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# The Hidden Vicious Cycles in Relationship Obsessive-Compulsive Disorder (ROCD) : A Psychological and Neurological Approach

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## Abstract
This study presents the hidden vicious cycles in Relationship Obsessive-Compulsive Disorder (ROCD) through an analysis of its symptoms alongside behavioral and emotional dynamics, for we rely on a descriptive-analytical approach informed by psychological studies, theories, and field experience. Our analysis is grounded in Weiner's causal theory and neuroscience, and our goal is to identify the most important vicious cycles that contribute to the disorder's persistence or exacerbation. The insights from this analysis can be instrumental in psychoeducation—a fundamental component of psychotherapy—as they help to explain the nature of the problem, its causes. We have, consequently, identified the most important vicious cycles operating at the psychological, behavioral, cognitive, emotional, relational, and neurological levels.
**Keyworsd :** Obsessive-Compulsive Disorder, Relationship Obsessive-Compulsive Disorder; Vicious cycles ; Neuropsychology

## Introduction
Despite various studies focusing on the clinical description of obsessive-compulsive disorder in relationships, the literature lacks—according to the researcher—a thorough description and analysis of the vicious cycles that explain what actually happens in the brain of a person with this disorder within the dynamic interaction between neurological, psychological, and social elements, although we did find some studies that presented individual models of these cycles. This research paper is therefore considered an important study that psychologists can use during the psychoeducation stage, which is a critical step in psychological treatment generally, as it will allow the patient to understand what is happening in their brain and behavior. This understanding will then help them as a complementary method to the techniques used to control obsessive thoughts. As is well known in clinical practice, a patient does not wait for the therapist or anyone else to tell them their thoughts are wrong and their thinking is distorted, but rather they must convince themselves that they have a real problem and understand its nature, its scientific causes, and how it affects and ruins their relationships. On the other hand, and according to a number of studies, there is a significant overlap between Relationship OCD and other mental disorders, an overlap which results in vicious cycles of causes and effects. We therefore ask the following questions:
- What are the components of the hidden vicious cycles in Relationship Obsessive-Compulsive Disorder?

- How do these components interact with each other on a psychological and neurological level?

**Hypotheses:**

-We hypothesize that the hidden vicious cycles in Relationship Obsessive-Compulsive Disorder are behavioral, emotional, psychological, and relational in nature.

-We further hypothesize that there is interaction and mutual influence between psychological and neurological elements within these hidden vicious cycles.

**Study Objectives:**

-To uncover the hidden vicious cycles in Relationship Obsessive-Compulsive Disorder and to identify their nature.

-To understand how psychological and neurological factors contribute to the disorder's persistence and severity.

-To encourage psychotherapists to use such studies in the context of psychoeducation during treatment, to explain the nature of the problem, its causes, its effects, and the factors that perpetuate the disorder.

**Study Methodology:**

Our goal in this study is to fill the scientific gap regarding vicious cycles in ROCD by presenting and expanding upon previous findings, while also relying on cognitive-behavioral theories and neurological studies that explain behaviors, so that we may extract and analyze these cycles. We took care to ensure the logical causality of each vicious cycle and to compare it with clinical symptoms within the framework of a case study derived from a number of field studies. Our methodology is based on a conceptual analysis of existing scientific literature and published clinical descriptions, rather than on the recruitment of clinical cases or the use of standardized assessment tools. The proposed vicious cycles were derived from a synthesis of empirical studies and theoretical models, and their validity rests on logical consistency and clinical plausibility.

**Study Concepts:**

**5.1. Obsessive-Compulsive Disorder:**

Many people believe obsessive-compulsive disorder is related to a single topic and type, namely cleanliness and disease, whereas it is actually a condition that causes a person to suffer from a set of obsessions (and compulsions) that result in compulsive actions, and it may touch on various specific topics such as cleanliness and fear of germs, obsessions related to risks (like constantly checking that the door or gas is turned off), obsessions related to order and perfectionism (such as needing to put everything in a precise place), obsessions related to religion (like an excessive fear of committing sins), and obsessions related to relationships.

**5.2. Relationship Obsessive-Compulsive Disorder:**

In ROCD, obsessive-compulsive disorder manifests as obsessive doubts and fears about emotional relationships and compulsive behaviors that are practiced to alleviate the suffering associated with these obsessions. Relationship obsessions often take the form of intrusive thoughts (e.g., “Is this the right person?”) and images concerning the partner, but they can

also appear as intrusive desires (e.g., the urge to leave the current partner) (Doron et al., 2014).

