The Association between Obsessive-Compulsive Disorder Symptom Dimensions and Relationship Functioning

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Abstract

Obsessive-compulsive disorder (OCD) affects individual functioning by causing obsessional anxiety and urges to avoid and perform senseless compulsive rituals. But OCD also affects, and is affected by, interpersonal functioning. The present study examined the associations between various theme-based OCD symptom dimensions and relationship variables in a sample of 21 couples in which one partner had an OCD diagnosis. Correlations were completed which associated the different OCD symptom dimensions with different relationship dynamics. Results indicated there to be less overall relationship satisfaction, more accommodation, more and perceived criticism in couples where the patient reported contamination OCD symptoms. The correlations also revealed less perceived criticism and more constructive communication in couples where the patient reported unacceptable thought OCD symptoms. These findings suggest that different OCD symptoms have different associations with relationship dynamics and suggest the need for further research on the interpersonal aspects of OCD.

Keywords: obsessive-compulsive disorder, relationship functioning, symptom dimensions

The Association between Obsessive-Compulsive Disorder Symptom Dimensions and Relationship Functioning

With 25 percent of adults being affected by anxiety-related problems at some point in their life, anxiety disorders are one of the most prevalent psychological problems (Barlow, 2002). Obsessive-Compulsive Disorder (OCD) is a type of anxiety disorder characterized by recurrent, unwanted, and seemingly bizarre thoughts, impulses, or doubts that evoke affective distress (i.e., obsessions); and repetitive behavioral or mental rituals performed to reduce this distress (i.e., compulsions; Abramowitz, 2006). In order for an individual to be diagnosed with OCD, his or her behaviors must be severe enough that everyday life is impacted. For example, an individual with OCD may believe that his hands are covered in bacteria; and therefore wash his hands so excessively that the skin becomes irritated. A patient might also repetitively doubt that her door is unlocked and that someone could break in, so she checks the door so much that it makes her late to work. Symptoms often vary in their severity over the course of the problem. Individuals with OCD can be comorbid with other anxiety or mood-related disorders.

The symptoms of OCD are very diverse and individuals have varying degrees of insight regarding the senselessness of their obsessions. In other words, some recognize their obsessions as unrealistic, and therefore have good insight. On the other hand, some strongly believe their obsessions are realistic, and therefore have poor insight. Individuals who have good insight are usually more responsive to treatment (Abramowitz, 2006). Patients' experiences with OCD also vary in the types of obsessions and compulsions they experience. Common symptoms include washing rituals, checking rituals, and violent, sacrilegious, and sexual obsessional thoughts. These variations of OCD result in

a variety of responses to treatment. However, cognitive-behavioral therapy (CBT) is the most effective psychological treatment for OCD (Abramowitz, 2006). CBT incorporates exposure and response prevention techniques where the patient gradually and repeatedly confronts obsessional cues and resists compulsive urges. Through CBT patients learn healthier ways to manage obsessional anxiety without engaging in compulsive behavior (Abramowitz, Baucom, Wheaton, Boeding, Fabricant, Paprocki, & Fischer, in press).

Due to the heterogeneity in OCD symptoms, researchers have identified various theme-based symptom dimensions. The Dimensional Obsessive-Compulsive Scale (DOCS) encompasses the four most prevalent symptom categories of OCD: contamination, responsibility of harm, unacceptable thoughts, and symmetry. The first dimension, contamination, focuses on obsessional concerns of coming into contact with someone or something that may result in illness. The compulsion for this dimension is excessive washing or cleaning whatever object or body part the person believes has been contaminated. For example, an individual may believe that if he touches a door handle he will contract a virus. Due to this obsession he avoids touching door handles; but if he must touch one he washes his hands several times following the contact with the handle.

The second dimension includes obsessional thoughts focused on responsibility for harm to oneself or others, and compulsions geared toward checking or seeking reassurance that no harm will (or has) come. An example of an individual with this dimension of OCD is someone whose obsession is focused on whether her front door is locked. Because of this obsession she checks the lock on the door several times prior to leaving home, and seeks constant reassurance from her partner that she locked the door before leaving.

