

Impact Parental Bonding and Relationship-Centered Obsessive-Compulsive Symptoms: The Moderating Role of Adult Attachment among Young Adults in Pakistan

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One of the most significant sources of psychological distress is romantic relationship difficulties. Relationship centered obsessive-compulsive (OC) symptoms are easily recognized as a discrete demonstration within the OCD spectrum. Romantic attachment insecurity is shaped by our early childhood experiences that establish into adult relationships. This pathway however, remains unclear. The present study considered whether adult attachment styles (anxiety and avoidance) moderate the relationship between parental bonding (care and overprotection) and relationship-centered OC symptoms among young adults in Pakistan. A cross-sectional design was used with 213 young adults (M age = 23.25, SD = 3.44). The young adults were recruited from universities in Islamabad. Data were collected using the measures such as Relationship Obsessive-Compulsive Inventory (Doron et al., 2012), the Parental Bonding Instrument (Parker et al., 1979), and the Experiences in Close Relationships Scale-Short Form (Wei et al., 2007). PROCESS macro, Model 1 (Hayes, 2022) was used for moderation analysis. All four moderation models were significant ($p < .05$). Attachment anxiety and avoidance each moderated the relationship between parental care, parental overprotection and relationship-centered OC symptoms. Parental bonding across Models, predicted ROC symptoms only at medium and high levels of attachment insecurity. The strongest effect appeared for the Parental Overprotection $\times$ Attachment Anxiety interaction ($\Delta R^2 = .052$, $p < .001$). These findings propose that adult attachment insecurity strengthens, rather than simply transmits. They also suggest the effect of adverse parental bonding on relationship-centered OC symptoms along with implications for clinical intervention. Also, for understanding relational psychopathology within a South Asian Pakistani cultural context.

Key words. Parental Bonding, Adult Attachment, Relationship-Centered OC Symptoms

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Romantic relationships play an important role to adult wellbeing. Difficulties within romantic relationships are the most common cause of psychological distress. Relationship-centered obsessive-compulsive (OC) symptoms are defined as persistent, intrusive doubts about the appropriateness of one's relationship, the worthiness of one's love, or a partner's suitability. These symptoms are gradually recognized as a discrete presentation within the OCD spectrum (Doron et al., 2014). "Relationship Obsessive-Compulsive Disorder" (ROCD) was the original presentation, recent work favors describing it as relationship-centered or partner-focused OC symptoms. Meanwhile, it reflects a symptom dimension rather than a separate diagnosis (Karmous et al., 2025). These symptoms are related to relationship dissatisfaction, high psychological distress, and impaired daily functioning. These symptoms however, occur across both clinical and non-clinical populations (Doron et al., 2012; Gorelik et al., 2023).

Attachment insecurity is among the most consistently recognized susceptibility factors. Individuals high in attachment anxiety fear abandonment. This fear of abandonment then leads to excessive reassurance seeking. Individuals high in avoidance are uncomfortable with closeness. They suppress attachment needs. Both dimensions predict symptom severity (Rezaei et al., 2023). Attachment insecurity also shapes adult relationship dynamics. Parents' attachment anxiety has been linked to concern with a child's social functioning (Azani Sadka et al., 2023). Elevated relationship-centered OC symptoms in one partner can increase symptoms and infidelity-related concern in the other (Littman et al., 2023). However, these symptoms are relationally embedded not just individually.

Parental bonding is defined as the quality of early emotional relationship between parents and children. It is theorized as a developmental antecedent to this susceptibility. Parental care (warmth, emotional availability) from overprotection (psychological control, restriction of autonomy) was distinguished by Parker et al. (1979). Poor parental bonding, particularly the combination of low care and high overprotection is commonly known as "affectionless control". It is strongly related with adult mood, anxiety, and OC-spectrum symptoms (Kidd et al., 2022; Gomes et al., 2023). Parenting low in warmth and high in control has been associated to relationship-centered OC symptoms. Specifically, a suggestion partly described by emotion-regulation difficulties such as alexithymia (Tamrchi et al., 2024).

In Pakistan, a collectivist culture in which parent-child bonds remain significant well into adulthood. Developing evidence similarly relates parental bonding and attachment quality to psychological distress and problematic relationship patterns. Especially, among young adults (Irfan et al., 2024; H. Fatima & Khalid, 2023). However, empirical work investigating relationship-centered OC symptoms within South Asian populations remains particularly limited. This limits how far Western findings can be generalized to this cultural context (Karmous et al., 2025).