**5.3. Hidden Vicious Cycles:**

These are sets of elements that interact with each other, thereby creating a circular causal relationship that increases the persistence and severity of the problem, and to treat the disorder effectively, these cycles must be broken, which first requires the client to understand and recognize their existence and impact.

**5.4. Cognitive Distortions:**

These are faulty, ingrained ways of thinking that result in maladaptive behaviors, such as overgeneralization, catastrophizing, and mind-reading (believing we know others' thoughts).

**5.5. Neuropsychological Approach:**

A scientific field that studies the relationship between neuroscience and psychology; that is, it examines how the brain's structure and its chemical and biological interactions affect human behavior, emotions, and thinking.

## 6. Vicious Cycles in Obsessive-Compulsive Disorder Related to Relationships

### 6.1. Neurological Specificity in Affected Individuals

In this study, we focus on the observable behavioral aspects of Relationship Obsessive-Compulsive Disorder, yet we must acknowledge that behind these manifestations lie specific neurological and pathological physiological elements, for the presence and role of neurological characteristics in the brain of a person with OCD should not be overlooked when discussing the vicious cycles we will address. Scientists in neurology and neuropsychology have identified specific brain anatomy and chemical interactions in people with OCD generally, and they have linked them to the pathological symptoms evident in the condition's behaviors. In a study by Moreira et al. (2017), patients with obsessive-compulsive disorder showed a reduction in the size of the right superior temporal sulcus (STS). This region is responsible for interpreting social cues from others—such as understanding their intentions and inferring what they are thinking or feeling—as it also integrates sensory information (hearing, sight, touch) with social contexts to form situational understanding (Pitcher, Valyear, Lenc, & Peelen, 2005). For example, during an interaction, a partner may act coldly due to fatigue or sadness, but the individual with ROCD may misinterpret these sensory signals as proof of diminishing love or neglect.

People with ROCD also exhibited significantly reduced connectivity in two separate subnetworks: the first includes the orbitofrontal cortex (OFC), temporal poles (TP), and subgenual anterior cingulate cortex (sgACC), and the second includes the Lingual Gyrus (LG) and the Central Posterior Gyrus (Moreira et al., 2017). To simplify the role of these regions, we refer to neurological studies that clarify what happens in the brain of a person with OCD and its subtypes, as according to Amodio and Frith (2006), the prefrontal cortex is fundamental for social cognitive abilities like self-reflection, self-awareness, and theory of mind, playing a key role in understanding oneself and others and in decision-making, while Alexandre and Brown (2011) have shown it is also responsible for predicting the possible consequences of others' actions (Grossmann, 2013). Consequently, any dysfunction in this neural region disrupts these very mental functions, which are then co-opted by the

individual's OCD so that their thoughts lead them to believe they understand the other person in a way that confirms their obsessions, which enables them to predict outcomes that are, in fact, their own pessimistic misinterpretations. For instance, if a partner mentions needing to answer her mother's call or check security cameras, the individual may immediately expect she is lying and speaking to someone else, despite the behavior being normal and reciprocal.

It is crucial to note the effect of the emotional aspect on sensory perception in OCD, as a person consumed by an obsession—such as a spouse's infidelity—experiences an emotional expectation that colors their processing of sensory stimuli (visual, auditory, etc.), which is akin to someone who, after a traumatic earthquake, continues to feel the ground shaking. The brain and senses can thus deceive a person into profound conviction despite being mistaken, a phenomenon supported by studies on the relationship between perception, feeling, and emotion (e.g., Dolcos et al., 2020 in Neuroscience & Biobehavioral Reviews), and this explains how anxiety creates a perpetual sense of threat and how negative emotions distort the perception of events, as seen in depression where sensory signals are exaggerated to match fears—such as hearing a non-existent phone ring or misidentifying a person. To clarify, consider an individual convinced his wife is cheating and using a secret phone, as his intense anxiety places his brain in a state of high alert, priming him to find confirming evidence in her behavior, words, or any ambiguous external sound (like a noise during a phone call), which his brain then processes to match his expectations. In neuroscience, this is termed predictive coding, where higher brain regions generate predictions sent to sensory regions, and mismatches with ascending sensory data produce prediction errors (Gabhart, Xiong, Bastos, 2025), so dominant expectations can control the interpretation of external sensory signals, leading someone to "hear" a message alert because they desperately expect one.