The third dimension concerns obsessional thoughts about sex, religion, or morality that are viewed as "unacceptable." Patients with this dimension often believe that because these thoughts have entered their mind, they will come true or that they accurately represent one's inner character. These individuals often engage in mental rituals to neutralize the obsessional thoughts. An example of this may be a father who has thoughts of killing his infant son. Because this obsessional thought is immoral, the father neutralizes the thought by thinking about the color blue until his anxiety decreases.

The fourth and final dimension concerns obsessions focused on the ideas of symmetry, completeness, and exactness. Individuals with these obsessions engage in compulsions related to ordering and repetition in order to set things just right (Abramowitz, Deacon, Olatunji, Wheaton, Berman, Losardo, Timpano, et al., 2010). For example, a woman is obsessed over how the pillows are arranged on her bed. Due to this obsession, she is the only person who can place the pillows on her bed and must place them the same way everyday.

Regardless of the dimension(s) into which an individual's OCD symptoms fit, obsessions and compulsions often impact more than just the person who is diagnosed. Because of the overt nature of many OCD symptoms, relationship functioning is often impacted. In a study examining how relationships impact OCD treatment, three different problems were encountered. Some partners assisted the OCD patient with their symptoms (i.e., accommodation; performing rituals for the patient), which in turn reinforces their symptoms. Other partners were critical of the symptoms, which then created relationship distress, only further intensifying the OCD symptoms. Finally, other couples had

preexisting relationship conflicts not stemming from the OCD; however, this unrelated distress also intensified the symptoms of the OCD patient (Abramowitz et al, in press).

Often it is difficult for a partner to fully understand the cognitions and behaviors of their loved one with OCD. A partner can easily become frustrated with his or her partner over time, or believe he or she is "crazy" and lose respect for him or her (Baucom, Stanton, & Epstein, 2003). A partner's accommodation, criticism, and communication patterns are some of the key behaviors that impact not only their partner's OCD, but also their relationship functioning as a whole. Not surprisingly, individuals with severe anxiety and OCD symptoms are more likely to be separated or divorced than those without these symptoms (Regier et al, 1990).

As alluded to previously, *accommodation* refers to a partner participating in their loved one with OCD's rituals, for example showering upon entering the house to avoid house contamination; assisting with avoidance, which could include always opening doors for their loved one; taking on duties that the person with OCD cannot complete because of their symptoms, like taking on extra jobs to bring in more household income because their loved one is too anxious to work; or helping their partner solve problems stemming from the OCD, which may include tailoring travel logistics to best accommodate to their loved one's obsessional thoughts (Calvocoressi, Mazure, Kasl, Skolnick, Fisk, Vegso, Van Noppen, & Price 1999; Shafran, Ralph, & Tallis, 1995). Accommodation can vary in severity. An example of subtle accommodation may be a partner who makes the bed a certain way because the OCD patient has obsessions about the need for symmetry and exactness, and needs to bed to be made in a specific manner. On the other hand, an example of extreme accommodation is a partner who showers five

times a day because her loved one with OCD believes she may become contaminated by contact with her partner. Accommodation may be voluntary, conducted by partners who believe that by helping to prevent or alleviate distress in this way they are demonstrating how much they love and care for their OCD-affected partner; but it can also be requested or demanded by the OCD patient, and partners often comply to avoid conflict (Abramowitz et al., in press).

A partner might also continue to accommodate the OCD patient's symptoms despite being aware that the accommodation behavior perpetuates the OCD symptoms resulting in increased distress (Calvocoressi et al., 1999). Partners, however, often see accommodation as the only solution to decreasing the stress of the OCD patient, and thus construct their accommodation into a "relationship system" that addresses the OCD symptoms, and alleviates their loved one's obsessions (Abramowitz et al., in press) Accommodation is a frequent behavior with 40%-88% of relatives accommodating their loved one's OCD symptoms to some degree (Calvocoressi, Lewis, Harris, Trufan, Goodman, McDougle, & Price 1995; Steketee, 1997). Despite the severity or manner in which the accommodation is acted on, accommodation ultimately strengthens OCD symptoms; adversely affects relationship functioning, and can diminish treatment effectiveness (Calvoressi et al., 1999).

