman A. Rethinking psychiatry: From cultural category to personal experience. New York: Free Press; 1988.
18. Rogler LH, Cortes DE. Help-seeking pathways: A unifying concept in mental health care. Am J Psychiatry 1993; 150: 554-61.
19. U. S. Department of Health and Human Services (USDHHS). Mental health: Culture, race, ethnicity- A supplement to mental health: A report of the surgeon general. USA: Substance Abuse and Mental Health Services Administration; 2001.
20. Clark DA, Inozu M. Unwanted intrusive thoughts: Cultural, contextual, covariational, and characterological determinants of diversity. J Obsessive Compuls Relat Disord 2014; 3: 195-204.
21. Sica C, Novara C, Sanario E. Culture and psychopathology: Superstition and obsessive- compulsive cognition`s and symptoms in a non-clinical Italian sample. Pers Individ Dif 2002; 32: 1001-12.
22. Bernstein DM. Anxiety disorders. In: Tseng W, Streltzer J. (editors). Culture and psychopathology. New York: Brunner/Mazel; 1997: 1-27.
23. Good BJ, Kleinman AM. Culture and anxiety: cross-cultural evidence for the patterning of anxiety disorders. In: Tuma AH, Maser JD. (editors). Anxiety and the anxiety disorders. New York: Lawrence Erlbaum Associates; 1985: 297-323.
24. Sadeghian H, Khodaei Ardakani MR, Eskandari H, Tamizi Z, Khodaii A. [Evaluation of symptoms of obsessive-compulsive disorder in patients referred to health centers in Tehran]. Psychiatric nursing 2013; 1: 21-29. (Persian)
25. Glaser BG. Theoretical sensitivity: Advances in the methodology of grounded theory. Mill Valley, CA: Sociology Press; 1978.
26. Hooman HA. [Practical guide to qualitative research]. Tehran: SAMT; 2014. (Persian)
27. Zakai MS. [Theory and method in qualitative research]. Social science quarterly 2002; 9: 41-69. (Persian)
28. Mohammadi B. [An introduction to qualitative research methodology]. Tehran: Institute of Humanities and Cultural Studies; 2008. (Persian)
29. First MB, Spitzer RL, Williams JBW, Karg RS. Structured Clinical Interview for DSM-5 Disorders (SCID-5-CV): Clinician version. Arlington, VA: American Psychiatric Publishing Incorporated; 2015.
30. Doron G, Derby DS, Szepsenwol O, Talmor D. Tainted love: Exploring relationship-centered obsessive-compulsive symptoms in two non-clinical cohorts. J Obsessive Compuls Relat Disord 2012; 1: 16-24.
31. Doron G, Derby D, Szepsenwol O, Talmor D. Flaws and all: Exploring partner- focused obsessive-compulsive symptoms. J Obsessive Compuls Relat Disord 2012; 1: 234-43.
32. Setareh Forouzan A, Mohammadkhani P, Hoshyari Z, Abbasi A. [Coordinates of structured clinical interview psychometrics for mental disorders statistical and diagnostic booklet version 5 and its clinical application in Iran]. Research project. Tehran: University of Social Welfare and Rehabilitation Sciences; 2018. (Persian)

33. Shabani A. [Evaluation of psychometric characteristics of structured clinical interviews for DSM-5- clinical version (SCID-5-CV) in the population of patients with psychiatric disorders in Tehran]. Research project. Tehran: Iran University of Medical Sciences; 2019. (Persian)
34. Heath H, Cowley S. Developing a grounded theory approach: a comparison of Glaser and Strauss. Int J Nurs Stud 2004; 41: 141-50.
35. Ferasat Khah M. [Qualitative research in the social sciences, with emphasis on "grounded theory" (GTM)]. Tehran: Agah; 2016. (Persian)
36. Hyrkas K, Appelqvist-Schmidlechner K, Oksa L. Validating an instrument for clinical supervision using an expert panel. Int Nurs Stud 2003; 40: 619-25.
37. Sadock BJ, Sadock VA, Ruiz P. Kaplan and Sadock's synopsis of psychiatry: Behavioral sciences/clinical psychiatry. 5th ed. North American: Wolters Kluwer; 2015.
38. Rachman S, De Silva P. Abnormal and normal obsessions. Behav Res Ther 1978; 16: 233-48.
39. Bloch MH, Landeros-Weisenberger A, Rosario MC, Pittenge C, Leckman JF. Meta-analysis of the symptom structure of obsessive compulsive disorder. Am J Psychiatry 2008; 165: 1532-42.
40. Williams MT, Farris SG, Turkheimer E, Pinto A, Ozanick K, Franklin ME, et al. The myth of the pure obsessional type in obsessive-compulsive disorder. Depress Anxiety 2011; 28: 495-500.
41. Juang Y, Liu C. Phenomenology of obsessive-compulsive disorder in Taiwan. Psychiatr Clin Neurosci 2001; 55: 623-7.
42. Cobey KD, Buunk AP, Roberts SC, Klipping C, Appels N, Zimmerman Y, et al. Reported jealousy differs as a function of menstrual cycle stage and contraceptive pill use: A within-subjects investigation. Evol Hum Behav 2012; 33: 395-401.
43. Pinto R, Arantes J. The relationship between sexual and emotional promiscuity and infidelity. Athens journal of social sciences 2016; 4: 385-98.