Clinical practice shows that relationship OCD often involves jealous obsessions. These can sometimes express a comorbid condition, such as obsessive jealousy (referenced in the DSM-5). When ROCD is accompanied by obsessive jealousy, the condition is more severe. This is particularly true when "quasi-hallucinations" occur—sensory experiences that convince the individual they have seen or heard proof of infidelity, such as an imaginary phone ring or a man's voice. This creates a vicious sequence whereby hearing an imaginary sensory stimulus leads to interpreting it as factual evidence, which reinforces obsessive thoughts and increases anxiety, prompting a search for proof, and the failure to find evidence then further amplifies the obsessive thoughts. Furthermore, the individual may seek external opinions on their suspicions, and those consulted—lacking full context and unaware of the perceptual disturbances driven by obsession—may offer superficial interpretations that seem to confirm the suspicions, thereby deepening the individual's doubt and cementing their conviction in their faulty narrative.

**6.2. The Vicious Cycle According to the Cognitive-Behavioral Model**

Here, we will start from the general and move to the specific, gradually delving into the details of symptoms, for we will begin with theoretical models derived from cognitive behavioral therapy, then move to models from neuropsychology, and attempt to connect them to understand the hidden vicious cycles in obsessive-compulsive disorder and how they interact. We will also present studies that confirm this where applicable, and in order for the

reader to understand the content of this research paper more accurately, it is important to note that we have based our plan and analysis on the following sequence: the clinical manifestations of relationship OCD lead to hidden vicious cycles, which then involve the interaction between the elements of those cycles, ultimately reinforcing the continuity and intensity of the disorder.

**6.2.1. The Vicious Cycle: Obsessive Thoughts – Anxiety – Compulsive Behavior – Reinforcement of Obsessive Thoughts**

Before presenting and analyzing the hidden vicious cycles, it is important to present what is mentioned in the Diagnostic and Statistical Manual V regarding obsessive-compulsive disorder and its symptoms, which are not listed separately but fall under the umbrella of obsessive-compulsive disorder (OCD) in general, a category that also includes obsessive jealousy as one of its specific related disorders. The symptoms are as follows:

**• Obsessive-Compulsive Disorder:**

A. The presence of obsessions, compulsions, or both:

Recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted and that cause marked anxiety or distress.

The individual attempts to ignore or suppress these thoughts, urges, or images, or to neutralize them with another thought or action (i.e., by performing a compulsion). Compulsions are defined by (1) and (2):

Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rigid rules.

These behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

B. The obsessions or compulsions are time-consuming (e.g., take more than one hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder. Specify if:

With good or adequate insight: The individual is certain or likely to recognize that the OCD beliefs are not true or may be untrue.

With poor insight: The individual believes that the OCD beliefs are likely to be true.

With lack of insight/delusional beliefs: The individual is completely convinced that the OCD beliefs are true.

Related to trichotillomania: The individual has a current or past history of trichotillomania.

OCD and other specific related disorders:

**• Obsessive Jealousy (as a related disorder):**

This is characterized by a preoccupation with a partner's perceived infidelity, which may reach delusional intensity. The preoccupations lead to repetitive behaviors or mental acts in response to the infidelity concerns, and these symptoms cause clinically significant distress or impairment and are not better explained by another mental disorder such as delusional disorder, jealous type, or paranoid personality disorder (American Psychiatric Association, 2013).

The cognitive behavioral model for explaining psychological disorders draws on theories such as Beck's cognitive theory (1952) and the concept of cognitive distortions. Based on this model, the core pathological cycle is as follows: a stimulus (a specific situation) triggers distorted thinking, which leads to negative emotions and feelings. These are followed by pathological or maladaptive behavior, which then confirms or reinforces the original distorted thinking. According to this school, the main problem is not the event itself but the individual's way of interpreting the situation, and this leads to specific psychological disorders, resulting in distressing emotions and maladaptive behaviors that ultimately reinforce the person's distorted core belief about their partner. This involves not just automatic negative thoughts but entrenched distorted thinking patterns (such as overgeneralization, mind-reading, catastrophizing, and exaggeration). From this theoretical basis, we can deduce secondary vicious cycles through the description of ROCD symptoms. This deduction integrates clinical symptoms from the DSM-5, cognitive-behavioral models, and Bowlby's attachment theory.