Moderation versus Mediation: Theoretical Rationale

Existing models often consider adult attachment as a mediator. In a mediation, however, parental bonding acts on symptoms indirectly through attachment. It depicts little about whom, or under what conditions, that effect is strongest. A moderation framework is instead used with diathesis-stress model. Differential-vulnerability accounts of psychopathology. In this attachment insecurity is a susceptibility factor that regulates the degree to which an environmental exposure (adverse parental bonding) interprets into symptoms. Rather than explaining a pathway that carries the exposure's effect forward (Doron et al., 2014). This dissimilarity has direct empirical example outside the ROCD literature. Attachment has been revealed to moderate rather than mediate the link between adverse early childhood experiences and later distress. This distress includes abuse history and adult attachment-related outcomes (Shen & Soloski, 2024). Interpersonal violence exposure and posttraumatic symptoms (Scott & Babcock, 2010). On this foundation, the present study represents adult attachment anxiety and avoidance as moderators of the parental bonding and relationship-centered OC symptoms.

Three research gaps are addressed in this study. First, whether adult attachment mediates or moderates the relation between parental bonding and relationship-centered OC symptoms. Second, existing literature is drawn mostly from Western samples. Limited data from Pakistan or South Asia is present. Third, the combination of both parental bonding and adult attachment has rarely been studied within a single moderation framework. The present study addresses these gaps by investigating: (1) the association between parental bonding and relationship-centered OC symptoms; (2) the association between adult attachment and relationship-centered OC symptoms; and (3) whether adult attachment moderates the

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relationship between parental bonding and relationship-centered OC symptoms among young adults in Pakistan.

Hypotheses

1. Parental care will be significantly negatively correlated with relationship-centered OC symptoms.
2. Parental overprotection will be significantly positively correlated with relationship-centered OC symptoms.
3. Attachment anxiety will be significantly positively correlated with relationship-centered OC symptoms.
4. Attachment avoidance will be significantly positively correlated with relationship-centered OC symptoms.
5. Adult attachment anxiety will significantly moderate the relationship between parental bonding and relationship-centered OC symptoms.
6. Adult attachment avoidance will significantly moderate the relationship between parental bonding and relationship-centered OC symptoms.

Method

Research Design

Quantitative cross-sectional research was used in the study. This design deemed appropriate for examining relationships between variables at a single point in time. It is commonly used in research to discover relations between early childhood experiences and current psychological symptoms. A moderation framework was also used to study whether adult attachment dimensions (anxiety and avoidance) moderate the relationship between parental bonding (care and overprotection). It was also used to examine the relation with relationship-centered obsessive-compulsive symptoms.

Participants

The sample included 213 young adults that were recruited from universities in Islamabad, Pakistan. G*Power analysis was used to calculate the required sample size for a moderated multiple regression analysis (Faul, Erdfelder, Buchner, & Lang, 2009). A linear multiple regression (fixed model, R^2 increase) with two predictors, an alpha level of .05, statistical power of .80, and a small-to-medium effect size ($f^2 = .05-.10$) indicated a minimum required sample size of approximately 130–180 participants. The final sample of 213 participants exceeded this requirement, providing adequate statistical power to detect the hypothesized interaction effects.

18- to 35-year-old participants were included in the study ($M = 23.25$, $SD = 3.44$). The majority of participants were male ($n = 159$, 74.6%) and female ($n = 54$, 25.4%). In respect to education, 46.5% were undergraduate students, 29.6% were graduates, and 23.9% were postgraduate students. Majority of the participants (83.1%) lived in nuclear family systems. 85.9% participants reported that both parents were alive and living together. Detailed demographic information is shown in Table 1 in the Results section

A purposive convenience sampling strategy was adopted, targeting university students in Islamabad who met the study's inclusion criteria. This approach is widely used in psychological research examining specific developmental or clinical constructs within accessible populations, as it enables efficient recruitment of participants who can meaningfully respond to the constructs under investigation — here, adult romantic

attachment and retrospective parental bonding, both of which require participants to have had relevant relational experience. Convenience and purposive sampling remain standard practice in university-based clinical psychology research where random sampling from a defined population frame is not logistically feasible. This strategy, however, limits the generalizability of findings to university-enrolled young adults in Islamabad, and caution is warranted in extending conclusions to the broader Pakistani population, a limitation addressed further in the Discussion.

Inclusion & Exclusion Criteria. The inclusion criteria included participants that are: (a) between the ages of 18 -35, (b) currently or previously in a romantic relationship for more than 6 months duration, (c) able to comprehend and respond to questionnaires in English, and (d) raised by at least one primary caregiver during the first 16 years of life. The exclusion criteria of the participants were excluded if they had a diagnosed neurological or psychiatric condition. Participants with such a diagnosis were excluded from the original sample.

Measures

Relationship Obsessive Compulsive Inventory (ROCI; Doron et al., 2012). The ROCI is a 14-item self-report measure. It is used for assessing relationship-centered obsessive compulsive symptoms. 5-point Likert scale is used to rate the items. The range is from 0 (Not at all) to 4 (Very much). Following the official scoring guidelines (Doron et al., 2012), items 2 and 8 are excluded from scoring. This however, considering a mean score based on 12 items. The clinical cut-off for clinically significant ROCD symptoms is a mean score of 2.13 (Melli et al., 2018). The ROCI has established strong reliability with a Cronbach's Alpha ranging from .84 to .89 (Doron, Derby, Szepsenwol, & Talmor, 2012). The present study, had an acceptable internal consistency (Cronbach's $\alpha = .789$).

