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BURDEN DIMENSIONS AND COPING STRATEGIES AMONG FAMILY CAREGIVERS OF PATIENTS WITH OBSESSIVE - COMPULSIVE DISORDER: A CROSS-SECTIONAL STUDY

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ABSTRACT

Background: Obsessive–compulsive disorder (OCD) is a chronic psychiatric disorder that produces significant functional impairment not only in patients but also in their family caregivers. Caregiving in OCD may involve emotional strain, disruption of family routines, financial difficulty, and reduced coping capacity.

Materials and Methods: This observational cross-sectional study was conducted in the Department of Psychiatry, SMS Medical College, Jaipur, from September 2024 to September 2025. A total of 100 patients diagnosed with OCD as per DSM-5-TR criteria and their 100 primary family caregivers were included. OCD severity was assessed using the Yale–Brown Obsessive Compulsive Scale. Caregiver burden was assessed using the Burden Assessment Scale, and coping strategies were evaluated using the Brief-COPE scale/Hindi-adapted coping scale.

Results: Among patients, 43% had extreme OCD, 33% had severe OCD, and 24% had moderate OCD. Most caregivers had moderate burden (56%), followed by severe burden (40%). The mean BAS total score was 94.51 ± 11.57. Social/family burden and mental burden were the most affected domains. Moderate coping was observed in 76% of caregivers, while 24% had low coping. OCD severity was significantly associated with caregiver burden and coping. Y-BOCS total score showed a positive correlation with BAS total score and a negative correlation with coping score.

Conclusion: Caregivers of patients with OCD experience substantial burden, particularly in social/family and mental domains. Routine caregiver assessment and coping-focused family interventions should be integrated into OCD management.

Keywords: Obsessive–compulsive disorder; caregiver burden; coping strategies; family caregivers; Y-BOCS; Burden Assessment Scale.

INTRODUCTION

Obsessive–compulsive disorder (OCD) is a chronic and disabling psychiatric disorder characterized by recurrent intrusive thoughts, images, urges, or impulses, and repetitive behaviours or mental acts performed to reduce anxiety or prevent feared consequences.[1] Although traditionally conceptualized as an anxiety-related condition, contemporary classifications recognize OCD as a distinct disorder because of its characteristic phenomenology, chronic course, neurobiological basis, and functional impact.[1] Epidemiological evidence suggests that OCD affects a substantial proportion of the general population, with lifetime prevalence estimates generally ranging from approximately 1% to 3%.[2] The disorder commonly begins during adolescence or early adulthood and frequently persists over time, leading to impairment in education, occupation, interpersonal relationships, family functioning, and quality of life.[2,3]

The impact of OCD extends beyond the affected individual. Because obsessions and compulsions are often time-consuming, distressing, and difficult to resist, patients may require repeated reassurance, supervision, assistance with rituals, avoidance of triggers, or modifications in daily routines. These illness-related demands frequently involve close family members, particularly in sociocultural settings where family-based care remains the principal source of support for persons with mental illness. In India, as in many collectivistic societies, relatives are usually expected to provide long-term emotional, practical, financial, and treatment-related support. Consequently, the family caregiver becomes an important but often overlooked participant in the illness experience.

Caregiver burden refers to the multidimensional strain experienced by individuals who care for a person with chronic illness. It includes objective consequences such as financial difficulty, disruption of routine family activities, occupational compromise, social restriction, and physical exhaustion, as well as subjective experiences such as worry, guilt, frustration, helplessness, emotional distress, and perceived loss of personal freedom.[4] In OCD, caregiver burden may be especially complex because caregivers may not only provide general support but may also become incorporated into the patient's compulsive rituals. Reassurance seeking, checking, washing, avoidance, repeated questioning, and resistance to interruption of rituals can create recurrent conflict within the household and may alter the functioning of the entire family system.[5]

Several studies have demonstrated that caregivers of patients with OCD experience significant levels of burden and impairment in quality of life. Gururaj et al. reported that severe OCD was associated with significant family burden, disability, and poor quality of life, often approaching the impact seen in schizophrenia 3. Grover and Dutt found that caregivers of patients with OCD experienced considerable objective and subjective burden, and that greater illness severity was associated with poorer caregiver quality of life.[6] Vikas et al. further demonstrated that, although patients with OCD may have lower disability than patients with depressive disorder in some domains, their caregivers may experience greater burden and family accommodation.[7] These findings challenge the misconception that OCD is a relatively benign disorder and highlight the need to evaluate its family-level consequences.