**6.2.2. The Vicious Cycle of Avoidance Behavior**

Avoidance is a behavior used by individuals with relationship OCD to alleviate feelings of anxiety and distress, and it is employed across psychological disorders in various forms depending on the problem's nature and severity. In ROCD, the person avoids engaging with obsessive thoughts, which provides temporary relief and reduces acute anxiety, but the obsessions quickly return because avoidance reinforces the idea that the thoughts are dangerous, thereby perpetuating the anxiety and strengthening the obsessive thoughts. Some studies support this analysis, such as the work of Gillan et al. (2014), which found that individuals with OCD tend to develop excessive avoidance habits, supporting an interpretation of OCD as a disorder of maladaptive habit formation, and further research is needed to characterize the causal role of physiological arousal and explicit fear in this process. This understanding is confirmed by other researchers, such as Xiong et al. (2021), whose study indicated that cognitive fusion and experiential avoidance are important factors in the persistence of OCD and that experiential avoidance can be a significant predictor of anxiety and depression in those with the disorder.

To clarify, we can use the example of a specific phobia, such as the fear of heights. Individuals with this phobia avoid the feared stimulus—like high places or flying—to temporarily reduce anxiety, but in the long term, sustained avoidance exacerbates the problem, akin to treating a disease with painkillers instead of addressing its root cause. Thus, the vicious cycle in ROCD is: obsessive thoughts provoke anxiety, which leads to avoidance behavior, which in turn increases the perceived threat and fear of the situation, thereby reinforcing the original obsessive thoughts.

### 6.2.3. The Vicious Cycle of Searching for Evidence and Constantly Testing the Partner

Clinical experience from psychology practitioners shows that individuals with ROCD constantly search for evidence to confirm their doubts and suspicions about a partner's infidelity, unsuitability, or the extent of their love. They also subject their partner to numerous and continuous tests to achieve a peace of mind that will alleviate their anxiety.

However, in reality, they become caught in another vicious cycle. Each time they engage in this behavior, their doubts multiply and shift to new issues and accusations. A secondary problem is that the more they test their partner—and the more their partner passes these tests—the more their obsessive thoughts intensify or shift to other new concerns.

This dynamic is acknowledged in numerous real-life cases where individuals report that increased justifications from their partner only amplify their suspicions. It should be noted that the evidence they use is often trivial and does not constitute conclusive proof, such as interpreting a 'like' on a social media post as evidence of betrayal, viewing the hiding of an online status indicator as proof the partner is talking to someone else, or believing a similarly named account must be a secret profile used for infidelity, along with other superficial and illogical forms of evidence.

Even if the patient encounters logical evidence proving their partner's innocence, they will find justifications to invalidate or dismiss this evidence. They will simply transition to a new obsessive idea and begin searching for evidence to support it. They also reject any form of calm, healthy discussion aimed at arriving at the truth. Their sole objective is to validate their accusations rather than to prove the other party's innocence. In fact, they approach the argument as a win-lose contest where the possibility of their suspicions being wrong is not entertained. This testing and evidence-seeking can also manifest in other areas, such as confirming doubts about their partner's suitability as a lifelong match, where they exhaust themselves with excessive thinking and devise tests that may involve lying, manipulation, or placing their partner in specific scenarios, yet they then find themselves in another spiral where they interpret their own psychological exhaustion as evidence that the relationship is unsuitable and their initial choice was wrong. This was confirmed by a study conducted by Doron, Derby, Szepsenwol, and Talmor (2012), which concluded that obsessive thoughts often conflict with the reality of the relationship and the individual's actual experiences, leading to fears that feel less consistent with the self and are often considered exaggerated or irrational reactions to events, thereby triggering severe anxiety and repetitive neutralizing behaviors like checking and seeking reassurance, which ultimately harms their daily life and relationship quality. From this perspective, the vicious cycle is: obsessive thoughts lead to anxiety, which triggers a search for evidence or constant testing of the partner, resulting in mental exhaustion, which then fuels the emergence of further obsessive thoughts.

### 6.2.4. The Vicious Cycle of Comparative Behavior

An individual with ROCD may compare their partner to other real people, individuals on social media, or even people from their imagination and dreams. This comparison may concern appearance, moral values, grooming, personality, behavior, or other characteristics. As a result, they feel anxious and dissatisfied with their partner, which reinforces their obsessive doubts about their partner's behavior or suitability as a life partner. Consequently,

they ignore all the positive aspects they were once convinced of at the relationship's beginning.

The vicious cycle here is as follows: obsessive thoughts trigger comparisons with others, which leads to anxiety and dissatisfaction, which in turn reinforces the obsessive doubts. Mental exhaustion, which in turn generates more obsessive thoughts.