Criticism is another response to OCD symptoms by partners that impacts relationship functioning and can lead to hostility, conflict, and emotional distancing. This, in turn, creates a negative environment that exacerbates relationship stress and anxiety symptoms (Steketee, 1997). Partner criticism can be measured through expressed emotions, which refers to the intensity of communication about thoughts and feelings

from one partner to another. Higher rates of expressed emotion has predicted poorer treatment outcome in individuals with anxiety disorders (Chambless, Aiken Steketee, & Hooley, 2001). Relatives who are the most critical of their partners were more likely to believe that their partner could control their deviant behavior but were simply unwilling to do so (Chambless et al, 2001).

Like accommodation, criticism might present in various forms. Hostile criticism (e.g., making personal derogatory remarks such as "you moron, what's wrong with you!?") negatively impacts anxiety symptoms and treatment outcome. However, nonhostile critical comments predicted good treatment outcome (Chambless & Steketee, 1999). For example, a partner communicating that he is frustrated that his wife's OCD symptoms interfere with their ability to go out for the evening is considered nonhostile criticism. Nonhostile criticism can boost the effects of treatment because the healthy partner motivates the OCD patient by expressing his or her dissatisfaction with the OCD symptoms, and does so without personally rejecting him or her (Chambless & Steketee, 1999). Perceived criticism, the degree to which the OCD patient believes his or her nonanxious partner is critical of the OCD symptoms and of them more generally, is also a factor in relationship functioning and symptom severity. Perceived criticism can be a powerful influence on anxiety symptoms. Chambless and Steketee (1999) demonstrated that the severity of a patient's symptoms are not related to a relative's hostility toward them, but instead are related to how critical a patient *perceives* their relatives to be toward them. Perceived criticism has also been shown to be an adverse factor for treatment, negatively impacting treatment outcome (Chambless & Steketee, 1999).

Effective communication is essential to any successful relationship; however, it becomes even more necessary when one partner exhibits OCD symptoms. OCD impacts an individual's social skills, which may make the patient reluctant to reveal personal information to their partner (Abbey, 2007). This lack of communication can become a problem for nonanxious partners, especially when they do not understand the reasoning behind a compulsive behavior. For example, consider a husband with OCD who has frequent contamination obsessions. To relieve these obsessions he cleans the house. However, his wife has just finished cleaning the house and she misinterprets his OCD-driven behavior as indicating that he feels her cleaning was not good enough (Baucom et al., 2003). If the wife had been aware that this was part of her husband's unwanted OCD symptoms, she might have been less likely to interpret his behavior as rude or hurtful.

Communication in partnerships affected by OCD can be difficult due to the sensitive nature of the obsessions. This may be one reason that families in which someone struggles with OCD have less healthy communication, affective involvement, and general functioning than unaffected families (Black, Gaffney, Schlosser, & Gabel, 1998). It is easier for relatives to allow the OCD symptoms to continue than it is to confront them. This is only made worse because individuals with anxiety symptoms are more likely to engage in avoidance behavior when presented with problems (Marcaurelle, Belanger, Marchand, Katerelos, & Mainguy, 2005). However, as mentioned previously, nonhostile constrictive criticism results in improved treatment outcomes. Communication patterns that exhibit empathy, hopefulness, and assertiveness are more positively associated with good treatment outcomes (Chambless & Steketee, 1999; Craske, Burton, & Barlow, 1989; Steketee, 1993).

Accommodation, criticism, and communication patterns all play important roles in how OCD impacts relationship functioning. These three factors are closely intertwined in how individuals with OCD and their partners perceive their relationships, and how couples rate their relationship satisfaction. These factors are also crucial in how they impact OCD treatment, often preventing successful treatment outcome (Chambless & Steketee, 1999). It is also important to recognize that OCD is a diverse disorder in terms of severity levels as well as symptom themes. Obsession severity is negatively correlated with relationship satisfaction (Abbey, 2007). However, research has not been done to investigate how relationship functioning is impacted across the four theme-based symptom dimensions of OCD. Due to the diverse nature of these four dimensions, it is important to investigate how each is associated with relationship functioning. By developing a better understanding of relationship functioning within each dimension, couple therapy strategies can be tailored to produce better outcomes for their patients. For example, an individual with a contamination obsession may be more likely to have a partner that engages in frequent accommodation, compared to an individual with unacceptable obsessions of a sexual nature. This same OCD patient may also struggle with effective communication with his or her partner, whereas the individual with the "unacceptable thought" obsession communicates well with his or her partner. Therapy for these two couples would need to target different aspects of relationship functioning in order to be most effective for both couples.