Parental Bonding Instrument (PBI; Parker et al., 1979). The PBI is a self-report measure with 25 items. It is used for assessing perceived parenting in the first 16 years of their life. It consists of two dimensions: care (12 items) and overprotection (13 items). A 4-point scale is used to rate the items. Starting from 0 (Very unlike) to 3 (Very like). Greater parental warmth and affection is indicated by higher scores on the care subscale. While higher scores on the overprotection subscale indicate Greater parental control and restriction of autonomy is therefore, depicted by higher scores on the overprotection subscale. The PBI has established good internal consistency across multiple cross-cultural validations. It has a Cronbach's alphas ranging from .62 to .88 across the Care and Overprotection subscales, and its long-term stability has been supported over periods of up to eleven years (Wilhelm & Parker, 1990). In the present study the Cronbach's alpha for care subscale was 0.72 and for overprotection it was 0.75 which is well within the acceptable range.

In the present study, a single combined-parent form was administered. In which participants responded based on their primary caregiver experience during the first 16 years of life. This however, reflecting the Pakistani collectivist family culture.

Experiences in Close Relationships Scale-Short Form (ECR-S; Wei et al., 2007). The ECR-S is a 12-item self-report measure. It is used to measure adult romantic attachments. It comprises of two subscales: anxiety (6 items) and avoidance (6 items). Items are rated on a 7-point Likert scale. Ranging from 1 (Disagree strongly) to 7 (Agree strongly). Higher scores on each subscale indicate greater attachment anxiety or avoidance respectively. Satisfactory internal consistency across six studies was demonstrated by Wei et al. (2007). It has a Cronbach's alpha ranging from .77 to .86 for the Anxiety subscale and .78 to .88 for the Avoidance subscale. In the present study, Cronbach's alphas are reported as high as .89 to .95.

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Procedure

Ethical approval was obtained prior to data collection from the Department of Psychology, Air University Islamabad Ethics Review Committee (Approval No.243136, dated 20th April, 2026). Participants were recruited through convenience and purposive sampling from universities in Islamabad. All participants were given an informed consent form. Questionnaires were administered in a single session. Participation was voluntary. The participants were informed of their right to withdraw at any time. Therefore, without any consequence. Confidentiality of all responses was maintained.

Statistical Analysis

IBM SPSS Statistics Version 27 was used to analyze the data. Descriptive statistics and Pearson product-moment correlations were computed for all study variables. The PROCESS macro-Version 5.0 was used for moderation analysis (Hayes, 2022) Model 1 with 5,000 bootstrap samples and 95% confidence intervals. All continuous predictor and moderator variables were mean-centered. This was done prior to analysis to reduce multicollinearity. Four separate moderation models were used, studying whether attachment anxiety and avoidance each moderated the relationship between parental care and ROC symptoms. Also, between parental overprotection and ROC symptoms.

Results

Table 1

Descriptive statistics of demographic characteristics (N = 213)

Variables	<i>M</i>	<i>SD</i>	<i>f</i>	%
Age (years)	23.25	3.44		
Gender				
Male			159	74.6
Female			54	25.4
Birth Order				
First born			48	22.5
Middle child			87	40.8
Last born			75	35.2
Only child			3	1.4
Education Level				
Undergraduate			99	46.5
Graduate			63	29.6
Postgraduate			51	23.9
Parental Status				
Both parents alive and living together			183	85.9
One parent deceased			15	7.0
Parents divorced			6	2.8
Parents separated			6	2.8
Both parents deceased			3	1.4
Relationship Status				
Currently single			102	47.9
Committed/Engaged			66	31.0
Married			24	11.3
Divorced			12	5.6
Separated			3	1.4
Family System				
Nuclear			177	83.1
Joint			33	15.5

Note. f = frequency, % = Percentage, M = Mean, SD = Standard Deviation

Table 1 represents the demographic characteristics. The sample consisted of 213 participants with a mean age of 23.25 years ($SD = 3.44$). The majority were male (74.6%), undergraduate students (46.5%), from nuclear family systems (83.1%), with both parents alive and living together (85.9%). Nearly half were currently single (47.9%), while 31.0% were in a committed or engaged relationship.

Table 2

Means, standard deviations, and Pearson correlations among study variables (N = 213)

Variables	M	SD	1	2	3	4
1. Parental Care	19.80	5.44	—			
2. Parental Overprotection	21.56	6.09	.754**	—		
3. Attachment Anxiety	27.13	7.06	-.083	-.056	—	
4. Attachment Avoidance	28.83	4.36	-.071	.011	.370**	—
5. ROC Symptoms	2.28	0.59	-.163*	-.111	.356**	.365**

Note. * $p < .05$. ** $p < .01$.

