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Research Paper: Comparison of Parenting Styles and Psychological Distress in Patients with Obsessive-Compulsive Disorder and Bipolar Disorder

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Abstract

Objective: Among psychological problems, mood disorders and obsessive-compulsive disorders impose huge costs on the society every year due to their recurring nature. In this regard, the present study was conducted with the aim of comparing parenting styles and psychological distress in patients with obsessive-compulsive and bipolar disorders.

Methods: The present study was applied in terms of its purpose and employed a causal-comparative (ex-post facto) design for data collection. The statistical population consisted of all patients diagnosed with Bipolar Disorder and Obsessive-Compulsive Disorder (OCD) who referred to psychiatric clinics in Ardabil during the second half of 2024. Participants were selected based on clinical interviews conducted by specialists according to DSM-5 criteria and their confirmed medical records. A total of 100 individuals (50 with Bipolar Disorder and 50 with OCD) were selected through purposive sampling based on the inclusion criteria. Data were collected using the Parenting Practices Questionnaire (PPQ) and the Depression Anxiety Stress Scales (DASS-21). The collected data were analyzed using Multivariate Analysis of Variance (MANOVA).

Results: The findings indicated that although the OCD group reported higher mean scores in psychological distress and the bipolar group reported higher levels of authoritative parenting, multivariate analysis (MANOVA) did not reveal any statistically significant differences between the two groups (Wilks' Lambda = .921, $F(12, 284) = 1.00$, $p = .44$). Similarly, univariate analyses (ANOVA) showed no significant differences in individual variables, including Depression ($p = .35$), Anxiety ($p = .69$), Stress ($p = .42$), Authoritative ($p = .15$), Authoritarian ($p = .62$), and Permissive parenting ($p = .57$). These results suggest that overall patterns of psychological distress and perceived parenting styles are largely similar across these two disorders, and the type of disorder alone does not account for substantial differences in these variables.

Conclusion: Therefore, the current research emphasizes the importance of paying attention to parenting styles and psychological distress of the system in obsessive-compulsive and bipolar disorders.

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1. Introduction

Mental disorders or mental illnesses are among the major health issues that concern governments, psychologists, and psychiatrists worldwid. These days, due to all kinds of problems and stresses that the residents of industrial cities suffer, there is a need to increase medical and psychological care in the field of mental disorders (Steuber & McGuire, 2023). One of the important factors in the formation and occurrence of mental illness is the education that a person has received during his life through family, friends, school, and work environment, and it also plays a great role in the formation of his mental disorders. Today, the residents of metropolitan cities are much more prone to suffering from various mental illnesses than those living in peripheral cities and villages (Brock et al., 2024). One of the chronic psychological disorders that cause serious harm to the mental, emotional and communication health of affected people is obsessive-compulsive disorder or thought-practical disorder (Malehmir et al., 2021).

Obsessive-compulsive disorder (OCD) is a chronic and disabling psychiatric condition characterized by the presence of obsessions, compulsions, or both (American Psychiatric Association [APA], 2022). Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, usually causing marked anxiety or distress. Individuals often attempt to ignore or suppress these thoughts, or to neutralize them with other thoughts or actions. Compulsions are repetitive behaviors such as washing, checking, ordering, hoarding, or mental acts such as praying, counting, or repeating words, which individuals feel compelled to perform in response to an obsession or according to rigid rules. These behaviors are intended to reduce distress or prevent a feared event, but they are excessive or not realistically connected to what they are meant to prevent (APA, 2022). According to DSM-5-TR diagnostic criteria, the presence of obsessions and/or compulsions must be time-consuming (taking more than one hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms should not be attributable to the physiological effects of a substance or another medical condition, and the disturbance should not be better explained by another mental disorder such as generalized anxiety disorder or body dysmorphic disorder (APA, 2022). Common symptoms of OCD include contamination fears and washing rituals, checking behaviors, ordering and symmetry obsessions, hoarding, and mental rituals such as repeating or neutralizing thoughts (Lee et al., 2020). OCD is among the most common psychiatric disorders worldwide, with a lifetime prevalence of approximately 2–3% in the general population (Reis et al, 2024). Due to its debilitating nature, OCD can seriously impair personal growth, emotional regulation, communication, and overall functioning (Stroch et al., 2019). Also, the results of Malehmir et al.'s studies (2021) showed that the prevalence of obsession in singles, people with low education and unemployed people is higher than other groups. Furthermore, the findings of Rezazadeh and Zarani (2022) indicated that