Family accommodation is an important mechanism linking OCD symptoms with caregiver distress. Accommodation occurs when family members participate in rituals, provide repeated reassurance, modify routines, facilitate avoidance, or reduce demands in order to minimize the patient's anxiety or conflict. Although such behaviours may provide short-term relief, they may reinforce compulsive cycles and contribute to persistence of symptoms. Torres et al. showed that both OCD severity and family accommodation were significantly associated with multiple dimensions of caregiver burden, indicating that symptom severity influences the caregiver not only directly but also through behavioural and relational changes within the family.

The way caregivers respond to chronic caregiving demands is influenced by their coping strategies. Coping has been conceptualized as the cognitive and behavioural efforts used to manage demands that are appraised as stressful or exceeding available resources.[8,9] In caregiving contexts, coping strategies may be broadly adaptive or maladaptive. Problem-focused coping, acceptance, positive reframing, seeking emotional or instrumental support, and planned problem solving may help caregivers manage distress and preserve functioning. In contrast, denial, behavioural disengagement, self-blame, avoidance, venting, or substance use may intensify distress and reduce caregiving effectiveness.[10] The Brief COPE inventory provides a structured approach to assessing these coping responses and has been widely used in health and psychiatric research.[10]

Understanding coping in caregivers of patients with OCD is clinically important because caregiver responses may influence both caregiver well-being and patient outcome. Adaptive coping may reduce distress, improve treatment collaboration, and support healthier family interactions. Conversely, maladaptive coping may increase burden, worsen interpersonal tension, and indirectly reinforce symptoms through excessive accommodation or avoidance. Thus, assessment of caregiver burden without parallel assessment of coping may provide an incomplete understanding of the caregiving experience.

Despite growing research on OCD-related disability and caregiver burden, Indian data focusing specifically on the dimensions of burden and coping strategies among family caregivers remain limited. Much of the available literature has examined overall burden, quality of life, or family accommodation, while fewer studies have systematically evaluated how different burden domains relate to coping patterns and OCD symptom severity. This gap is particularly relevant in tertiary care settings, where patients often present with moderate-to-severe illness and families are deeply involved in long-term management.

The present study was therefore conducted to assess burden dimensions and coping strategies among family caregivers of patients diagnosed with OCD attending a tertiary care psychiatry centre in Jaipur. The study also examined the relationship between OCD symptom severity, caregiver burden, and coping. By identifying the burden domains most affected and the coping patterns used by caregivers, the study aims to contribute evidence that may guide caregiver-focused psychoeducation, family interventions, coping-skills training, and culturally appropriate psychosocial support for families managing OCD.

MATERIALS AND METHODS

This observational, cross-sectional study was conducted in the Department of Psychiatry, SMS Medical College, Jaipur, over a one-year period from September 2024 to September 2025, after obtaining approval from the Research Review Board and Institutional Ethics Committee. The study was designed to assess burden dimensions and coping strategies among family caregivers of patients diagnosed with obsessive–compulsive disorder (OCD), and to examine their relationship with OCD symptom severity. The study population consisted of patients with OCD attending the psychiatry services of SMS Medical College, Jaipur, along with their primary family caregivers who were involved in day-to-day patient care. A total of 100 patients diagnosed with OCD and 100 corresponding family caregivers were included in the study.

Patients were included if they were aged between 18 and 60 years, belonged to either gender, fulfilled DSM-5-TR diagnostic criteria for OCD, and provided written informed consent. Patients with comorbid psychiatric disorders such as anxiety disorders, depressive disorders or tic disorders, significant medical illnesses, neurodevelopmental disorders, or substance dependence other than nicotine and tobacco use disorders were excluded. Family caregivers were eligible if they were aged between 30 and 60 years, were living with the patient for at least one year, were closely involved in the patient's daily activities, were willing to participate, and were able to read or understand Hindi or English. Caregivers with psychiatric disorders, significant medical illnesses except diabetes mellitus and hypertension, or substance dependence other than nicotine and tobacco were excluded.