The bivariate relationships between study variables (Table 2) were examined using the Pearson product moment correlation analysis. Parental care was significantly negatively correlated with ROC symptoms ($r = -.163$, $p = .018$), while parental overprotection was not significantly correlated with ROC symptoms ($r = -.111$, $p = .105$), partially supporting H1 but not H2. A strong positive correlation between care and overprotection ($r = .754$, $p < .001$) indicated multicollinearity, likely reflecting the cultural context of the Pakistani sample wherein overprotective behaviors are intertwined with expressions of care.

Both attachment anxiety ($r = .356$, $p < .001$) and attachment avoidance ($r = .365$, $p < .001$) were significantly positively correlated with ROC symptoms, supporting H3 and H4. Attachment anxiety and avoidance were also significantly correlated with each other ($r = .370$, $p < .001$). Neither parental care neither parental overprotection was significantly correlated with attachment anxiety or avoidance (all $p > .05$), suggesting that attachment insecurity does not simply mediate the parenting ROC relationship but may instead moderate it.

Table 3

Moderation analysis: Parental care $\times$ attachment anxiety predicting ROC symptoms (N = 213)

Variable	B	SE	t	p	95% CI
Constant	2.275	.038	60.32	< .001	[2.201, 2.350]
Parental Care (X)	-.016	.007	-2.42	.017	[-.029, -.003]
Attachment Anxiety (W)	.032	.007	4.70	< .001	[.018, .045]
Care $\times$ Anxiety	-.002	.001	-2.40	.017	[-.004, .000]

Note. $R^2 = .173$, $F(3, 209) = 9.76$, $p < .001$. $\Delta R^2 = .029$ for interaction term.

Table 4

Conditional effects of parental care on ROC at levels of attachment anxiety (N = 213)

Attachment Anxiety	B	SE	t	p	95% CI
Low (-7.13)	.001	.008	.103	.918	[-.015, .017]
Medium (-1.13)	-.013	.006	-2.09	.038	[-.026, .000]
High (7.87)	-.034	.012	-2.99	.003	[-.057, -.012]

Note. * $p < .05$. ** $p < .01$.

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Model 1: Parental Care × Attachment Anxiety

The overall model was significant, $F(3, 209) = 9.76, p < .001, R^2 = .173$. Parental care ($B = -.016, SE = .007, t(209) = -2.42, p = .017$) and attachment anxiety ($B = .032, SE = .007, t(209) = 4.70, p < .001$) were significant predictors. The interaction (Care × Anxiety) was significant ($B = -.002, SE = .001, t(209) = -2.40, p = .017, \Delta R^2 = .029$), confirming moderation. Simple slope analysis (Table 4) showed that parental care significantly predicted ROC symptoms at medium ($B = -.013, p = .038$) and high ($B = -.034, p = .003$) levels of anxiety, but not at low levels ($B = .001, p = .918$).

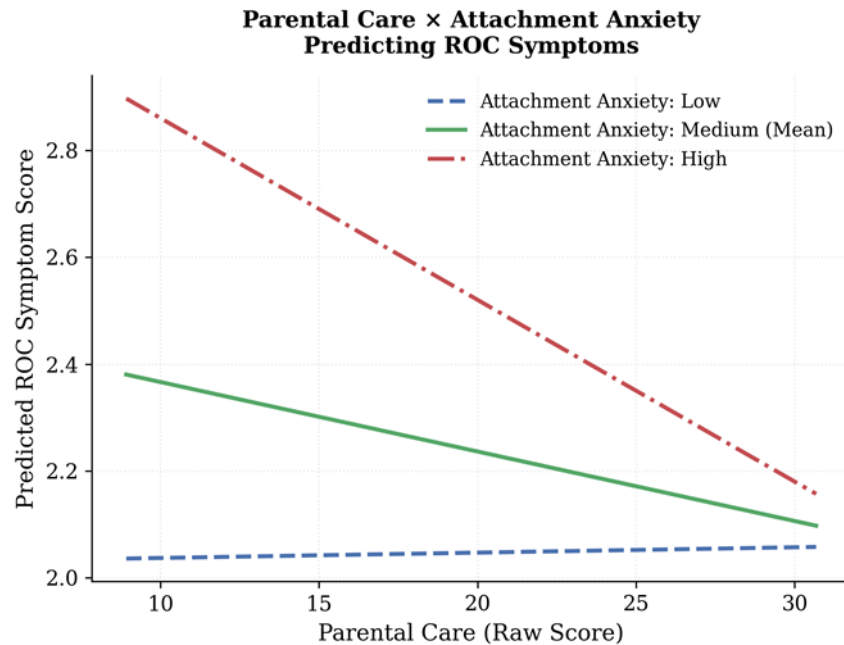


Figure 1. Parental care predicting ROC symptoms at low, mean, and high levels of attachment anxiety.