the prevalence rate of obsessive-compulsive disorder in the Iranian population falls within the range of 1.9–2.5%.

Among the common mental disorders in society, we can mention bipolar disorder (Malehmir et al., 2021). Bipolar disorder is a severe and recurrent psychiatric condition characterized by distinct episodes of mania, hypomania, and major depression (American Psychiatric Association, 2022). A manic episode is defined as a distinct period of abnormally and persistently elevated, expansive, or irritable mood, accompanied by increased activity or energy, lasting at least one week and present most of the day, nearly every day. During this period, at least three symptoms (or four if the mood is only irritable) must be present, including inflated self-esteem or grandiosity, decreased need for sleep, pressured speech, flight of ideas or racing thoughts, distractibility, increased goal-directed activity or psychomotor agitation, and excessive involvement in risky activities. The disturbance is sufficiently severe to cause marked impairment in social or occupational functioning, to necessitate hospitalization, or to present with psychotic features (American Psychiatric Association, 2022). A hypomanic episode involves similar symptoms but lasts at least four consecutive days and is observable by others, though it is not severe enough to cause marked impairment or require hospitalization. In contrast, a major depressive episode is characterized by a period of at least two weeks with depressed mood or loss of interest/pleasure, accompanied by at least five symptoms such as significant weight or appetite change, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, diminished concentration, and recurrent thoughts of death or suicide (American Psychiatric Association, 2022). According to DSM-5-TR, the diagnosis of bipolar disorder requires the occurrence of at least one manic episode. The disorder is associated with substantial impairment in functioning, high rates of recurrence, and increased risk of suicide. (Strom, 2024). Its recurrent nature and alternating mood states significantly affect emotional regulation, interpersonal relationships, and occupational functioning (Koender, 2020). In different studies, the prevalence of bipolar disorder type 1 is between 0 and 2.4%, bipolar disorder type 2 is between 0.3 and 4.8%, and the whole spectrum of bipolar disorder is between 2.6 and 7.8% (Kaplan and Sadock, 2017). The frequency of bipolar disorder in the Iranian population is reported as 7.9% (Jolfaei et al., 2019). Also, the results of Malemir et al.'s study (2020) showed that the prevalence of bipolar disorder in single people is more than married people and unemployment plays an important role in bipolar disorder. Therefore, it can be said that the prevalence of bipolar disorder in singles, people with low education and people without specific jobs is more than other groups. The results of studies show that environmental factors, especially parenting styles, have a significant impact on the formation and spread of obsessive-compulsive and bipolar disorder (DaryayeLaal et al., 2019; Kochar et al ,2023). Also, parenting styles can be mentioned as effective factors in the mental health of family members (Sudhir et al.,