Participants were recruited using a convenience sampling technique based on availability and willingness to participate. After enrolment, written informed consent was obtained from both patients and caregivers. Sociodemographic and clinical details were recorded using a structured proforma. Patient-related variables included age, sex, residence, marital status, education, socioeconomic status, duration of illness, duration of treatment, number of hospitalizations, and clinical severity of OCD. Caregiver-related variables included age, sex, education, occupation, marital status, socioeconomic status, relationship with the patient, burden dimensions, and coping strategies.

Diagnosis of OCD was made according to DSM-5-TR criteria. The Mini International Neuropsychiatric Interview version 7.0.2 was administered to both patients and caregivers to screen for psychiatric comorbidities. Severity of OCD symptoms was assessed using the Yale–Brown Obsessive Compulsive Scale (Y-BOCS). The Y-BOCS evaluates obsessions and compulsions separately and provides a total severity score based on items assessing time spent, interference, distress, resistance, and control over symptoms. Caregiver burden was assessed using the Burden Assessment Scale (BAS), which measures perceived burden across multiple domains, including financial burden, work burden, social and family burden, mental burden, physical burden, and spouse-related burden. Coping strategies were evaluated using the Brief-COPE scale/Hindi-adapted stress coping behaviour scale, a 28-item instrument assessing different coping responses, including problem-focused, emotion-focused, and dysfunctional coping patterns.

The primary outcome variables were caregiver burden dimensions and coping strategies among family caregivers of patients with OCD. The secondary outcome was the correlation of OCD severity with caregiver burden and coping. Data were entered and analyzed using Statistical Package for Social Sciences software. Descriptive statistics were used to summarize sociodemographic and clinical variables. Quantitative variables were expressed as mean and standard deviation, while categorical variables were presented as frequencies and percentages. Chi-square test was used for categorical associations, while independent t-test was used for continuous variables where appropriate. Correlation analysis was performed to assess the relationship between Y-BOCS scores, BAS scores, burden dimensions, and coping scores. A p-value of less than 0.05 was considered statistically significant. Ethical principles, including voluntary participation, confidentiality, informed consent, and the right to withdraw without affecting treatment, were strictly maintained throughout the study.

RESULTS

A total of 100 patients diagnosed with obsessive–compulsive disorder (OCD) and their 100 primary family caregivers were included in the study. The results were summarized under sociodemographic characteristics, clinical profile, caregiver burden, coping strategies, and association/correlation analyses between OCD severity, caregiver burden, and coping.

Sociodemographic profile of patients: The majority of patients belonged to the 31–40 years age group, accounting for 49% of the study population, followed by 30% in the 18–30 years age group and 21% in the 41–60 years age group. Thus, nearly four-fifths of the patients were below 40 years of age. Male patients constituted 53% of the sample, while females constituted 47%, showing a near-equal gender distribution with a slight male predominance. Regarding residence, 60% of patients were from urban areas and 40% were from rural areas. More than half of the patients were married, comprising 54% of the total sample, while 27% were single, 13% were divorced, and 6% were widowed. With respect to educational status, the largest proportion had high school education (52%), followed by university education (30%). Illiterate and elementary-educated

patients together accounted for 18% of the sample. Socioeconomically, most patients belonged to the middle socioeconomic class (65%), followed by low socioeconomic class (23%) and high socioeconomic class (12%) [Table 1].