44. Zengel B, Edlund J, Sagarin B. Sex differences in jealousy in response to infidelity: Evaluation of demographic moderators in a national random sample. Pers Individ Dif 2013; 54: 47-51.
45. Vangelisti AL, Gerstenberger M. Communication and marital infidelity. In: Duncombe J, Harrison K, Allan G, Marsden D. (editors). The state of affairs: Explorations in infidelity and commitment. Mahwah: Erlbaum; 2004: 59-78.
46. Rokach A, Philibert-Lignières G. Intimacy, loneliness and infidelity. Open Psychol J 2015; 8: 71-77.
47. Christian-Herman J, O'Leary KD, Avery-Leaf S. The impact of severe negative events in marriage on depression. J Soc Clin Psychol 2001; 20: 24-40.
48. De Smet O, Buysse A, Brondeel R. Effect of the breakup context on unwanted pursuit behavior perpetration between former partners. J Forens Sci 2011; 56: 934-41.
49. Rusbult CE. Commitment and satisfaction in romantic associations: A test of the investment model. J Experim Soc Psychol 1980; 16: 172-86.
50. Burnett R. Encyclopedia of personal relationships. 7th ed. New York: Marshall Cavendish; 1990.
51. Croyle KL, Waltz J. Emotional awareness and couples' relationship satisfaction. J Marit Fam Ther 2002; 28: 435-44.
52. Lavalekar A, Kulkarni P, Jagtap P. Emotional intelligence and marital satisfaction. J Psychiatr Res 2015; 5: 185-94.
53. Burns D. The perfectionist's script for self-defeat. Psychol Today 1980: 34-51.
54. Burns D. The spouse who is a perfectionist. Medical aspects of human sexuality 1983; 17: 219-30.
55. Wells A, Mathews G. Attention and emotion: a clinical perspective. United Kingdom: Erlbaum; 1994.
56. Abramowitz JS, Whiteside S, Kalsy SA, Tolin DF. Thought control strategies in obsessive-compulsive disorder: a replication and extension. Behav Res Therapy 2003; 41: 529-40.
57. Rachman S. A cognitive theory of compulsive checking. Behav Res Ther 2002; 40: 625-39.
58. Müller J, Roberts JE. Memory and attention in obsessive-compulsive disorder: A review. J Anxiety Disord 2005; 19: 1-28.
59. Tolin DF, Woods CM, Abramowitz JS. Relationship between obsessive beliefs and obsessive-compulsive symptoms. Cognit Ther Res 2003; 27: 657-69.
60. De Oliveira IR. Standard and innovative strategies in cognitive behavior therapy. Croatia: InTech Press; 2012.
61. Wilson KA, Chambless DL. Inflated perceptions of responsibility and obsessive-compulsive symptoms. Behav Res Ther 1999; 37: 325-35.
62. Carpenter L, Chung MC. Childhood trauma in obsessive compulsive disorder: The roles of alexithymia and attachment. Psychol Psychother 2011; 84: 367-88.
63. Givi AM, Hassan Abi M. [Evaluation of obsessive-compulsive personality disorder in patients with obsessive-compulsive disorder referred to psychiatric clinics 2002-2003]. MD. Dissertation. Kermanshah University of Medical Sciences, 2004. (Persian)

64. Fava M, Nierenberg AA, Quitkin FM, Zisook S, Pearlstein T, Stone A, et al. A preliminary study on the efficiency of sertraline and imipramine on anger attacks in atypical depression and dysthymia. Psychopharmacol Bull 1997; 33: 101-3.
65. Fava M, Rappe SM, West J, Herzog DB. Anger attacks in eating disorders. Psychiatr Res 1995; 56: 205-12.
66. Fava M, Rosenbaum JF, McCarthy M, Pava J, Steingard R, Bless E. Anger attacks in depressed outpatients and their response to fluoxetine. Psychopharmacol Bull 1991; 27: 275-9.
67. Fava M, Rosenbaum JF, Pava JA, McCarthy MK, Steingard RJ, Bouffides E. Anger attack in unipolar depression, Part 1: Clinical correlates and response to fluoxetine treatment. Am J Psychiatry 1993; 150: 1158-63.
68. Fava M, Vuolo RD, Wright EC, Nierenberg AA, Alpert JE, Rosenbaum JF. Fenfluramine challenge in unipolar depression with and without anger attacks. Psychiatr Res 2000; 94: 9-18.
69. Rosenbaum JF, Fava M, Pava JA, McCarthy MK, Steingard RJ, Bouffides E. Anger attacks in unipolar depression, Part 2: Neuroendocrine correlates and changes following fluoxetine treatment. Am J Psychiatry 1993; 150: 1164-8.
70. Gould RA, Ball S, Kaspi SP, Otto MW, Pollack MH, Shekhar A, et al. Prevalence and correlates of anger attacks: a two site study. J Affect Disord 1996; 39: 31-8.
71. Whiteside SP, Abramowitz JS. Obsessive compulsive symptoms and expression of anger. Cognit Ther Res 2004; 28: 259-68.
72. Fletcher GJO, Simpson JA, Thomas G. Ideals, perceptions, and evaluations in early relationship development. J Pers Soc Psychol 2000; 79: 933-40.
73. Overall NC, Fletcher GJO, Simpson JA. Regulation processes in intimate relationships: The role of ideal standards. J Pers Soc Psychol 2006; 91(4): 662-85.