2021). The methods that parents choose to raise their children or the opinions that parents have about their children are called parenting styles, and it can also include the standards and rules that parents create for their children (Dorri Mashhadi et al., 2022). Child rearing methods include two main and important criteria: parental affection and control, based on these two criteria, parenting styles can be divided into three main and important categories: authoritative, negligent and domineering style (Kuppens & Ceulemans (2019). Bastani and Safakish (2022) observed in their research that there is no positive and significant correlation between parenting methods and obsessive-compulsive disorder. Also, Arman et al. (2019) concluded in their research that there is a significant difference between two groups of children and adolescents with manic-sad disorder in terms of parenting styles. The parenting style framework is designed for parents or primary caregivers to describe and analyze their child-rearing practices (Yaffe, 2023). This model illustrates how parental behaviors and attitudes influence children's development and psychological outcomes. Authoritative style: Characterized by high responsiveness combined with reasonable control. Parents establish clear rules while showing warmth and support, fostering independence and responsibility in children. Authoritarian style: Defined by high control and low responsiveness. Parents emphasize obedience and strict discipline, often with limited emotional warmth. Permissive style: Marked by high responsiveness and low control. Parents are nurturing and flexible but impose few rules or boundaries, which may lead to difficulties in children's self-regulation. Neglectful (uninvolved) style: Characterized by low responsiveness and minimal control. Parents show little involvement or guidance, which can negatively affect children's emotional and social development (Bahmani, et al ,2023). Studies have demonstrated that parenting styles play a significant role in the emergence and persistence of obsessive-compulsive symptoms. For instance, Rezazadeh and Zarani (2022) reported that the prevalence of obsessive-compulsive disorder in the Iranian population is considerable. Moreover, findings from international research indicate that negative parenting styles, through the reinforcement of maladaptive perfectionism, can exacerbate obsessive-compulsive symptoms (Hu et al, 2023). In line with these results, a study conducted among Iranian adolescents revealed that authoritarian and permissive parenting styles are positively associated with increased obsessive-compulsive symptoms (Tamrchi et al, 2024).

One of the effective factors in the formation and persistence of obsessive-compulsive disorder and bipolar disorder is psychological distress (Keyvanlo et al., 2022; Adams et al., 2018). Psychological disturbance is a non-medical term that is an introduction to acute periods and psychological disturbance, which first manifests with short-term depression symptoms of specific distress, anxiety and stress (Keles et al., 2022). Psychological distress refers to a set of negative emotional reactions such as anxiety, depression, stress, and cognitive difficulties, which can disrupt

individual and social functioning (Scandurra et al., 2024). This condition not only threatens mental health but also has serious consequences for academic performance, social relationships, and overall quality of life (Roy, et al, 2025). Also, this state is sometimes called collapse in special situations after a person experiences physical and mental pressure (Lee et al., 2020). Davoudian et al. (2022) concluded in their research that there is a positive and significant correlation between psychological flexibility, difficulty in emotion regulation, and intolerance of ambiguity with psychological distress and obsessive-compulsive disorder in patients with type 2 diabetes. Also, in the study of Wasley & Eden (2021), it was found that more than 60% of the variance in psychological distress can be predicted by adaptive and maladaptive coping styles and the quantity and perceived satisfaction of social support.

Due to the fact that obsessive-compulsive and bipolar disorder has many effects on the personal, family, professional and social life of affected people and affects all aspects of life and leads to a decrease in the quality of life of these people (American Psychiatric Association, 2022). Also, considering that most of the researches conducted in the field of parenting styles and obsessive-compulsive disorder have been conducted on teenagers (Thiyagarajan et al., 2023) and very little researches have been conducted on other stages of life, we are trying to fill this empty space in the research that has remained empty. cover the Based on this, getting to know these patients and examining the status of their parenting styles, mental distress and brain-behavioral system is necessary for the progress of their life. Also, due to the fact that the studies in this field are limited and that currently no research has been conducted on the variables of parenting styles, mental distress and brain-behavioral system in patients with obsessive-compulsive disorder, bipolar and normal. The researcher is trying to find out the role of these three variables and compare it with these three groups in the society in order to open another perspective about these disorders for therapists. Based on this, the current research seeks to answer this question, is there a difference between parenting styles and distress in obsessive-compulsive disorder, bipolar?