Table 1: Sociodemographic profile of patients with OCD

Variable	Category	Frequency	Percentage
Age group	18–30 years	30	30.0
	31–40 years	49	49.0
	41–60 years	21	21.0
Sex	Male	53	53.0
	Female	47	47.0
Residence	Rural	40	40.0
	Urban	60	60.0
Marital status	Single	27	27.0
	Married	54	54.0
	Divorced	13	13.0
	Widowed	6	6.0
Education	Illiterate	8	8.0
	Elementary	10	10.0
	High school	52	52.0
	University	30	30.0
Socioeconomic status	Low	23	23.0
	Middle	65	65.0
	High	12	12.0

Clinical profile and OCD severity

The duration of illness was ≤5 years in 38% of patients, 5.1–10 years in 37%, and more than 10 years in 25% of patients. Thus, three-fourths of the patients had illness duration of up to 10 years, while one-fourth had a duration exceeding 10 years. Duration of treatment was ≤5 years in 59% of patients, 5.1–10 years in 37%, and more than 10 years in only 4% of patients. Regarding hospitalization history, 26% of patients had no previous hospitalization, 41% had one hospitalization, 23% had two hospitalizations, and 10% had three or more hospitalizations.

The mean Y-BOCS obsession score was 14.96 ± 4.31, while the mean compulsion score was 14.66 ± 4.24. The mean total Y-BOCS score was 29.62 ± 6.73, with scores ranging from 17 to 40. Based on OCD severity classification, 24% of patients had moderate OCD, 33% had severe OCD, and 43% had extreme OCD. Overall, 76% of the patients were categorized as having severe or extreme OCD, indicating that most patients in the study had a high symptom severity profile [Table 2; Figure 1].

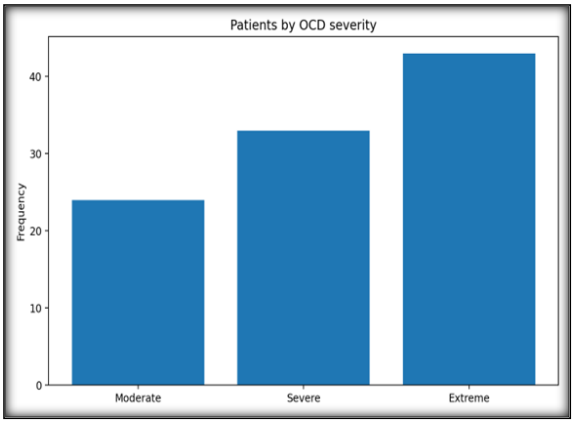

Figure 1: Distribution of patients according to OCD severity.

Table 2: Clinical profile and OCD severity among patients

Variable	Category / Score	Frequency / Mean ± SD	Percentage
Duration of illness	≤5 years	38	38.0
	5.1–10 years	37	37.0
	>10 years	25	25.0
Duration of treatment	≤5 years	59	59.0
	5.1–10 years	37	37.0
	>10 years	4	4.0
Hospitalizations	None	26	26.0
	One	41	41.0
	Two or more	33	33.0
Y-BOCS obsession score	Mean ± SD	14.96 ± 4.31	—
Y-BOCS compulsion score	Mean ± SD	14.66 ± 4.24	—
Y-BOCS total score	Mean ± SD	29.62 ± 6.73	—
OCD severity	Moderate	24	24.0
	Severe	33	33.0
	Extreme	43	43.0

Sociodemographic profile of caregivers

Among caregivers, the largest proportion belonged to the 30–40 years age group (40%), followed by 41–50 years (37%) and 51–60 years (23%). Female caregivers constituted 69% of the sample, whereas male caregivers constituted 31%. Regarding education, 44% of caregivers had high school education and 42% had university education, while 8% were illiterate and 6% had elementary education. Thus, 86% of caregivers had at least high school-

level education. Most caregivers were working, accounting for 70% of the sample, while 30% were not working. The majority were married (83%), followed by single (8%), widowed (6%), and divorced (3%). In terms of relationship with the patient, spouses formed the largest caregiver group (46%), followed by mothers (26%), siblings (25%), and fathers (3%). This showed that caregiving responsibilities were mainly undertaken by spouses and close first-degree relatives [Table 3].

