



Family Accommodation in Caregiving Family Members of Patients with Obsessive-Compulsive Disorder and Its Associated Clinical and Demographic Factors

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Abstract

Background: Family accommodation, a common behavior among relatives of patients with obsessive-compulsive disorder (OCD), may contribute to the persistence of the disorder and may hinder treatment response.

Objectives: This study aimed to investigate family accommodation among family members who provide care for patients with OCD and to examine associated demographic and clinical factors.

Methods: In this cross-sectional analytical study, 113 patients with OCD and 113 caregiving family members were recruited from two psychiatric clinics in Guilan Province, Iran, between 2022 and 2023. Data were obtained from psychiatric records, clinical interviews, and three instruments: the Global Assessment of Functioning, the self-rated Family Accommodation Scale, and the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS).

Results: Current OCD symptom severity at the time of assessment was positively correlated with family accommodation. Conversely, symptom improvement (the difference between initial and current Y-BOCS scores documented in the records) and overall patient functioning were negatively correlated with family accommodation ($P < 0.01$). Stepwise multiple linear regression analysis indicated that higher global functioning and male caregiver gender were independently and negatively associated with family accommodation, accounting for 16.4% of the variance (adjusted $R^2 = 0.164$, $P < 0.001$). Independent-samples t tests and one-way analyses of variance showed no significant differences in family accommodation between groups ($P > 0.05$).

Conclusions: Family accommodation is significantly associated with current patient functioning and caregiver gender among patients undergoing treatment for OCD. These findings underscore the importance of monitoring family accommodation and suggest that integrating family-focused strategies into clinical management may improve treatment outcomes.

Keywords: Caregiving, Family Accommodation, Obsessive-Compulsive Disorder

1. Background

Obsessive-compulsive disorder (OCD) is a chronic psychiatric condition with a global prevalence ranging from 1% to 3%, typically emerging during adolescence or early adulthood (1, 2). The core clinical presentation involves persistent, unwanted intrusive thoughts or urges (obsessions) that cause substantial distress, coupled with repetitive physical or mental acts (compulsions)

performed to alleviate this anxiety (1, 3). This chronic symptom cycle severely disrupts daily functioning, leading to reduced quality of life (2, 4), vocational impairment (5), and substantial strain on interpersonal relationships and financial stability (6-8).

OCD places a considerable burden on family members and caregivers. Its core features frequently draw relatives into symptom accommodation to varying degrees. This

phenomenon, known as family accommodation (FA), refers to specific reactions and behavioral adaptations by relatives in response to the patient's symptoms, a dynamic that can maintain the disorder (7, 9). Although observed in other mental health conditions (10, 11), FA is particularly prominent in OCD. Accommodation may involve directly participating in compulsions (eg, carrying out cleaning rituals), providing repeated reassurance to neutralize obsessive doubts, or substantially modifying household routines to prevent triggering the patient's distress (12). Research indicates that FA is widespread, with up to 90% of relatives reporting such behaviors (11, 13, 14) and nearly half engaging in them daily (15). Although these actions may temporarily alleviate acute anxiety, they can interfere with the habituation process required for recovery and thereby prolong the illness (16). Consequently, FA may undermine the effectiveness of evidence-based interventions such as exposure and response prevention (ERP) by reinforcing avoidance patterns (14).

A substantial body of evidence links FA with adverse clinical trajectories and treatment outcomes. Higher levels of accommodation consistently correlate with greater OCD symptom severity and broader functional decline (8, 11, 12, 17, 18). Families with high levels of FA may also experience poorer responses to cognitive-behavioral therapies (19), greater relational impairment (12), and poorer long-term prognoses (20). Accordingly, modern therapeutic protocols explicitly target reductions in accommodating behaviors as a component of comprehensive OCD management.

The role of FA in OCD has been examined in one Iranian pediatric study (21); however, the prevalence and impact of these behaviors among caregivers of Iranian adults remain largely unexplored. Furthermore, prior investigations (9, 12-18) have often focused on a limited set of variables, limiting a comprehensive understanding of factors associated with accommodation. A defining feature of the present research was the deliberate recruitment of primary, highly involved caregivers who were screened to exclude severe psychiatric disorders, thereby helping to isolate nonpathological accommodating dynamics.