Accordingly, in the present study, we examined associations between OCD symptom dimensions and relationship dynamics. First, we made the following predictions concerning contamination OCD symptoms since this symptom dimension is the most

overt manifestation of OCD and is most likely, relative to other types of OCD, to directly impact the non-OCD partner: Specifically, we predicted that contamination would be negatively associated with overall relationship satisfaction (for both the OCD patient and healthy partner) and with constructive communication, and positively associated with partner accommodation and perceived criticism. We also had hypotheses about the unacceptable thoughts dimension since it is the least overt and most sensitive type of OCD symptom, and the one least likely to directly affect partners of those with OCD or elicit hostility from them. Specifically, we hypothesized that the unacceptable thoughts dimension would be negatively associated with perceived criticism and positively association with constructive communication. We did not have a priori hypotheses regarding the responsibility for harm or the symmetry/exactness OCD dimensions.

Methods

Participants

Data were collected from 21 couples, of which one partner had a DSM diagnosis of OCD, who participated in a treatment study examining cognitive-behavioral couple therapy for OCD. The patients were recruited through media advertisement and through referrals from primary care and mental health providers (e.g., marital therapists) local to the Raleigh-Durham-Chapel Hill (research triangle) area who are familiar with our treatment center and its research. Patient advocacy groups (e.g., NAMI) and associations (e.g., OCF, ADAA) that post research trials on the interest were also contacted as a means to further publicize the study.

Participants were selected using the following inclusion and exclusion criteria: Inclusion: (a) Married or living together for at least one year, (b) one partner has a DSM-

IV-TR diagnosis of OCD for at least 1 year; (c) Willing to attend all 12 therapy sessions as a couple; (d) Patient and partner fluent in English; (e) No previous cognitive-behavioral treatment for OCD. Exclusion: (a) Current suicidal ideation; (b) Current substance abuse or dependence; (c) Current mania, psychosis, or, borderline or schizotypal personality disorder; (d) Current domestic violence or physical abuse.

Measures

The following measures were used to assess OCD symptoms and relationship functioning:

Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010). The DOCS is a 20-item self-report measure that assesses the severity of the four most consistently replicated OCD symptom dimensions which correspond to the measure's four subscales: (a) contamination, (b) responsibility for harm and mistakes, (c) symmetry/ordering, and (d) unacceptable thoughts. Five items (rated 0 to 4) assess the following parameters of severity of each dimension: (a) time occupied by obsessions and rituals, (b) avoidance, (c) distress, (d) functional interference, and (e) difficulty disregarding the obsessions and refraining from rituals. The DOCS subscales have excellent reliability in clinical samples (α = .94-.96), and the measure converges well with other measures of OCD symptoms (Abramowitz et al., 2010).

Yale-Brown Obsessive Compulsive Scale (YBOCS; Goodman et al., 1989). The YBOCS is a widely used interview measure of global OCD symptom severity that assesses obsessions and compulsions independent of symptom theme. It includes a symptom checklist and 10-item severity scale that has good reliability, validity, and is sensitive to the effects of treatment. This will be our primary outcome measure of OCD

to be administered at pre-post- and follow-up assessments.

Dyadic Adjustment Scale (DAS; Spanier, 1976). The DAS is a 32-item scale assessing relationship satisfaction in married or cohabitating couples. Scores below 100 indicate relationship distress, whereas scores above 110 indicate relationship satisfaction (Spanier, 1976). The DAS is the most widely used measure of overall relationship satisfaction, has excellent reliability ($\alpha = .96$), and has been validated through its capacity to differentiate between relationally distressed and satisfied couples in a wide variety of community samples.

Family Accommodation Scale (FAS; Calvocoressi et al., 1999) The FAS is a 13-item measure that is completed by a family member of someone with OCD to assess the frequency of accommodating OCD symptoms over the course of a week. For the purposes of the present study, the wording of items was changed to refer to “your spouse or partner with OCD” rather than "the patient with OCD" (e.g., “How often did you participate in behaviors related to your spouse/partner’s compulsions?"). The FAS assesses partner’s/spouses’ participation in symptom-related behavior, changes in routine due to OCD symptoms, and distress caused by symptom accommodation. The instrument is strongly correlated with relevant subscales of the Questionnaire on Resources and Stress for Families with Chronically Ill or Handicapped Members (Calvocoressi et al., 1999).