Table 5

Moderation analysis: Parental care × attachment avoidance predicting ROC symptoms (N = 213)

Variable	B	SE	t	p	95% CI
Constant	2.276	.037	61.52	< .001	[2.203, 2.349]
Parental Care (X)	-.006	.006	-.861	.390	[-.018, .007]
Attachment Avoidance (W)	.050	.010	4.91	< .001	[.030, .070]
Care × Avoidance	-.004	.001	-3.62	< .001	[-.007, -.002]

Note. $R^2 = .173, F(3, 209) = 9.76, p < .001. \Delta R^2 = .029$ for interaction term.

Table 6

Conditional effects of parental care on ROC at levels of attachment avoidance (N = 213)

Attachment Avoidance	B	SE	t	p	95% CI
Low (-4.83)	.015	.010	1.46	.146	[-.005, .036]
Medium (.169)	-.006	.006	-.988	.324	[-.019, .006]
High (4.169)	-.023	.006	-3.90	< .001	[-.035, -.012]

Note. * $p < .05$. ** $p < .01$.

Model 2: Parental Care × Attachment Avoidance

The overall model was significant, $F(3, 209) = 12.65$, $p < .001$, $R^2 = .192$. Attachment avoidance ($B = .050$, $SE = .010$, $t(209) = 4.91$, $p < .001$) significantly predicted ROC symptoms, while parental care alone did not ($B = -.006$, $p = .390$). The Care × Avoidance interaction was significant ($B = -.004$, $SE = .001$, $t(209) = -3.62$, $p < .001$, $\Delta R^2 = .041$). Simple slopes (Table 6) revealed that parental care predicted ROC symptoms significantly only at high avoidance ($B = -.023$, $p < .001$), but not at low or medium levels.

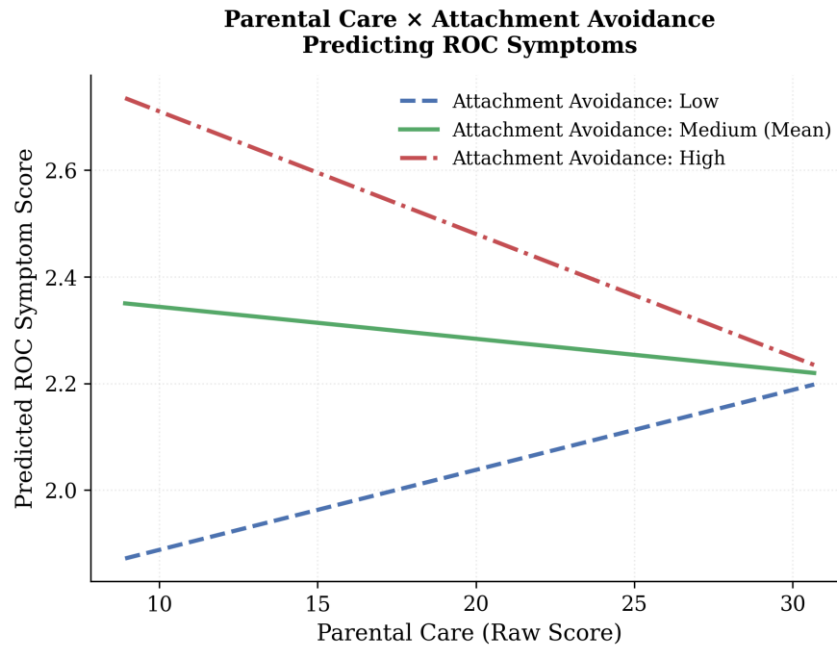


Figure 2. Parental care predicting ROC symptoms at low, mean, and high levels of attachment avoidance.

Table 7

Moderation analysis: Parental overprotection × attachment anxiety predicting ROC symptoms (N = 213)

Variable	B	SE	t	p	95% CI
Constant	2.276	.037	61.21	< .001	[2.203, 2.349]
Overprotection (X)	-.014	.005	-2.65	.009	[-.025, -.004]
Attachment Anxiety (W)	.033	.006	5.42	< .001	[.021, .045]
Overprotection × Anxiety	-.003	.001	-3.96	< .001	[-.004, -.002]

Note. $R^2 = .187$, $F(3, 209) = 12.13$, $p < .001$. $\Delta R^2 = .052$.

Table 8

Conditional effects of parental overprotection on ROC at levels of attachment anxiety (N = 213)

Attachment Anxiety	B	SE	t	p	95% CI
Low (-7.13)	.007	.005	1.30	.196	[-.003, .016]
Medium (-1.13)	-.011	.005	-2.21	.028	[-.021, -.001]
High (7.87)	-.037	.010	-3.77	< .001	[-.057, -.018]

Note. * $p < .05$. ** $p < .01$.