2. Objectives

This study investigated multiple clinical and sociodemographic dimensions associated with family accommodation, including illness-related variables (illness duration, age at onset, OCD subtypes, and symptom severity), treatment-related factors (treatment duration, medication resistance, and patient insight), comorbidities, and demographic characteristics.

3. Methods

3.1. Study Design and Setting

This cross-sectional analytical study was conducted between 2022 and 2023. Participants were recruited from two outpatient psychiatric clinics in Rasht, Guilan Province, Iran. Both centers are specialized public/academic psychiatric referral clinics that predominantly serve patients with moderate-to-severe clinical presentations.

3.2. Participants and Sampling

The study included patients with OCD and their family caregivers aged 18 to 70 years who were recruited from two psychiatric clinics in Guilan Province. Patients were required to have a primary diagnosis of OCD, a Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) score of at least 16 at initial clinic referral, and at least 1 year of continuous treatment at the clinics. For each patient, a family member was selected based on the following criteria: having the most frequent contact with the patient; being most involved in the treatment process; serving as the primary contact for clinical staff in emergencies; having provided care for at least 1 year; not caring for another family member with a severe illness (eg, a psychotic disorder); and having no lifetime psychiatric diagnosis, including psychotic disorders, OCD, intellectual disability, or illegal drug/substance use or abuse. Participants with a history of major medical conditions that could affect data collection were excluded to maintain assessment integrity. This exclusion did not include controlled conditions such as diabetes, hypertension, or hyperlipidemia.

Eligible participants were recruited using consecutive sampling during regular follow-up visits. To ensure transparency and to evaluate potential selection bias, the screening flow was documented. A total of 165 patients with a primary diagnosis of OCD were initially screened. Of these, 28 were excluded because they did not meet the eligibility criteria (eg, baseline Y-BOCS score < 16, treatment duration < 1 year, or comorbid psychotic disorders). An additional 14 eligible patients were excluded because they lacked a qualifying primary family caregiver who met the inclusion criteria, and 10 patient-caregiver dyads declined to participate. Ultimately, 113 unique patient-caregiver dyads (n = 226 individuals) were enrolled. Each caregiver was uniquely paired with one patient.

3.3. Data Collection and Instruments

The data collection process was structured to distinguish retrospectively extracted clinical-record data from current cross-sectional assessments. Patient Y-BOCS scores at treatment initiation (baseline/initial referral)

were extracted retrospectively from existing psychiatric charts. In contrast, current OCD symptom severity (current Y-BOCS), current family accommodation levels (caregiver Family Accommodation Scale for Obsessive-Compulsive Disorder-Self-Rated [FAS-SR]), and overall patient functioning (Global Assessment of Functioning [GAF]) were measured prospectively and concurrently at study enrollment. The symptom-change, or OCD severity difference, variable was calculated retrospectively as the arithmetic difference between the baseline Y-BOCS score extracted from records and the current Y-BOCS score measured at study entry. Missing or ambiguous responses on clinical checklists or scales were minimized through immediate face-to-face clarification during administration; any remaining incomplete data fields were handled using listwise deletion during statistical analysis.

3.3.1. Data Checklist

The data checklist collected clinical and demographic information, including the number and types of comorbid psychiatric disorders, OCD duration, age at OCD onset, treatment duration, family history of OCD, OCD subtype, OCD severity, resistance to OCD medication, and patient insight into OCD.

3.3.2. Yale-Brown Obsessive-Compulsive Scale

The Y-BOCS, is widely used to assess the presence and severity of OCD symptoms. This clinician-administered scale consists of a comprehensive symptom checklist covering obsessions and compulsions, followed by a severity assessment. The total severity score ranges from 0 to 40, with higher scores indicating more severe symptoms. Its psychometric properties have been extensively evaluated (22). In one Iranian study, the symptom checklist demonstrated an internal consistency of 0.97, the severity component had an internal consistency of 0.95, and test-retest reliability was 0.99 (23). A separate Iranian study (24) confirmed strong psychometric performance, reporting high Cronbach alpha values, excellent test-retest and split-half reliability, and robust concurrent validity compared with a structured DSM-IV clinical interview.