2. Methods

2.1. Research Design and Participants

The present study was applied in nature and employed a causal-comparative design. The statistical population consisted of all individuals who referred to psychological clinics and psychiatric offices in Ardabil city during the second half of 2024. Sampling was conducted using a purposive method. Based on clinical interviews by a psychologist and the diagnostic criteria of the DSM-5, as well as confirmation from psychiatrists through medical records, two groups of patients were selected: those with bipolar disorder and those with obsessive-compulsive disorder (OCD**).** In total, 100 participants were included, with 50 patients diagnosed with bipolar disorder and 50 patients diagnosed with OCD. The two groups were matched in terms of age and gender to control for these variables. Inclusion criteria were: willingness to participate in the study, age between 20

and 50 years, having a confirmed diagnosis of bipolar disorder or OCD according to DSM-5 criteria. Exclusion criteria were: lack of cooperation or motivation, substance abuse, presence of other comorbid psychiatric disorders alongside bipolar disorder or OCD. To control for comorbidity, detailed clinical interviews and medical record reviews were conducted, and only individuals with a single diagnosis of either bipolar disorder or OCD were included.

2.2. Instruments

Parenting Practices Questionnaire (PPQ): This questionnaire was originally developed by Baumrind (1971) and consists of 30 items divided into three subscales: authoritative style (10 items), authoritarian style (10 items), and permissive style (10 items). Each item is rated on a 5-point Likert scale (from "strongly agree" to "strongly disagree"), scored from 0 to 5. The validity of the original questionnaire was confirmed through factor analysis, and its reliability was reported using Cronbach's alpha: 0.82 for the authoritative style, 0.86 for the authoritarian style, and 0.75 for the permissive style. In Iran, the questionnaire was translated and validated by Minaei and Nikzad (2017), and subsequent studies (e.g., Hosseini, 2017) confirmed acceptable reliability coefficients for the adapted version.

Depression Anxiety Stress Scales (DASS): The present scale was designed by Lovibond & Lovibond (1995) to assess psychological distress. The Depression Anxiety Stress Scales (DASS-21) is a self-report instrument that measures symptoms of depression, anxiety, and stress. The short form consists of 21 items, divided into three subscales: Depression (7 items): items 3, 5, 10, 13, 16, 17, 21& Anxiety (7 items): items 2, 4, 7, 9, 15, 19, 20 &Stress (7 items): items 1, 6, 8, 11, 12, 14, 18. Each item is rated on a 4-point Likert scale (from "not at all" to "very much"), scored from 0 to 3. Higher scores indicate greater severity of depression, anxiety, and stress. Validity and reliability of the original version: Lovibond & Lovibond (1995) reported satisfactory construct validity through factor analysis. Cronbach's alpha coefficients were 0.91 for depression, 0.84 for anxiety, and 0.90 for stress, with the total scale reliability estimated at 0.93. Other studies: Henry and Crawford (2005) reported Cronbach's alpha of 0.88 (depression), 0.82 (anxiety), and 0.90 (stress). Anthony (2006) found alpha coefficients of 0.97 (depression), 0.92 (anxiety), and 0.95 (stress), with correlations between depression and stress (0.48), anxiety and stress (0.53), and anxiety and depression (0.28). Iranian version: Samani and Jokar (2007) examined the psychometric properties of the DASS-21 in Iran. Test-retest reliability was estimated at 0.80 (depression), 0.76 (anxiety), and 0.77 (stress). Cronbach's alpha was 0.81 (depression), 0.74 (anxiety), and 0.78 (stress) (Amiri et al., 2016). After administration, the results were analyzed using SPSS-26 software and the multivariate analysis of variance (MANOVA) statistical test.

2.3. Method of Implementation

To conduct the present study, after obtaining the necessary permissions and completing the initial coordination with the administrators of clinics across Ardabil city, the researcher visited these centers for sampling. Following

preliminary agreements and securing their consent to collaborate, the inclusion criteria and characteristics of the required participants were explained to the clinic staff. Subsequently, the researcher interviewed each referred patient after reviewing their medical records. Upon obtaining their informed consent to participate, the researcher conducted a clinical interview based on DSM-V criteria. After the interview and confirmation of diagnosis by a psychiatrist, the researcher provided the Parenting Questionnaire and the Psychological Distress Scale to patients diagnosed with obsessive-compulsive disorder and bipolar disorder, accompanied by thorough explanations, for them to complete.