Model 3: Parental Overprotection × Attachment Anxiety

The overall model was significant, $F(3, 209) = 12.13$, $p < .001$, $R^2 = .187$. Both overprotection ($B = -.014$, $SE = .005$, $t(209) = -2.65$, $p = .009$) and anxiety ($B = .033$, $SE = .006$, $t(209) = 5.42$, $p < .001$) significantly predicted ROC symptoms. The Overprotection × Anxiety interaction was significant ($B = -.003$, $SE = .001$, $t(209) = -3.96$, $p < .001$, $\Delta R^2 = .052$), representing the strongest moderation effect across all models. Simple slopes (Table 8) showed that overprotection significantly predicted ROC at medium ($B = -.011$, $p = .028$) and high ($B = -.037$, $p < .001$) anxiety, but not at low levels.

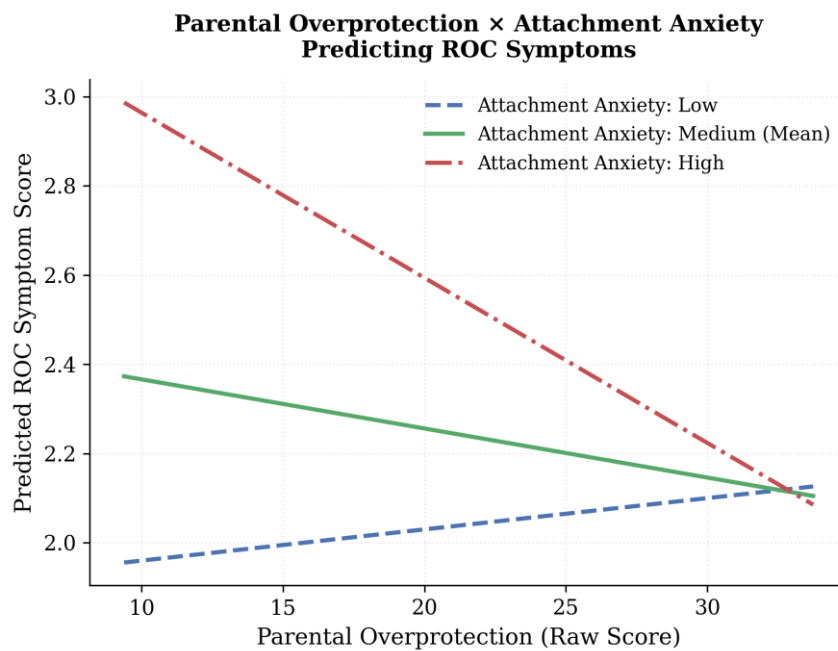


Figure 3. Parental overprotection predicting ROC symptoms at low, mean, and high levels of attachment anxiety.

Table 9

Moderation analysis: Parental overprotection × attachment avoidance predicting ROC symptoms (N = 213)

Variable	B	SE	t	p	95% CI
Constant	2.284	.038	60.35	< .001	[2.209, 2.358]
Overprotection (X)	-.007	.006	-1.13	.261	[-.018, .005]
Attachment Avoidance (W)	.050	.011	4.69	< .001	[.029, .071]
Overprotection × Avoidance	-.003	.001	-2.39	.018	[-.005, .001]

Note. $R^2 = .169$, $F(3, 209) = 7.98$, $p < .001$. $\Delta R^2 = .023$.

Table 10

Conditional effects of parental overprotection on ROC at levels of attachment avoidance (N = 213)

Attachment Avoidance	B	SE	t	p	95% CI
Low (-4.83)	.007	.010	.724	.470	[-.012, .026]
Medium (.169)	-.007	.006	-1.22	.223	[-.019, .004]
High (4.169)	-.019	.006	-2.98	.003	[-.031, -.006]

Note. * $p < .05$. ** $p < .01$.

Model 4: Parental Overprotection × Attachment Avoidance

The overall model was significant, $F(3, 209) = 7.98, p < .001, R^2 = .169$. Attachment avoidance ($B = .050, SE = .011, t(209) = 4.69, p < .001$) was a significant predictor, while overprotection alone was not ($B = -.007, p = .261$). The Overprotection × Avoidance interaction was significant ($B = -.003, SE = .001, t(209) = -2.39, p = .018, \Delta R^2 = .023$). Simple slopes (Table 10) revealed that overprotection significantly predicted ROC only at high avoidance ($B = -.019, p = .003$), but not at low or medium levels.