Table 3: Sociodemographic profile of caregivers

Variable	Category	Frequency	Percentage
Age group	30–40 years	40	40.0
	41–50 years	37	37.0
	51–60 years	23	23.0
Sex	Male	31	31.0
	Female	69	69.0
Education	Illiterate	8	8.0
	Elementary	6	6.0
	High school	44	44.0
	University	42	42.0
Occupation	Working	70	70.0
	Not working	30	30.0
Marital status	Single	8	8.0
	Married	83	83.0
	Divorced	3	3.0
	Widowed	6	6.0
Kinship with patient	Father	3	3.0
	Mother	26	26.0
	Sibling	25	25.0
	Spouse	46	46.0

Caregiver burden and coping: Caregiver burden was assessed using the Burden Assessment Scale. The mean total BAS score was 94.51 ± 11.57, with scores ranging from 64 to 114. Among the burden dimensions, the highest mean score was observed for social and family burden, with a mean of 28.95 ± 4.28. This was followed by mental burden, with a mean score of 23.98 ± 2.69. The mean physical burden score was 11.22 ± 2.13, spouse burden was 12.20 ± 2.40, financial burden was 9.15 ± 2.00, and work burden was 9.01 ± 1.82. Thus, social/family and mental burden contributed the highest scores among the assessed burden domains [Table 4].

Table 4: Caregiver burden dimensions and coping scores

Variable	Mean ± SD	Minimum	Maximum
Financial burden	9.15 ± 2.00	4	12
Work burden	9.01 ± 1.82	4	12
Social and family burden	28.95 ± 4.28	18	36
Mental burden	23.98 ± 2.69	16	27
Physical burden	11.22 ± 2.13	5	15
Spouse burden	12.20 ± 2.40	7	18
BAS total score	94.51 ± 11.57	64	114
Coping total score	30.66 ± 8.24	13	42

When caregiver burden was categorized into levels, 56% of caregivers had moderate burden, 40% had severe burden, and only 4% had low burden. Therefore, 96% of caregivers had either moderate or severe burden. Coping assessment showed a mean total coping score of 30.66 ± 8.24, with scores ranging from 13 to 42. On categorization, 76% of caregivers had moderate coping and 24% had low coping. No caregiver was categorized as having high coping in the summarized data. This indicated that while most caregivers had moderate coping scores, nearly one-fourth had low coping ability [Table 5; Figure 2].

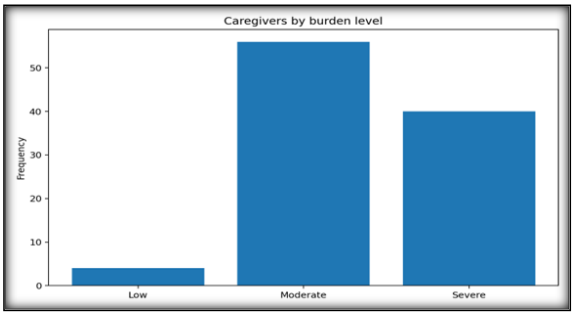

Figure 2: Distribution of caregivers according to burden level.

Table 5: Distribution of caregiver burden and coping levels

Variable	Category	Frequency	Percentage
Caregiver burden level	Low	4	4.0
	Moderate	56	56.0
	Severe	40	40.0
Caregiver coping level	Low	24	24.0
	Moderate	76	76.0

Association between OCD severity, caregiver burden, and coping: A statistically significant association was observed between OCD severity and caregiver burden level. Among caregivers of patients with moderate OCD, 75.0% had moderate burden, 16.7% had low burden, and 8.3% had severe burden. Among caregivers of patients with severe OCD, 51.5% had severe burden and 48.5% had moderate burden. Among caregivers of patients with extreme OCD, 48.8% had severe burden and 51.2% had moderate burden. The association between OCD severity and caregiver burden was statistically significant, with $\chi^2 = 22.676$ and $p = 0.0001$. This showed that the distribution of burden levels differed significantly across OCD severity groups [Table 6].

OCD severity was also significantly associated with caregiver coping level. Among caregivers of patients with moderate OCD, 83.3% had moderate coping and 16.7% had low coping. Among caregivers of patients with severe OCD, 90.9% had moderate coping and 9.1% had low coping. Among caregivers of patients with extreme OCD, 60.5% had moderate coping and 39.5% had low coping. This association was statistically significant, with $\chi^2 = 10.418$ and $p = 0.0055$. Thus, the proportion of caregivers with low coping was highest in the extreme OCD group [Table 6].