Communication Patterns Questionnaire (CPQ; Christensen & Sullaway, 1984). The CPQ is a 23-item measure of how a couple communicates before, during, and after discussion of a relationship problem. Scores on three CPQ subscales have been shown to differentiate between distressed and non-distressed couples: the Mutual Constructive

Communication subscale (five items), the Avoidance/Witholding subscale (three items), and the Demand/Withdraw subscale (six items). These three subscales have alpha coefficients ranging from .86 to .62, with a mean of .71 (Christensen & Shenk, 1991).

Perceived Criticism Measure (PCM; Hooley & Teasdale, 1989). The single Likert scale item asks the individual to report how much criticism he or she receives from the partner. We are using two versions of the item, so the respondent also reports how much criticism he or she gives the partner.

Procedure

Patients first underwent a diagnostic interview conducted by a trained interviewer using the Structured Clinical Interview for DSM-IV (SCID-IV). Following diagnosis, the patient completed all of the measures listed above, except the DOCS and YBOCS which were administered in interview format. The non-OCD affected partner completed the DAS, FAS, and CPQ only. The present study used only baseline (pre-treatment) data.

The Institutional Review Board (IRB) approved the study. Procedures were taken to minimize risk to all participants, with any risks being outweighed by potential benefits of the study. The selection of participants was fair for the nature of the study. Informed consent was provided to all participants. Data was collected in an appropriate manner, ensuring the safety and confidentiality of all participants and their information provided. All rights of the participants were protected over the course of the study. Demographic characteristics of the sample are summarized in Table 1.

Table 1:

Demographic Characteristics of OCD Patients and their Partners

	OCD patients	Partners
Mean age (SD)	33.81 (10.54)	35.85 (10.99)
Number of females	20	3
Number of Caucasians	19	18
Mean years of education	13	11.80

Results

Analysis Plan

We tested our hypotheses using a correlational design. Data collected from the 21 couples, in which one partner had a DSM diagnosis of OCD, were examined using Pearson Correlations in SPSS. We considered correlations with alpha levels at or below .05 as significant.

Clinical Characteristics

Group means and standard deviations on the study measures appear in Table 2. The Y-BOCS score of 26.29 indicates that the group had global OCD symptoms in the severe range. Regarding the individual OCD symptom dimensions, scores on the DOCS subscales indicated that contamination, responsibility, and unacceptable thought symptoms were within the clinical range of scores. However, the present sample evidenced exactness/symmetry symptoms that were below the mean score obtained in other groups of OCD patients (Abramowitz et al., 2010).

With regard to relationship functioning, our sample's DAS score indicated that the average couple was within the range of being well adjusted (Spanier, 1976). Our sample's mean FAS score indicated a moderately high amount of accommodation from the partner (Calvocoressi et al, 1999). The average amount of perceived criticism patients in our sample reported was within a moderate range (Hooley & Teasdale, 1989). Finally, the average constructive communication as rated by partners in our sample was also moderate (Christensen & Sullaway, 1984).

Correlation Analyses

The results of our correlational analyses are presented in Table 3. As hypothesized, we found a strong significant negative correlation between contamination

OCD symptoms and overall relationship satisfaction as rated by the partner (higher scores on the DAS indicate better relationship satisfaction while higher scores on the DOCS indicate more severe OCD symptoms), although this association was not found regarding the patient's rating of relationship satisfaction. Consistent with our predictions, we found strong significant positive correlations between contamination OCD symptoms and both accommodation and perceived criticism. Further, as hypothesized, unacceptable thoughts were significantly negatively associated with perceived criticism, and positively associated with constructive communication. No other significant correlations were obtained.