3.3.3. Global Assessment of Functioning

The GAF provides a global rating of psychological, social, and occupational or school functioning. The scale ranges from 1 to 100, with higher scores indicating better functioning and fewer disruptions in daily roles. The scale is divided into 10-point bands with descriptive anchors for typical functioning at each level. Research has supported its reliability and validity across clinical and research

settings (25). The Persian-adapted GAF has also been used in Iranian studies (26).

3.3.4. Family Accommodation Scale for Obsessive-Compulsive Disorder-Self-Rated

The FAS-SR is a 19-item self-report instrument designed for relatives of adults with OCD (27, 28). In the present study, the Persian adaptation was developed from the original adult self-rated format described by Pinto et al. (27, 28), with linguistic and cultural refinements informed by the previously studied Iranian parent-report pediatric version (21). Conceptual equivalence was evaluated by an expert panel that included a psychiatrist and a clinical psychologist after forward-back translation. No items were structurally modified or removed after pilot testing with 30 caregivers because the wording was considered clear and culturally appropriate (28). Pinto et al. reported excellent internal consistency (Cronbach alpha = 0.90) (27), whereas the Chinese study reported a Cronbach alpha of 0.87 and a test-retest coefficient of 0.97 (28). In the present sample of 113 adult caregivers, the Persian FAS-SR had a Cronbach alpha of 0.90, indicating excellent internal consistency.

3.4. Statistical Analysis

Descriptive statistics (means, standard deviations, frequencies, and percentages) were calculated to summarize sample characteristics. To evaluate bivariate associations with the continuous outcome of family accommodation (FAS-SR total score), Pearson correlation coefficients (r) were used for normally distributed clinical measures (eg, age, illness duration, and Y-BOCS scores), whereas Spearman rank correlation coefficients (ρ) were used for nonnormally distributed or categorical variables. Normality of continuous variables was assessed using the Shapiro-Wilk test combined with visual inspection of normal Q-Q plots. Group differences in mean accommodation scores across categorical demographic and clinical factors were evaluated using independent-samples t tests and one-way analysis of variance (ANOVA). The Levene test was used to assess homogeneity of variance across groups.

To identify independent clinical and demographic factors associated with family accommodation, stepwise multiple linear regression analysis was performed. Stepwise selection was chosen within an exploratory framework to identify the most salient independent clinical and demographic contributors from a large pool of candidate variables without an established hierarchical priority in adult Iranian populations. Accordingly, this approach was used for hypothesis generation rather than to establish a definitive explanatory model. Candidate variables entered into the initial model included patient

age, caregiver age, patient gender, caregiver gender, patient marital status, caregiver marital status, family relationship, comorbidity presence, major depressive disorder, generalized anxiety disorder (GAD), current Y-BOCS severity, overall GAF functioning, age at onset, illness duration, treatment duration, family history of OCD, treatment resistance, and patient insight. Regression assumptions were assessed as follows: linearity using residual scatterplots; independence of errors using the Durbin-Watson test; homoscedasticity by plotting standardized residuals against predicted values; and multicollinearity using Tolerance and Variance Inflation Factor (VIF) indices. Residual normality was evaluated using normal P-P plots and the Shapiro-Wilk test applied to regression residuals. All statistical analyses were performed using SPSS software, version 26, with a 2-tailed significance level of $P < 0.05$.

3.5. Ethical Considerations

This research involving human participants received formal approval from the Ethics Committee and Scientific Review Board of Guilan University of Medical Sciences (approval reference: IR.GUMS.REC.1401.240). All procedures adhered to applicable national regulations and institutional guidelines. All participants provided voluntary written informed consent before enrollment.

4. Results

4.1. Sample Characteristics and Group Comparisons

The final study sample comprised 113 unique patient-caregiver dyads ($N = 226$ individuals). The mean age of the patients was 40.78 ± 13.91 years, and the mean age of the caregivers was 47.80 ± 11.78 years. Table 1 presents the sociodemographic and clinical characteristics of the sample and group differences in family accommodation scores.