A statistically significant association was also found between caregiver burden level and coping level. Among caregivers with low burden, all had moderate coping. Among those with moderate burden, 85.7% had moderate coping and 14.3% had low coping. Among caregivers with severe burden, 60.0% had moderate coping and 40.0% had low coping. The association was statistically significant, with $\chi^2 = 9.774$ and $p = 0.0075$ [Table 6].

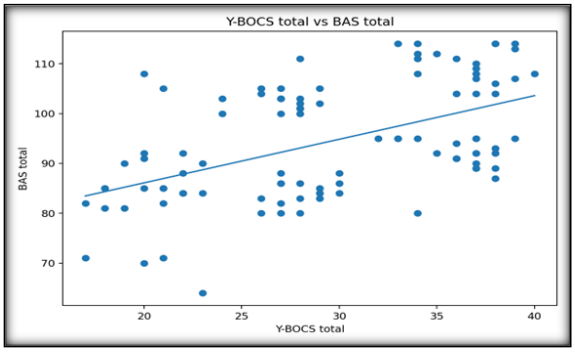

Figure 3: Relationship between Y-BOCS total score and BAS total

Correlation analysis: Correlation analysis showed that Y-BOCS total score had a significant positive correlation with total caregiver burden score. The correlation coefficient between Y-BOCS total and BAS total was $r = 0.509$, with $p < 0.001$. Among individual burden domains, Y-BOCS total score showed a significant positive correlation with financial burden ($r = 0.409$, $p < 0.001$), work burden ($r = 0.387$, $p = 0.0001$), social and family burden ($r = 0.310$, $p = 0.0017$), mental burden ($r = 0.460$, $p < 0.001$), physical burden ($r = 0.501$, $p < 0.001$), and spouse burden ($r = 0.307$, $p = 0.0019$). Thus, all burden dimensions showed statistically significant positive correlations with OCD severity.

In contrast, coping total score showed a statistically significant negative correlation with Y-BOCS total score, with $r = –0.216$ and $p = 0.031$. This indicated that higher OCD severity scores were associated with lower coping scores in the correlation analysis. The strongest positive correlations with Y-BOCS total were observed for BAS total score and physical burden, followed by mental burden and financial burden [Table 6; Figure 3].

DISCUSSION

The present study found that family caregivers of patients with obsessive–compulsive disorder (OCD) experienced substantial burden, with 56% reporting moderate burden and 40% reporting severe burden. The mean total BAS score was 94.51 ± 11.57, and the highest burden scores were observed in the social/family and mental burden domains. These findings indicate that caregiving in OCD is not limited to practical assistance but extends into the emotional and relational functioning of the family. This pattern is consistent with the chronic, intrusive, and ritualistic nature of OCD described in DSM-5-TR, where obsessions and compulsions produce distress, consume time, and interfere with daily functioning.[1] The present findings also align with epidemiological and clinical literature showing that OCD often begins early and persists over time, thereby placing long-term demands on family systems.[2] In the present study, 25% of patients had illness duration of more than 10 years and 76% had severe or extreme OCD, which may explain the high burden profile observed among caregivers.

The predominance of moderate-to-severe caregiver burden in this study is comparable with previous Indian and international studies. Gururaj et al. reported that severe OCD was associated with significant family burden, disability, and impaired quality of life, and highlighted that the psychosocial impact of OCD may approach that of schizophrenia in several domains.[3] Grover and Dutt similarly observed considerable objective and subjective burden among caregivers of OCD patients and found that greater illness severity was associated with poorer caregiver quality of life.[6] Vikas et al. also demonstrated that OCD produces substantial caregiver burden and family accommodation, despite being traditionally considered less disabling than psychotic disorders.[7] The present study supports these observations, as nearly all caregivers reported clinically relevant burden, with only 4% falling in the low-burden category.

In the present study, the highest burden was observed in social and family burden, followed by mental burden. This domain-wise distribution is important because OCD symptoms often occur within the

household and can directly affect family routines, interpersonal relationships, privacy, and emotional climate. Torres et al. showed that caregiver burden in OCD is multidimensional and includes interference in personal life, dependence, irritation, guilt, insecurity, and embarrassment 8. Siu et al., in a Hong Kong study of 77 patient–caregiver dyads, found that almost all caregivers reported objective burden, most commonly because of disruption of daily routines and patient demands.[15] Similarly, Thomas et al. found that OCD-related psychosocial dysfunction was associated with significant family burden, challenging the view that OCD is a relatively mild neurotic disorder.[20] These findings are consistent with the present study, where social/family burden was the most affected domain.