Table 2:

Means and Standard Deviations on Study Measures

Variable	*M*	*SD*
OCD symptoms		
Global symptoms (YBOCS)	26.29	5.40
DOCS contamination	9.33	6.32
DOCS responsibility	9.38	5.62
DOCS unacceptable thoughts	9.29	6.14
DOCS exactness/symmetry	3.00	4.17
Relationship measures		
DAS (Partner)	108.10	13.74
FAS (Partner)	35.25	12.79
Perceived Criticism (Patient)	5.0	3.10
Constructive Communication (Partner)	1.70	9.14

Table 3:

Pearson r Correlations for OCD Dimensions and Relationship Conflicts

	Contamination	Responsibility of Harm	Unacceptable Thoughts	Exactness, Symmetry
DAS-partner	**-.46***	-.42	.26	.06
DAS-patient	**-.27**	-.08	.33	.01
FAS-partner	**.64****	.09	-.40	.05
Perceived Criticism-patient	**.51***	.08	**-.49***	-.05
Constructive Communication-partner	**-.19**	-.22	**.47***	-.27

* Correlation is significant at .05 level (2-tailed).

* Correlation is significant at .01 level (2-tailed).

Bold figures show hypothesized results.

Discussion

Although there has been substantial research studying the individual negative effects of OCD symptoms, there has been little work examining how OCD symptoms are associated with interpersonal relationships. Previous studies have looked at individual self-report measures of intimacy, self-disclosure, and overall relationship satisfaction in romantic relationships (Abbey, 2007). However, there are only very few studies examining the effect OCD has on the patient, as well as a non-anxious partner in a clinical setting. The present study allowed for us to examine specifically, the association between different OCD symptoms and various relationship dynamics. Our hypotheses regarding contamination OCD symptoms were partially supported. While the *patient's* relationship satisfaction was unrelated to contamination, partner's ratings of relationship satisfaction were negatively associated with the patient's degree of contamination symptoms. Likely, due to their overt and demanding nature, contamination symptoms produce high strain on a relationship. The partner's accommodation, however, might negatively affect his or her level of relationship satisfaction more than it affects the patient's, who might be satisfied in a relationship where his or her partner "helps" with OCD symptoms. This is consistent with our finding that contamination was positively associated with partner accommodation. Our findings might also signify a disconnect in the relationship, suggesting that a patient does not truly grasp how much of an effect his or her contamination symptoms have on his or her partner. Therefore the patient does not rate relationship satisfaction as poorly as the partner. Further research should continue to study this disconnect, and whether it also exists in other symptoms dimensions of OCD.

One element that can decrease relationship satisfaction is the amount of accommodation present in a relationship. Our hypothesis predicting that accommodation would be associated with greater contamination symptoms was supported. This is consistent with the idea that accommodation occurs most frequently in relationships where the patient's obsessional fears and compulsive rituals are overt, such as with the extreme avoidance that is often observed with contamination obsessions, and the clear impairment in everyday functioning that is commonly observed with washing and cleaning rituals, which can get in the way of opening doors, cooking, and shopping. Due to the salience of these symptoms, partners are more likely to be involved in decreasing the patient's distress by engaging in accommodating behaviors that allow for the patient to avoid these activities. In contrast, other OCD symptoms, such as violent intrusive thoughts and mental rituals, do not lend themselves to accommodation since these obsessions and compulsions might occur exclusively in the patient's mind.

A second element which impacts relationship satisfaction is the amount of criticism someone perceives he or she is receiving from his or her partner. We predicted that in relationships where the patient displayed contamination symptoms, the patient would also report greater perceived criticism. This hypothesis was supported. This result is consistent with the idea that because contamination symptoms are so present in both the lives of the patient and partner, and require more accommodation, a patient is more likely to perceive his or her partner as highly critical since the partner is altering his or her behavior to accommodate the symptoms. These results further suggest that accommodation and perceived criticism might be directly linked. So as a partner

performs more accommodation, the patient might believe that the partner is more critical of him or her. Further research, however, is needed to study this specific relationship.

We also predicted that contamination symptoms would be associated with poorer constructive communication, further impacting overall relationship satisfaction. However, this hypothesis was not supported, suggesting that couples, despite the over nature of contamination symptoms, may still communicate effectively about their relationship problems.

We predicted that unacceptable thought OCD symptoms would be associated with reduced perceived criticism as rated by the patient. This hypothesis was supported. One explanation for these results is that couples communicate in a more healthy way about these types of symptoms, leading to the perception that one's partner is less critical. Less perceived criticism might also be present because the OCD symptoms associated with unacceptable thoughts are often covert in nature, and therefore less likely to require accommodation from a partner. This may result in less perceived criticism by the patient.