As shown in Table 1, most patients were female (80.5%), married (61.1%), and aged 20 to 50 years (77.0%). Caregivers had a nearly equal gender distribution (51.3% male) and were predominantly spouses (52.2%) or parents (36.3%). Regarding clinical profiles, 63.7% of patients had at least one comorbid psychiatric disorder, with GAD being the most prevalent (39.8%). The most frequent obsession subtypes were contamination (72.6%) and symmetry/ordering (37.2%). More than half of the patients (54.9%) had early-onset OCD (≤ 18 years), and 76.1% reported a positive family history of OCD. The mean baseline overall functioning score (GAF) was 74.59 ± 8.08 .

Independent-samples *t* tests and one-way ANOVAs were conducted to evaluate differences in family

accommodation scores across categorical demographic and clinical groups. Levene's test showed that the assumption of homogeneity of variance was met for all analyzed variables except caregiver marital status ($F = 4.359$, $P = 0.039$). Consequently, the nonsignificant *t*-test result for caregiver marital status ($t = -0.152$, $P = 0.882$) should be interpreted with caution. As summarized in Table 1, no statistically significant differences in family accommodation scores were observed across the demographic or clinical subgroups ($P > 0.05$).

4.2. Correlations With Continuous Clinical Variables

To improve the presentation of the primary data, continuous clinical variables were summarized in a separate correlation matrix (Table 2). Pearson (*r*) and Spearman (ρ) coefficients were used according to the normality profiles.

Continuous demographic measures, including patient age, caregiver age, and age at OCD onset, were not significantly correlated with family accommodation scores ($P > 0.05$). Similarly, overall illness duration ($r = 0.04$) and total treatment duration ($r = 0.10$) were not significantly associated with family accommodation. Baseline OCD symptom severity documented at treatment initiation was also not correlated with family accommodation ($r = 0.13$, $P > 0.05$).

In contrast, current OCD symptom severity measured concurrently at study assessment showed a significant moderate positive correlation with family accommodation ($r = 0.33$, $P < 0.01$). Retrospective symptom change, calculated as the difference between baseline and current Y-BOCS scores, was significantly and negatively correlated with family accommodation ($r = -0.25$, $P < 0.01$). Concurrent global functioning (GAF) showed the strongest significant negative association with family accommodation ($r = -0.34$, $P < 0.01$).

4.3. Multiple Linear Regression

A stepwise multiple linear regression model was used to identify independent factors associated with family accommodation from the complete pool of candidate demographic and clinical variables. The regression analysis yielded two statistically significant steps (Table 3).

In Model 1, global functioning was entered as the sole significant independent correlate ($F = 16.476$, $P < 0.001$). Model 1 had an adjusted R^2 value of 0.130, indicating that global functioning accounted for approximately 13.0% of the variance in family accommodation scores.

In Model 2, caregiver gender was added alongside global functioning ($F = 11.176$, $P < 0.001$). Model 2 had an adjusted R^2 value of 0.164, indicating that the combination of lower

Table 1. Demographic and Clinical Characteristics of the Sample and Group Differences in Family Accommodation ^a