3. Results

According to the demographic findings of the present study, out of 150 respondents, 75 were men (50%) and 75 were women (50%). Among the men, 25 were diagnosed with obsessive-compulsive disorder (33.3%), 25 with bipolar disorder (33.3%), and 25 were healthy controls (33.3%). Similarly, among the women, 25 were obsessive (33.3%), 25 were bipolar (33.3%), and 25 were normal (33.3%). Regarding age distribution, in the group aged 20–30 years (n = 50), 15 were obsessive (30%), 17 were bipolar (34%), and 18 were normal (36%). In the 30–40 age group (n = 35), 13 were obsessive (37.1%), 9 were bipolar (25.7%), and 13 were normal (37.1%). In the 40–50 age group (n = 45), 14 were obsessive (31.1%), 14 were bipolar (31.1%), and 17 were normal (37.8%). In participants over 50 years (n = 20), 6 were obsessive (30%), 6 were bipolar (30%), and 8 were normal (40%). With respect to educational level, at the undergraduate level (n = 30), 8 were obsessive (26.7%), 12 were bipolar (40%), and 10 were normal (33.3%). At the diploma level (n = 36), 8 were obsessive (22.2%), 13 were bipolar (36.1%), and 15 were normal (41.7%). At the graduate level (n = 22), 10 were obsessive (45.5%), 7 were bipolar (31.8%), and 5 were normal (22.7%). At the bachelor's level (n = 23), 8 were obsessive (34.8%), 5 were bipolar (21.7%), and 10 were normal (43.5%). Finally, at the postgraduate level (n = 39), 13 were obsessive (33.3%), 12 were bipolar (30.8%), and 14 were normal (35.9%).

Table 1

Means and Standard Deviations of Psychological Distress Subscales and Parenting Styles in OCD and Bipolar Groups

Disorders		Depression	Anxiety	Stress	NPR	Authoritative	Authoritarian	Permissive	NSP
Bipolar	M	13.18	12.58	12.04	37.80	31.66	27.92	30.42	90.00
	N	50	50	50	50	50	50	50	50
	SD	2.28	2.07	2.33	4.09	3.92	4.13	4.34	8.07
Ocd	M	13.44	12.92	12.56	38.92	30.20	27.90	31.38	89.48
	N	50	50	50	50	50	50	50	50
	SD	2.44	3.20	2.77	4.11	4.07	4.60	4.71	7.80
Total	M	13.49	12.82	12.18	38.50	31.08	27.67	30.91	89.67
	N	150	150	150	150	150	150	150	150
	S	2.38	2.52	2.54	4.17	4.00	4.23	4.54	7.54

Table 1 presents the descriptive statistics for psychological distress subscales (depression, anxiety, stress, and total distress) and parenting style dimensions (authoritative, authoritarian, permissive, and total parenting score) across two groups: bipolar disorder and obsessive-compulsive disorder (OCD) .In terms of psychological distress, the OCD group showed higher mean scores in depression (M = 13.40, SD = 2.44), anxiety (M = 12.92, SD = 3.20), and stress (M = 12.56, SD = 2.78) compared to the bipolar group (depression: M = 13.18, SD = 2.28; anxiety: M = 12.58, SD = 2.07; stress: M = 12.04, SD = 2.33). The total distress score was also higher in the OCD group (M = 38.92, SD = 4.11) than in the bipolar group (M = 37.80, SD = 3.91) .Regarding parenting styles, the bipolar group scored higher in authoritative parenting (M = 31.66, SD = 4.13), whereas the OCD group reported lower scores in this dimension (M = 30.20, SD = 4.60). Authoritarian parenting scores were nearly identical across groups (OCD: M = 27.90; Bipolar: M = 27.92). Permissive parenting was slightly more prevalent in the OCD group (M = 31.38, SD = 7.77) compared to the bipolar group (M = 30.42, SD = 8.07). The total parenting style score was marginally higher in the bipolar group (M = 90.00, SD = 7.54) than in the OCD group (M = 89.48, SD = 7.77) .These findings suggest that individuals with OCD may experience higher levels of psychological distress and tend to perceive their parents as more permissive and less authoritative, whereas bipolar individuals report a more balanced parenting experience.