Finally, we predicted that unacceptable thought symptoms would be associated with greater constructive communication. This hypothesis was supported, and a possible explanation for this finding is that because unacceptable thought symptoms are so sensitive in nature (often regarding sexual or violent themes), they require better communication between the patient and partner. It is also possible that lower perceived criticism leads to more constructive communication, because the patient believes there to be less resentment from one's partner, allowing for an open dialogue in the relationship.

In concert, these results suggest an important association between different OCD symptoms and relationship dynamics. Specifically, accommodation and perceived

criticism are likely to be present the more a patient reports contamination symptoms. Past research has shown that both accommodation and criticism from a partner or family member can lead to poor treatment outcome (Calvocoressi et al, 1999; Chambless et al, 2001). Therefore, when clinicians are conducting CBT and exposure and response prevention therapy (ERP) with someone affected by OCD, it is important to involve the patient's spouse or partner and incorporate psychoeducation into the initial session in order for both the partner and patient to fully understand the negative effects of accommodation and criticism on treatment.

In line with our results, psychoeducation should specifically be emphasized with patients who report contamination OCD symptoms, since these symptoms are more strongly associated with overall poor relationship satisfaction, accommodation, and perceived criticism. However, these relationship dynamics should not be ignored in patients who report other OCD symptoms, and psychoeducation should be incorporated in their therapy as well.

Our results also suggest the need for assessment of relationship dynamics in clinical settings. Specifically, clinicians should assess (by self report as well as interview) overall relationship satisfaction, accommodation behaviors, perceived criticism, and how the partners communicate. These assessments allow for clinicians to observe the nature of these dynamics, and which of them should be addressed most thoroughly in treatment. Again in line with our results, these assessments should specifically be completed in couples where the patient reports contamination symptoms, because these dynamics are more likely to be present in these relationships.

Limitations of our study that should be considered include our sample size and demographics. With 21 couples participating, our sample was small. Our sample was also quite homogenous, with 37 of 42 participants being Caucasian, and 20 of the 21 patients being female. Future research should seek to recruit a larger and more heterogeneous sample, in order to provide a more balanced look at the nature of relationship functioning when one partner has OCD.

Our study was also limited by the fact that all of the assessment instruments were self-report measures. While patients and partners did complete these measures separately to reduce any influence one may cause the other, it is possible the participants were impacted by social desirability bias as well as malingering in their reports. Future research should seek to construct studies using observational measures in the clinical setting. Both patient and partner behaviors could be coded to assess their relationship functioning.

These limitations withstanding, our study has allowed for a better understanding of the specific role a partner plays in an OCD patient's life. Unintentionally, partners can exacerbate or maintain OCD symptoms through accommodation, or by failing to correct perceived criticism. Inversely, partners can also aid in the treatment process by facilitating constructive communication.

Past research has illustrated that relationship functioning impacts treatment outcome and patient symptom severity (Calvoressi et al, 1999; Chambless et al, 2001; Steketee, 1997; Chambless & Steketee, 1999; Black et al, 1998; Marcaurelle et al, 2005; Abramowitz et al, 2012; Baucom et al, 2003). However, our study has specified the link between OCD symptoms and relationship functioning by presenting specific associations

between OCD symptom dimensions and relationship dynamics. This new research can now be used in clinical settings to provide the most effective couple's therapy treatment for the patient's symptoms.

Future research should continue to investigate further associations between relationship dynamics and specific OCD symptoms with larger and more diverse samples. Future studies may also choose to focus on patients with responsibility of harm or symmetry symptoms and look into the most significant relationship dynamics associated with these symptoms, since our sample reported very low rates of these symptoms.

Our study has been a great first step in investigating the associations between relationship dynamics and OCD symptom dimensions. Due to the diverse nature of OCD, it is important for treatments to examine all aspects of a patient's lifestyle, including their intimate relationships. Couple's therapy, mixed with CBT and ERP, may prove to be an effective treatment for patients in romantic relationships. And our results can help in this treatment approach by signaling likely relationship dynamics in association with displayed symptoms.

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