**6.2.5. The Vicious Cycle of Perfectionism**

A person with ROCD may establish rigid, ideal standards for a life partner or for the characteristics of an ideal relationship, and when confronted with a reality that differs from these standards or when they fail to achieve their desired ideal, they interpret this discrepancy as proof of their partner's fundamental unsuitability, thus creating a vicious cycle where obsessive thoughts foster unrealistic idealism, whose inevitable failure then reinforces the original obsessive thoughts. One study indicated that the more intimate the relationship with the person with OCD, the greater the focus on the partner's real or imagined flaws (Hatfield & Sprecher, 1986), a concept operationalized by researcher Doron et al. (2012) in the development of the Partner-Related Obsessive-Compulsive Symptoms Inventory (PROCSI), a 24-item scale measuring severity across six domains: physical appearance, social traits, morality, and emotional characteristics.

**6.2.6. The Vicious Cycle Related to Cognitive Distortions**

As a foundational element, cognitive distortions are faulty, ingrained ways of thinking that manifest in various forms, whereby normal events become sources of chronic anxiety due to catastrophic misinterpretations, and individuals with OCD persistently interpret neutral stimuli in this exaggerated, threatening manner (Doron et al., 2005). Several studies have framed obsessive-compulsive disorder within cognitive theories, including the work of Rachman (1997), which posits that obsessive thoughts stem from catastrophic misinterpretations of intrusive mental events, meaning the obsessions persist for as long as the misinterpretations continue, and vice versa, thereby creating a self-sustaining loop.

**6.2.7. The Vicious Cycle of Feeling Inadequate**

A feeling of personal inadequacy in a patient with ROCD can powerfully reinforce obsessive thoughts, leading them to believe they are unworthy of their partner and that infidelity is therefore inevitable, which initiates another vicious cycle wherein feelings of inadequacy trigger obsessive thoughts, resulting in anxiety that prompts social isolation, which in turn further deepens the obsessive thoughts.

## 7. Vicious Cycles in Bowlby's Attachment Theory

### 7.1. The Vicious Cycle of Anxious Attachment

According to Bowlby's attachment theory, early developmental experiences lead individuals to form either secure or insecure attachments with primary caregivers. Among the insecure styles, anxious attachment is characterized by a pervasive fear of abandonment across social relationships. This fear drives compulsive attachment behaviors that often suffocate the partner.

The partner may then withdraw to escape the psychological pressure of constant pursuit, scrutiny, and attempted control. The individual with ROCD interprets this withdrawal as confirmation of betrayal or unsuitability, thereby intensifying their suspicions and obsessive

thoughts. This dynamic is supported by research. A study (N=329) found that fear of self-compassion mediates the relationship between attachment anxiety and OCD symptom severity, while fear of receiving compassion mediates between attachment avoidance and symptom severity (McNeil, 2023). Another study by Leeuwen et al. (2020) revealed a clear association between insecure attachment styles (anxious and avoidant) and OCD symptoms, suggesting the utility of attachment-based therapeutic approaches.

Thus, the vicious cycle proceeds as follows: an insecure, anxious attachment style generates obsessive thoughts and compulsive behaviors, which lead to partner withdrawal, which in turn reinforces the individual's fear of abandonment and obsessive doubts to partner suffocation and withdrawal, which is then misinterpreted, further increasing the obsessive thoughts.

## 8. Vicious Cycles Associated with the Behavior of the Life Partner:

### 8.1. The Vicious Cycle of Reassurance-Seeking Behavior:

The search for reassurance is a behavior common to most presentations of OCD, yet it is particularly evident and impactful in Relationship OCD, where the individual repeatedly asks their partner for validation in an attempt to dispel obsessive thoughts or calm the anxiety they cause. The partner, often wanting to alleviate conflict and preserve the relationship, provides this reassurance. However, this dynamic is ultimately counterproductive: while the reassurance offers temporary comfort, it inadvertently reinforces the obsessive-compulsive cycle by validating the need for such external validation. Once the effect wears off, the anxiety and obsessive thoughts return with greater intensity. This is supported by research, such as the work of Özdemir (2025), which defines reassurance-seeking as a repetitive solicitation of agreement from others to reduce distress, a behavior strongly associated with OCD and highlighting a significant area for further clinical investigation, including the development of specific diagnostic considerations and measurement tools crucial for psychotherapy. The resulting vicious cycle is: obsessive thoughts generate anxiety, which drives reassurance-seeking behavior, and while this provides temporary relief, it ultimately strengthens the obsessive thoughts.