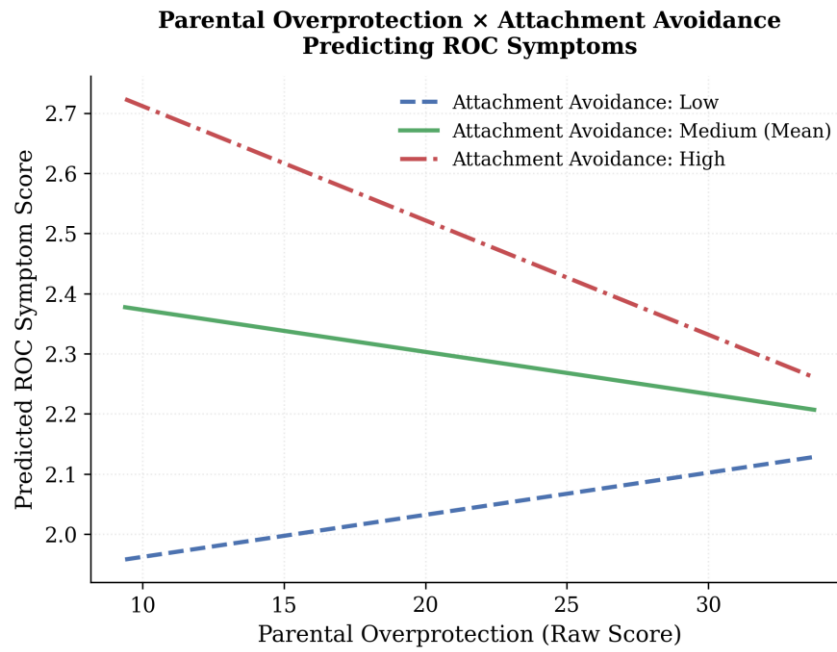


Figure 4. Parental overprotection predicting ROC symptoms at low, mean, and high levels of attachment avoidance.

Discussion

The present study examined whether adult attachment moderates the relationship between parental bonding and ROC symptoms. Especially, among young adults in Pakistan. Consistent with the study hypotheses, all four moderation models were statistically significant. Adult attachment anxiety and avoidance were each associated with the strengthening the relationship between parental bonding (care and overprotection) and ROC symptoms. The consistent pattern across models was that parental bonding was significantly associated with ROC symptoms only (when attachment insecurity was at medium or high levels). It was not associated not when attachment insecurity was low. Since, the design is cross-sectional and correlational. Statistical association has been used as evidence for this interpretation. Therefore, it does not form a causal relationship mechanism. They are consistent with, but do not establish. The idea that attachment insecurity functions as a condition under which the association between parental bonding and ROC symptoms increase or strengthen.

The finding that parental care was significantly negatively correlated with ROC symptoms ($r = -.163, p = .018$) is consistent with Doron et al.'s (2014) theoretical framework. This proposes that early neglect in emotional caregiving experiences is associated with negative internal working models of others as unreliable. This may in turn be linked to susceptibility to obsessive relational doubting in adult relationships. This framing describes a plausible developmental pathway. However, rather than a demonstrated causal sequence. The present data cannot establish whether early caregiving experiences preceded,

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contributed to, or simply co-occurred with later relational cognitions. Since, both were measured retrospectively and simultaneously in adulthood.

In comparison, to H2, parental overprotection did not show a significant correlation with ROC symptoms. Several alternative, non-mutually-exclusive explanations may account for this finding. The present data does not allow us to arbitrate between them. First, the strong correlation between care and overprotection ($r = .754$) indicates substantial shared variance between the two PBI subscales in this sample. This may have statistically suppressed or attenuated the independent association of overprotection with ROC symptoms at the bivariate level. This could reflect genuine conceptual overlap in how these constructs are experienced in this population. It could reflect a limitation of applying the PBI's original two-dimensional structure to a sample where they are not clearly differentiated. Second, this finding may reflect a culturally specific pattern. This pattern especially in the Pakistani cultural context in which overprotective parenting practices are common. They are often experienced as a demonstration of care rather than as psychologically intrusive (Irfan et al., 2024). Third, restriction of range or measurement invariance in how the PBI overprotection items are interpreted across cultural contexts cannot be ruled out. This would also produce an attenuated bivariate association. This however, without suggesting that overprotection is psychologically inert in this population.

However, overprotection was significantly associated with ROC symptoms through its interaction with attachment anxiety. This is the largest interaction effect observed across the four models ($\Delta R^2 = .052$, $p < .001$). It suggests that the association between overprotection and ROC symptoms may not be uniformly absent. But rather conditional on the co-occurrence of attachment anxiety. One interpretation is that individuals who experienced overprotective parenting and high attachment anxiety may be more likely to show heightened vigilance about autonomy and control within adult relationships. However, this remains one of several possible interpretations consistent with the data. Alternative explanations including shared-method variance between self-reported overprotection, attachment anxiety, and ROC symptoms. All are measured through self-report in a single sitting cannot be excluded from the results.