Variables	Values	Family Accommodation	Test Statistic (t/F)	P Value
Patient Age Category (y)			0.168	0.954
20 - 30	31 (27.4)	25.06 ± 12.32		
31 - 40	25 (22.1)	25.36 ± 10.33		
41 - 50	31 (27.4)	26.00 ± 12.16		
51 - 60	15 (13.3)	26.40 ± 13.28		
61 - 70	11 (9.7)	28.36 ± 14.17		
Caregiver Age Category (y)			0.026	0.999
20 - 30	11 (9.7)	26.18 ± 11.40		
31 - 40	20 (17.7)	25.45 ± 10.93		
41 - 50	26 (23.0)	26.08 ± 13.45		
51 - 60	40 (35.4)	25.62 ± 10.98		
61 - 70	16 (14.2)	26.56 ± 14.85		
Patient Gender			-0.366	0.715
Female	91 (80.5)	25.68 ± 12.11		
Male	22 (19.5)	26.73 ± 11.74		
Caregiver Gender			1.552	0.123
Female	55 (48.7)	27.67 ± 12.37		
Male	58 (51.3)	24.19 ± 11.49		
Patient Marital Status			-0.737	0.463
Single	44 (38.9)	24.84 ± 12.45		
Married	69 (61.1)	26.55 ± 11.74		
Caregiver Marital Status ^b			-0.152	0.882
Single	13 (11.5)	25.31 ± 14.92		
Married	100 (88.5)	25.96 ± 11.65		
Familial Relationship			0.682	0.565
Parent	41 (36.3)	25.88 ± 11.33		
Spouse	59 (52.2)	24.98 ± 11.87		
Child	11 (9.7)	30.64 ± 12.93		
Sibling	2 (1.8)	26.50 ± 28.99		
Clinical Comorbidity			-0.134	0.893
Absent	41 (36.3)	25.68 ± 11.71		
Present	72 (63.7)	26.00 ± 12.24		
Family History of OCD			-0.861	0.391
No	27 (23.9)	24.15 ± 12.10		
Yes	86 (76.1)	26.43 ± 11.99		
Treatment Resistance			-1.831	0.070
No	91 (80.5)	24.88 ± 12.24		
Yes	22 (19.5)	30.05 ± 10.14		
Patient Insight Level			1.675	0.192
Good/Fair	57 (50.4)	24.44 ± 11.77		
Poor	34 (30.1)	25.71 ± 12.24		
Absent/Delusional	22 (19.5)	29.91 ± 11.82		

^a Values are expressed as No. (%) or mean ± SD.

^b Levene's test indicated heterogeneous variances ($P = 0.039$); the t test should be interpreted cautiously.

patient functioning and female caregiver gender explained 16.4% of the total variance in family accommodation scores.

In Model 2, global functioning remained significantly and inversely associated with family accommodation ($\beta = -0.378$, $t = -4.208$, $P < 0.001$), and caregiver gender emerged

Table 2. Bivariate Correlations Between Continuous Clinical Variables and Family Accommodation

Continuous Predictor Variable	Mean $\pm$ SD	Family Accommodation	P Value
Patient Age (y)	40.78 $\pm$ 13.91	$r = 0.07$	0.461
Caregiver Age (y)	47.80 $\pm$ 11.78	$r = 0.01$	0.916
Age of OCD Onset (y)	19.16 $\pm$ 6.79	$r = 0.07$	0.461
Total Illness Duration	21.62 $\pm$ 13.21	$r = 0.04$	0.674
Total Treatment Duration	5.39 $\pm$ 5.51	$r = 0.10$	0.292
Baseline Y-BOCS Severity	29.41 $\pm$ 3.72	$r = 0.13$	0.169
Current Y-BOCS Severity	15.63 $\pm$ 6.06	$r = 0.33^a$	< 0.001
Retrospective Y-BOCS Difference	13.78 $\pm$ 6.16	$r = -0.25^a$	0.008
Global Assessment of Functioning	74.59 $\pm$ 8.08	$r = -0.34^a$	< 0.001

^a Correlation is significant at the 0.01 level (2-tailed).

Table 3. Stepwise Multiple Linear Regression Models Associated with Family Accommodation ^a

Model / Variable	B	SE	β	t	P Value	95% CI	Tolerance	VIF
Model 1 (Adj. R² = 0.130)								
(Constant)	68.12	10.26	—	6.639	< 0.001	[47.80, 88.44]	—	—
Global Functioning	-0.56	0.14	-0.371	-4.059	< 0.001	[-0.83, -0.29]	1.000	1.000
Model 2 (Adj. R² = 0.164)								
(Constant)	71.35	9.98	—	7.146	< 0.001	[51.58, 91.12]	—	—
Global Functioning	-0.57	0.14	-0.378	-4.208	< 0.001	[-0.84, -0.30]	0.999	1.001
Caregiver Gender	-4.95	2.17	-0.205	-2.281	0.025	[-9.25, -0.65]	0.999	1.001