### 8.2. The Vicious Cycle of Constant Self-Defense:

In most clinical cases, the partner of an individual with ROCD finds themselves in a perpetual state of self-defense due to relentless accusations, as they naturally seek to prove their innocence and maintain the relationship. However, the individual with ROCD interprets this defensive behavior through the lens of their pathology, viewing justified explanations and defenses not as evidence of innocence but as further proof of deceit or unsuitability, leading them to think, “Her very defense proves my thoughts are correct.” This creates a destructive loop where a normal, logical reaction to false accusation is pathologized, thereby fueling further doubt and obsessive scrutiny, trapping both parties in a cycle that prevents rational resolution. The vicious cycle is therefore: obsessive thoughts provoke constant accusations, which trigger the partner’s defensive behavior, which is then misinterpreted as confirmation of guilt, thereby amplifying doubt, anxiety, and disbelief, which in turn reinforces the original obsessive thoughts.

**9. Vicious Cycles in Overlap with Other Mental Disorders:**

A significant clinical challenge is the accurate differential diagnosis when disorders share overlapping symptoms, which leads us to examine the co-occurring vicious cycles that form when ROCD exists alongside other psychological conditions.

**9.1. The Vicious Cycle Between ROCD and Depression:**

Individuals with ROCD often endure symptoms for extended periods, which can severely deteriorate their relationship, leading to conflict, separation, or social isolation, and these profound psychosocial consequences are potent risk factors for the development of depression. Depression, in turn, exacerbates ROCD symptoms by reinforcing a pessimistic worldview and cognitive rigidity, making obsessive thoughts more resistant to challenge, a dynamic confirmed by studies such as Overbeek et al. (2002), which found comorbid depression negatively impacts OCD treatment outcomes. Furthermore, as explained by researchers like Lowenstein (2025), the social isolation inherent to severe OCD can directly contribute to depressive states, creating a bidirectional, self-perpetuating cycle where ROCD symptoms lead to social isolation and psychological exhaustion, which foster depression, which then intensifies the symptoms of ROCD.

**9.2. The Vicious Cycle Between ROCD and Social Anxiety:**

Social anxiety disorder, characterized by a fear of negative evaluation by others, can directly fuel relationship-focused obsessions, as the individual becomes hyper-vigilant about their partner's perceptions and judgments. This anxiety morphs into obsessive doubts about the relationship's stability and their own desirability, and the ensuing compulsive monitoring or avoidance behaviors then intensify their broader social anxiety, creating a feedback loop where social anxiety increases self-monitoring and relationship obsessions, which in turn amplifies the original social anxiety.

**9.3. The Vicious Cycle Between ROCD and Insomnia:**

Sleep is a fundamental physiological need, and its disruption has severe consequences for cognitive function, emotional regulation, and psychological health. Insomnia can be both a comorbid condition and a consequence of ROCD, as obsessive rumination commonly intrudes during nighttime quiet, preventing sleep onset. The partner, often wanting to alleviate conflict and preserve the relationship, provides this reassurance. However, this dynamic is ultimately counterproductive: while the reassurance offers temporary comfort, it inadvertently reinforces the obsessive-compulsive cycle by validating the need for such external validation. Once the effect wears off, the anxiety and obsessive thoughts return with greater intensity.

**10. The Vicious Cycle of Social Media:**

As is well known, social media and its content exert a significant influence on our lives and thoughts, and recently a vast number of videos have proliferated from individuals without psychological credentials who offer advice, analyze behavior, and propagate toxic ideas, as they claim to understand women or human psychology by making sweeping judgments based on personal experiences, past traumas, or anecdotal stories of betrayal which are, in reality, unique experiences that cannot be generalized to all individuals, who differ in personality, upbringing, life stages, and personal circumstances. We are all distinct, with unique