Both attachment anxiety and avoidance were significantly and positively correlated with ROC symptoms. A pattern consistent with previous findings reported by Doron et al. (2012) in other cultural contexts. This convergence is a distinguished feature of the present study. As it suggests the association between attachment insecurity and ROC symptoms may generalize across cultural settings. Though replication in Pakistan alone does not establish generalizability across the diversity of Pakistani society. Given the sample's composition (see Limitations). The association between avoidance and ROC symptoms is worth noting conceptually. Although, avoidant individuals are typically considered as suppressing attachment-related needs. The positive association with ROC symptoms observed here suggests that avoidance may co-occur with relational obsessions rather than eliminate them. A pattern that would be reliable with Doron et al.'s (2014) observation that ROC symptoms-related compulsions can include avoidance of relational commitment. Though again, the cross-sectional design means this remains an association rather than a established casual mechanism.

The pattern is consistent across all four models. In which parental bonding was associated with ROC symptoms only at medium-to-high levels of attachment insecurity. It is compatible with a diathesis-stress framing. In which parenting experiences represent one of several distal factors. However, whose statistical association with ROC symptoms depends on the presence of attachment insecurity. This interpretation is one of several that the data

can support. It is an equally plausible alternative. Such that both parental bonding recall and attachment insecurity are jointly shaped by a third, unmeasured factor. The unmeasured factors include current relationship distress, general negative affectivity, or retrospective recall bias. In which could produce a similar statistical pattern without either parental bonding or adult attachment functioning as it is described here. Longitudinal designs would be needed to demonstrate between these possibilities.

Conclusion

The present study offers preliminary evidence from a Pakistani university sample that adult attachment insecurity is associated with the strength of the relationship between parental bonding and ROCD symptoms. All four moderation models were significant, with a consistent pattern in which the association between parenting-related variables and ROCD symptoms was more pronounced at higher levels of attachment insecurity. Given the cross-sectional design, these findings should be understood as identifying a statistical pattern warranting further investigation rather than establishing a causal or developmental sequence. The results also point to the value of culturally grounded research in clinical psychology: while the association between attachment insecurity and ROCD symptoms appears broadly consistent with findings from other cultural contexts, the pattern observed for overprotection in this sample may reflect features specific to this population, sample, or measurement approach, and should be interpreted cautiously pending replication.

Implications

These findings are correlational. They are derived from a single non-clinical, university-based sample. They may nonetheless offer hypothesis-generating implications for practice. Clinicians working with clients presenting with ROC symptom-related concerns might consider assessing adult attachments as part of a broader case formulation. Since attachment anxiety and avoidance were associated with ROC symptoms in this sample. However, this should not be taken to imply that attachment insecurity is a required or sufficient antecedent to ROCS. Addressing attachment patterns alone will resolve ROC symptoms. Attachment-informed approaches within cognitive behavioral therapy can be used for this purpose. For example, addressing maladaptive relational schemas or intolerance of relational uncertainty may be one reasonable component of a broader treatment plan. (Doron et al., 2014). Although this suggestion is drawn from the present correlational findings and existing theory. This however, is not drawn from a treatment trial, and would benefit from direct testing in intervention research. Similarly, psychoeducation on the role of early relational experiences may be a reasonable component of care for some clients. This may be offered as among others rather than as an evidence-based protocol validated by this study.

Limitations and Future Directions

Several limitations demonstrate the requirements of the interpretation of these findings. First, and most, the cross-sectional research design excludes any causal or directional inference. All relations reported here should be read as concurrent statistical relationships rather than evidence of causal preference. Second, potential response biases are produced by reliance on self-report measures. Social desirability and retrospective recall bias in the PBI, and raises the likelihood that observed associations partially reflect shared method variance. Third, the sample was employed from universities in Islamabad and was mainly male (74.6%). This limits generalizability to non-student, non-urban, and more gender-balanced populations in Pakistan. Fourth, the use of a combined-parent form of the PBI, while intended to accommodate Pakistani collectivistic cultural households, proceeds from the instrument's original separate mother/father administration. This may limit direct comparability with studies using the standard two-form approach. It also cannot rule out that participants who had different caregivers in mind when responding. This however,

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introducing measurement ambiguity. Fifth, the strong correlation between the care and overprotection subscales in this sample raises the possibility that these dimensions were not clearly differentiated by participants. Therefore, it complicates interpretation of their distinct associations with ROC symptoms.

Future research retaining longitudinal research designs would help clarify the parental bonding, attachment, and ROC symptoms. This could help differentiate between the alternative explanations raised above. Studies including clinical samples, more gender-balanced and geographically diverse recruitment. However, also using separate maternal/paternal PBI forms would also strengthen confidence in these patterns. Qualitative research exploring how parental bonding and relationship-centered obsessions are subjectively experienced. This would be of great help within the Pakistani cultural context. Finally, future studies might examine whether internal working models help account for the statistical associations observed here. Ideally using these designs that are capable of testing mediational pathways rather than cross-sectional moderation alone.

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