^a Model 1: $F = 16.476$, $P < 0.001$; Model 2: $F = 11.176$, $P < 0.001$; Durbin-Watson = 1.692. Variable coding: Caregiver Gender (Male = 1, Female = 0).

as a significant independent negative correlate ($\beta = -0.205$, $t = -2.281$, $P = 0.025$). Unstandardized coefficients indicated that for each 1-unit increase in the patient's raw global functioning score, family accommodation decreased by 0.57 units ($B = -0.57$, 95% CI: [-0.84, -0.30]), whereas male caregivers had family accommodation scores an average of 4.95 units lower than those of female caregivers ($B = -4.95$, 95% CI: [-9.25, -0.65]).

All linear regression assumptions were met: independence of errors was confirmed by a Durbin-Watson statistic of 1.692, and multicollinearity was absent, as indicated by a tolerance of 0.999 and a VIF of 1.001 across both predictors.

5. Discussion

The primary objective of this study was to investigate the clinical characteristics of family accommodation and its associated sociodemographic and clinical factors in an adult Iranian OCD sample. A notable feature of this research was the inclusion of healthy caregivers who were free of major psychiatric disorders, OCD, or substance use

disorders. Previous studies, such as those by Albert et al. (15), have suggested that the quality of care and family dynamics may be substantially influenced by the psychological state of both groups. With 113 unique families included, this study represents one of the larger cohorts examining family accommodation in adults with OCD, following cohorts such as the 141 participants in the Albert et al. (15) study. Consistent with previous literature in adult populations, caregivers were predominantly spouses (52.2%) or parents (36.3%) (2, 16-18).

The mean age at OCD onset was 19.16 years, which is slightly higher than values reported in some other adult studies (8, 29). This difference may reflect cultural tendencies to delay seeking specialized psychiatric care, particularly given the high proportion of women in our sample, who may report symptom exacerbation associated with major life events such as puberty or pregnancy (30). Furthermore, our sample showed high chronicity and symptom severity, consistent with referral populations attending specialized tertiary clinics. Family accommodation was highly prevalent among Iranian relatives of patients with OCD, with every participant

reporting at least one accommodating behavior weekly, consistent with international evidence (12, 17, 29).

5.1. Demographic Variables

Consistent with several previous investigations, our findings indicated no significant associations between demographic variables, such as age, gender, or marital status, and family accommodation (8, 16, 29, 31). Conversely, some research, such as that by Shrinivasa et al., has reported trends toward higher family accommodation among female caregivers, although these associations often disappear in multivariate analyses after clinical factors are introduced (17). The absence of demographic associations in our Iranian sample suggests that family accommodation may be more closely related to illness-specific features than to general demographic characteristics, emphasizing the need for clinicians to focus on specific clinical presentations and functional impairments, regardless of caregiver or patient age and background.

5.2. Comorbid Disorders

We observed no significant independent associations between comorbid conditions, such as generalized anxiety disorder or major depressive disorder, and overall family accommodation. This finding is consistent with those of Watson et al. (16) and Kuru et al. (29), who also reported no predictive role for anxiety and depression. In contrast, Lee et al. (8) and Wu et al. (31) reported associations between co-occurring anxiety or stress and family accommodation, although these associations were often scale-dependent. These discrepancies suggest that, although specific comorbidities may influence certain accommodating subbehaviors (7), overall family accommodation may be more directly related to primary OCD pathology. Consequently, therapeutic interventions should prioritize reducing primary OCD symptoms when addressing family dynamics.

5.3. Severity of OCD and Functional Impairment

A central finding of this study was the significant positive correlation between concurrent OCD symptom severity and family accommodation, together with a significant negative correlation between overall patient functioning and family accommodation. Although baseline Y-BOCS scores did not correlate with current family accommodation, retrospective symptom change (the difference between baseline and current severity) showed a significant inverse relationship. These findings are consistent with a substantial body of literature identifying current OCD severity and functional

impairment as key correlates of family accommodation (8, 16, 29, 31-33). The cross-sectional nature of the current assessments precludes causal inference regarding whether greater symptom severity leads to increased family accommodation or whether accommodating behaviors hinder symptom improvement. Nevertheless, the observed association underscores the close relationship between family accommodation and patient impairment, particularly in family-oriented cultural contexts such as Iran, where relatives may be closely involved in patients' daily routines (34).