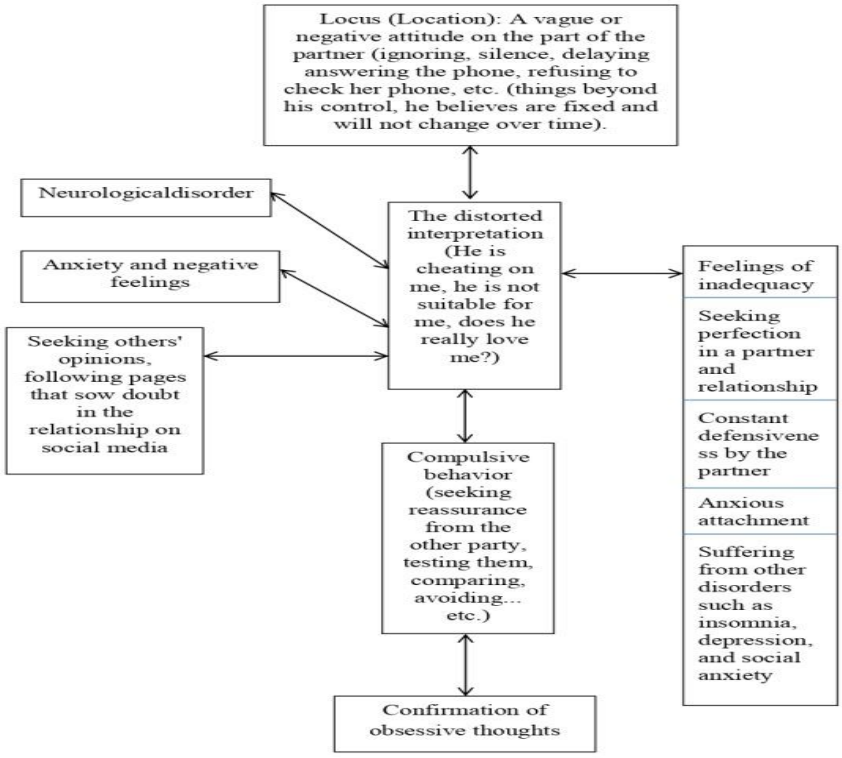
personalities and experiences that defy direct comparison; however, there are individuals who accept these toxic and false ideas as truth. For example, a content creator on TikTok explicitly listed signs of a woman's infidelity, stating verbatim: “When a woman tells you she has to end the call because her mother is sick, or wants to talk to a friend on another line, or needs to sleep because she is tired, be sure she is lying and is going to talk to the other man,” and such content, which incites suspicion and resentment between partners, becomes a significant exacerbating factor for the obsessive thoughts of someone suffering from ROCD, especially when they read supportive comments from others who have often had negative relational experiences, thereby creating an echo chamber of similar opinions. If we were to reverse the roles, however, and ask whether ending a call for similar mundane reasons always indicates infidelity, we would find no scientific or logical evidence to support such absolute claims.

Several studies support this analysis, including recent research by Guazzini et al. (2022), which indicated that nearly all types of OCD are affected by social media in terms of mood, and that individuals with OCD attribute greater importance to such content than those without the disorder. The evidence, though preliminary, encourages further investigation into how people with OCD interact with social networks, as they appear more susceptible to their influence. It is therefore important to acknowledge that the family, as the fundamental social unit, is greatly impacted by social media posts, including malicious fake news and hate speech (Shitor & Qazadi, 2022, p. 149), and unfortunately, another vicious cycle is created here, wherein toxic content finds a receptive audience among those seeking validation for their obsessive doubts, offering temporary relief by making their fears feel shared and justified. The cycle is: obsessive thoughts lead to searching for evidence on social media and seeking others' opinions, which results in believing toxic content, thereby reinforcing the original obsessive thoughts.

**11. The Integrative Model According to Causal Theory:**

In this chapter, we will rely on Bernard Weiner's causal attribution theory to construct an integrated model that synthesizes the various elements discussed in the previous sections. As a reminder, causal attribution theory posits that specific dimensions influence how individuals interpret events in their lives: Locus (whether the cause is internal or external), Stability (the extent to which causes are constant over time), and Controllability (whether the individual can control the causes), in addition to other possible structures like intentionality and globality (Weiner et al., 1985). We will attempt to present the various components of the integrative model of vicious cycles in ROCD based on this theory in the following diagram (Figure 1) to clarify the reciprocal interactions between external and internal components, and we encourage psychotherapists to use such diagrams during psychoeducation to explain symptom dynamics and their consequences, provided they are tailored to the individual patient's presentation.

Fig.1. The integrative model of the vicious cycles in relationship




Source : From the researcher's work.

**12. Conclusion :**

In conclusion, we can state that studying the vicious cycles in Relationship Obsessive-Compulsive Disorder is a crucial step for understanding the detailed dynamics of its symptoms, as we have identified a network of interactions that combine symptoms, external stimuli, and the partner's behaviors, alongside cognitive, emotional, psychological, and neurological factors, all of which contribute to the disorder's persistence and can increase its severity, particularly without intervention. This is compounded by the frequent comorbidity of ROCD with other psychological disorders such as insomnia and depression, where a bidirectional, causal relationship exists. At the behavioral, cognitive, emotional, and relational levels, we have delineated the core elements forming these vicious cycles, which include:

Obsessive thoughts leading to anxiety, which drives compulsive behavior, thereby reinforcing the obsessive thoughts.