A significant association was observed between OCD severity and caregiver burden in the present study. Caregivers of patients with severe and extreme OCD had higher proportions of severe burden compared with those caring for patients with moderate OCD, and this association was statistically significant (χ^2 = 22.676, p = 0.0001). Correlation analysis further showed a significant positive correlation between Y-BOCS total score and BAS total score (r = 0.509, p < 0.001), as well as significant positive correlations with all individual burden dimensions. These findings are consistent with the use of Y-BOCS as a standard measure of OCD symptom severity and support the clinical relevance of symptom severity in determining caregiver outcomes.[5] Suculluoglu-Dikici et al. also reported that Y-BOCS obsession, compulsion, and total scores were positively correlated with caregiver burden, and that disease duration, treatment duration, and hospitalizations were associated with higher burden.[11] El-Slamon et al. similarly found that caregivers of patients with severe OCD had higher burden and lower coping ability.[12]

The positive correlation between OCD severity and all burden domains in the present study suggests that worsening symptoms affect caregivers through multiple pathways rather than through a single burden component. Physical burden showed one of the strongest correlations with Y-BOCS total score, followed by mental burden and financial burden. This may reflect the cumulative effect of time spent in caregiving, supervision of rituals, repeated reassurance, treatment visits, and disruption of occupational functioning. Comparable findings have been reported in studies assessing caregiver burden across psychiatric disorders. Ayalew et al., in Ethiopia, found that caregivers of persons with mental illness commonly experienced moderate-to-severe objective burden, with financial strain, disruption of routines, reduced leisure, and caregiver health effects being important burden domains.[16] Alzahrani et al. also reported that caregiver burden in mental illness is influenced by patient-related, caregiver-related, and household-related factors, including close relationship to the patient and female caregiving role.[17]

The present study also found that caregiver coping was significantly related to OCD severity. Caregivers of patients with extreme OCD had the highest proportion of low coping, and the association between OCD severity and coping level was statistically significant (χ^2 = 10.418, p = 0.0055). In correlation analysis, Y-BOCS total score showed a significant negative correlation with coping total score (r = –0.216, p = 0.031), indicating that higher OCD severity was associated with lower coping scores. This finding is consistent with the stress-appraisal model of Lazarus and Folkman, which proposes that coping depends on the balance between perceived demands and available resources.[9] When OCD symptoms are severe, repetitive, and difficult to manage, caregivers may experience reduced confidence and diminished coping capacity. Carver's Brief COPE framework further supports the importance of differentiating adaptive coping strategies from dysfunctional coping responses.[10]

The significant association between caregiver burden and coping level observed in this study further strengthens the link between burden and coping. Among caregivers with severe burden, 40% had low coping, whereas only 14.3% of caregivers with moderate burden had low coping. This association was statistically significant (χ^2 = 9.774, p = 0.0075). Mehra, Avasthi, and Grover reported that stigma among caregivers of OCD patients was associated with higher burden and reduced use of adaptive coping strategies such as social involvement and positive communication.[13] Dikeç et al. similarly found a positive relationship between anxiety and perceived family burden among first-degree caregivers of outpatients with mental disorders, emphasizing that caregiver distress and burden reinforce each other.[21] These observations support the present finding that higher burden is accompanied by poorer coping capacity.

The present study also showed that caregivers were predominantly female (69%) and most commonly spouses, mothers, or siblings. This pattern is consistent with the caregiving structure seen in Indian and other collectivistic societies, where close family members are usually the primary providers of emotional, practical, and treatment-related support. Previous studies have also shown that female caregivers and caregivers closely related to the patient often report higher burden because of greater emotional involvement, household responsibilities, and time spent in care.[17] Although the present study did not find all sociodemographic associations to be statistically significant, the descriptive caregiver profile reflects the central role of women and close relatives in OCD caregiving.