5.4. Family History of Psychiatric Disorders

A family history of OCD was not significantly correlated with family accommodation in our sample. Although 76% of patients had affected relatives, our strict exclusion of caregivers with current clinical OCD may have influenced this finding. Similar to the approaches of Gomes et al. (32) and Cosentino et al. (35), ensuring caregiver psychological health was necessary in our design to isolate nonpathological accommodating behaviors. Future research should evaluate how subclinical caregiver psychopathology interacts with family dynamics to influence accommodation levels.

5.5. Methods and Measures

A recurring challenge in family accommodation research is the heterogeneity of assessment tools (16, 18). By administering the self-rated FAS-SR concurrently with patient interviews, this study sought to capture caregiver perspectives while minimizing reporting bias. Although various associated factors have been proposed in the literature, current OCD severity and functioning consistently emerge as important correlates across different methodologies (20). Standardized and culturally adapted measurement tools remain essential for generating comparable cross-cultural data in future studies.

5.6. Strengths

A major strength of this study was the recruitment of a sizable paired sample of patients and healthy caregivers, allowing assessment of family accommodation without the confounding effects of severe caregiver psychopathology. Furthermore, the rigorous cultural adaptation and strong internal reliability of the Persian FAS-SR (27) support its use in this population. Finally, multivariate modeling helped isolate the independent associations of global functioning and caregiver gender from a broad range of candidate clinical variables.

5.7. Study Limitations

Several limitations should be acknowledged. First, the cross-sectional design precludes causal inferences regarding the direction of the observed associations. Second, baseline pretreatment Y-BOCS scores were extracted retrospectively from clinical records, introducing potential documentation inconsistencies compared with prospectively measured current variables. Third, the recruitment strategy introduced substantial selection bias. Participants were recruited exclusively from two specialized academic clinics, thereby overrepresenting patients with severe, chronic, treatment-seeking OCD. In addition, the strict eligibility criteria excluded patients without an active caregiver and those whose caregivers had severe psychopathology. Consequently, the findings have limited generalizability to patients with milder OCD symptoms, those not engaged in psychiatric care, individuals from dysfunctional family systems, or other ethnic populations across Iran. Fourth, broader family-functioning dynamics were not comprehensively assessed and may also play an important role in accommodation behaviors. Fifth, although the FAS-SR has previously been used in two Iranian studies and a Persian translation is available on the official Yale University scale website, despite extensive efforts, we were unable to access psychometric information for the scale. Therefore, in the present study, we reported only its internal consistency reliability. Future studies should collect and report more comprehensive information on the psychometric properties of this scale. Finally, stepwise regression is inherently exploratory and susceptible to sample-specific overfitting; therefore, the identified associated factors should be interpreted cautiously and cross-validated in independent cohorts.

5.8. Conclusions

Concurrent illness severity and patient functional status were significantly associated with family accommodation in adults with OCD. The family accommodation score may serve as a useful clinical indicator for measuring, monitoring, and following family involvement in clinical care. Investigating interventions designed to reduce family accommodation may help improve treatment outcomes for patients with OCD. These findings also highlight the need to develop and implement culturally adapted family-focused interventions in Iranian psychiatric settings.

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Footnotes

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Authors' Contribution: MK contributed substantially by shaping the study concept, carrying out the investigations, designing the methodology, overseeing project administration, preparing the initial manuscript draft, performing data analysis and interpretation, and revising the manuscript for important intellectual content. AB participated actively in data collection, project coordination, methodological development, and drafting the original version of the manuscript. HF played a central role in conceptualizing the research, conducting fieldwork, refining methods, managing project operations, writing the first draft, analyzing and interpreting findings, and providing critical revisions to the final text.

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