Obsessive thoughts triggering anxiety, which results in avoidance behavior, heightening the perceived seriousness of the situation and fueling further obsessive thoughts.

Obsessive thoughts provoking anxiety, which initiates a search for evidence or constant testing of the partner, leading to psychological exhaustion and the emergence of new obsessions.

Obsessive thoughts prompting comparisons with others, causing mental exhaustion, which then generates additional obsessive thoughts.

An insecure attachment style fostering anxiety and obsessive thoughts, which compel obsessive behaviors that suffocate the partner and prompt their withdrawal, consequently increasing the obsessive thoughts.

- Feelings of inadequacy generating obsessive thoughts and anxiety, leading to social isolation, which in turn intensifies the obsessive thoughts.
- Obsessive thoughts creating anxiety, which seeks outlet in reassurance-seeking behavior that provides only temporary relief before reinforcing the obsessive thoughts.

Obsessive thoughts causing the partner to constantly defend themselves, which breeds suspicion, anxiety, and disbelief in their explanations, thereby amplifying the obsessive thoughts.

**Several cycles are interconnected with other disorders, including:**

ROCD symptoms leading to social isolation and psychological exhaustion, which foster depression, which then exacerbates the ROCD symptoms.

Social anxiety causing excessive self-monitoring or avoidance of others, which facilitates indulgence in relationship obsessions, thereby increasing the social anxiety.

Obsessive worries and anxiety contributing to insomnia, which then intensifies the obsessive worries.

**Further cycles are linked to external factors such as social media:**

Obsessive thoughts prompting a search for evidence on social media through others' opinions, leading to belief in toxic content, which reinforces the original obsessive thoughts.

Regarding the integrated model of the ROCD vicious cycle, we have relied on the framework of causal attribution theory, beginning with an ambiguous or negative action by the partner which is perceived as uncontrollable and stable from the sufferer's perspective, leading to cognitive distortions—or faulty interpretations—such as overgeneralization, mind-reading, and catastrophizing. The individual then engages in compulsive behaviors in response to these misinterpretations, a process further influenced by various external and internal factors such as neurological predispositions, general anxiety, consulting others, or exposure to toxic social media content, and it can also be compounded by additional factors like feelings of inadequacy, insomnia, depression, or social anxiety. This culminates in the confirmation of the initial obsessive thoughts and the reinforced belief that the partner's perceived negative traits are fixed and unchangeable, leading to a global negative judgment based on isolated or ambiguous events.

Following this analysis, it is essential to emphasize that awareness and acknowledgment of the problem constitute the first critical step toward treatment, where a therapist may need to explain these vicious cycles to illustrate what is occurring in the mind and brain of someone with ROCD, as well as the consequential damage, since a set of interconnected elements come to dominate their thinking and judgment, which ruins relationships and leads to false accusations. It is also vital to recognize the profound psychological pain experienced by the

individual with ROCD, who is convinced their interpretations reflect reality, and the resulting relational damage, as they live under constant psychological pressure, hypervigilance, and rumination focused on negative thoughts such as "my partner is unfaithful," "they are not right for me," or "do they really love me?". Finally, we must remember that individuals with ROCD are not "crazy" and should not be stigmatized, for while we all experience misconceptions and distorted thinking, the distinction for those with ROCD lies in the intensity and controllability of these thoughts, which cause significant psychological harm to both themselves and their partners, in addition to the influencing neurological and clinical factors specific to the disorder.

Finally, we invite researchers in psychology and scientists specializing in neuroscience to conduct interdisciplinary studies for an in-depth examination of the vicious cycles we have presented, as well as those not yet addressed, particularly within Relationship Obsessive-Compulsive Disorder and its related branch of obsessive jealousy—whether as an independent disorder or a comorbid condition—and to investigate the impact of other mental disorders on obsessive thought patterns. We must also emphasize the need for focused research on the psychological and neurological impact of ROCD on the partner, especially after enduring such pressure long-term, and how this experience may affect their future relationships in the event of separation.

We further call for dedicated attention to how toxic content on social media can exacerbate obsessive thoughts and compulsive behaviors in OCD, for the importance of this topic extends beyond its clinical significance as an under-discussed disorder to its role as a potential destroyer of families, one that can leave serious psychological effects on children in cases of divorce or if the disorder escalates into verbal or physical abuse, with profound consequences for the mental health of the affected partner. Psychological treatment is possible for such cases, however, and the first essential step remains acknowledging the problem and seeking resolution before it worsens.

## 13. Bibliography

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