The finding that 76% of caregivers had moderate coping and 24% had low coping suggests that most caregivers had some coping capacity, but a substantial proportion remained vulnerable. Mahajan, Grover, and Chakrabarti emphasized that caregiving in OCD may also have positive dimensions, and that positive caregiving experiences

are influenced by social support, adaptive coping, reduced accommodation, and better caregiver quality of life.[18] Dikici et al. reported that caregiver burden was a key predictor of impaired quality of life across physical, psychological, social, and environmental domains among caregivers of OCD patients.[14] Together, these findings indicate that burden reduction and coping enhancement should be considered complementary clinical goals.

Family accommodation is another important explanatory factor in OCD caregiving. Although family accommodation was not directly measured in the present study, the observed relationship between OCD severity, caregiver burden, and coping is compatible with previous evidence showing that accommodation increases as symptom severity increases and contributes to caregiver strain. Torres et al. demonstrated that family accommodation and OCD severity were significantly associated with multiple caregiver burden dimensions.[8] Siu et al. also reported that accommodation behaviours such as reassurance and participation in rituals contributed to burden in Chinese families of adults with OCD.[15] This suggests that psychoeducation should not only address caregiver stress but also guide families on how to reduce symptom-reinforcing accommodation while maintaining supportive involvement.

Limitations: The present study had certain limitations. First, it was a single-centre, hospital-based study conducted in a tertiary care psychiatric setting, which may limit the generalizability of the findings to community populations or primary-care settings. Second, the cross-sectional design allowed assessment of caregiver burden, coping strategies, and OCD severity at a single point in time; therefore, causal relationships or changes over the course of illness and treatment could not be determined. Third, the study used convenience sampling, which may have introduced selection bias. Fourth, caregiver burden and coping were assessed using structured rating scales, and responses may have been influenced by recall bias, social desirability, or reluctance to disclose family-related distress. Finally, although the study assessed important burden dimensions and coping patterns, other relevant variables such as family accommodation, perceived stigma, social support, caregiver quality of life, personality factors, and treatment adherence were not evaluated in detail.

Overall, the present findings reinforce that OCD is a family-level disorder in terms of its psychosocial impact. Caregiver burden was high, coping was often only moderate, and symptom severity was significantly associated with both greater burden and poorer coping. These findings are consistent with Indian and international literature showing that OCD-related caregiving involves emotional strain, family disruption, social restriction, financial difficulty, and reduced quality of life.[3,6,7,11] The study adds to the evidence from an Indian tertiary-care setting and highlights the need to incorporate caregiver assessment into routine OCD management. Caregiver psychoeducation, coping-skills training, family-based interventions, stigma reduction, and strategies to reduce maladaptive accommodation may help reduce caregiver burden and improve long-term outcomes for both patients and families.

CONCLUSION

The study demonstrated that family caregivers of patients with obsessive–compulsive disorder experience considerable burden, with the majority reporting moderate to severe levels of burden. Social/family burden and mental burden were the most affected domains, indicating that OCD has a marked impact on family functioning and caregiver emotional well-being. Most caregivers had moderate coping ability, but nearly one-fourth showed low coping. Greater OCD severity was significantly associated with higher caregiver burden and poorer coping, and Y-BOCS total score showed significant positive correlations with all burden dimensions and a negative correlation with coping score. These findings highlight that OCD should be understood not only as an individual psychiatric disorder but also as a condition with substantial family-level consequences.

Recommendations: Routine assessment of caregiver burden and coping should be incorporated into the clinical management of patients with OCD. Caregiver-focused psychoeducation should be provided to improve understanding of OCD symptoms, treatment expectations, relapse prevention, and healthy caregiving practices. Structured interventions aimed at strengthening adaptive coping, reducing emotional distress, and improving problem-solving skills may help reduce caregiver burden. Family-based interventions should also address excessive reassurance, ritual participation, and other accommodation behaviours that may maintain OCD symptoms. Future studies should be multicentric, longitudinal, and community-based, with larger samples and inclusion of additional variables such as family accommodation, stigma, social support, caregiver quality of life, and treatment adherence, so that more comprehensive caregiver-support models can be developed.

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