Table 2

Wilks' Lambda and Other Multivariate Indices from MANOVA Analysis

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	0.99	5061.05	6.00	142.00	0.00
	Wilks' Lambda	.005	5061.05	6.00	142.00	0.00
	Hotelling's Trace	213.85	5061.05	6.00	142.00	0.00
	Roy's Largest Root	213.85	5061.05	6.00	142.00	0.00
Disorder	Pillai's Trace	.081	1.005	12.00	286.00	0.44
	Wilks' Lambda	.92	1.00	12.00	284.00	0.44
	Hotelling's Trace	.085	.996	12.00	282.00	0.45
	Roy's Largest Root	.057	1.36	6.00	143.00	0.23

A multivariate analysis of variance (MANOVA) was conducted to examine the combined effect of diagnostic group (OCD vs. Bipolar) on the set of eight dependent variables (three distress subscales and five parenting style dimensions). The overall test indicated that the group effect was not statistically significant (Wilks'Λ=.921, F(12, 284)=1.00, p=.449). This primary finding suggests that, when considering all eight

variables simultaneously, the pattern of psychological distress and perceived parenting styles does not significantly differ between the OCD and Bipolar groups.

Table 3

Univariate ANOVA Results for Group Differences in Dependent Variables

Source	Dependent Variable	Sum of Squares	df Error	Mean Square	F	Sig	Eta
Disorder	Depression	11.77	1	5.89	1.04	0.36	0.01
	Anxiety	4.65	1	2.33	0.36	0.70	0.00
	Stress	11.08	1	5.54	0.86	0.43	0.01
	Authoritative	60.65	1	30.33	1.91	0.15	0.02
	Authoritarian	16.81	1	8.41	0.47	0.63	0.00
	Permissive	23.09	1	11.55	0.56	0.57	0.01
Error	Depression	829.72	93	5.64			
	Anxiety	940.84	93	6.40			
	Stress	947.06	93	6.44			
	Authoritative	2329.22	93	15.85			
	Authoritarian	2654.18	93	18.06			
	Permissive	3042.78	93	20.70			
Total	Depression	28152.00	100				
	Anxiety	25624.00	100				
	Stress	23211.00	100				
	Authoritative	147347.00	100				
	Authoritarian	117543.00	100				
	Permissive	146411.00	100				
Corrected Total	Depression	841.49	99				
	Anxiety	945.49	99				
	Stress	958.14	99				
	Authoritative	2389.87	99				
	Authoritarian	2670.99	99				
	Permissive	3065.87	99				

Subsequent univariate ANOVAs were performed to identify which specific variables contributed to the non-significant overall MANOVA result. None of the dependent variables reached statistical significance at the conventional $\alpha=.05$ level. Specifically, the group effect was non-significant for Depression ($F(1,93)=1.04, p=.355$), Anxiety ($F(1,93)=0.36, p=.696$), Stress ($F(1,93)=0.86, p=.425$), Authoritative ($F(1,93)=1.91, p=.151$), Authoritarian ($F(1,93)=0.47, p=.629$), and Permissive ($F(1,93)=0.56, p=.574$). Although the effect

size (η2) for Authoritative parenting was the largest among the parenting styles, the power to detect this difference was low (Power=.28 based on $F(1,93)=1.91$).

4. Discussion

The present study aimed to examine differences between individuals with obsessive-compulsive disorder (OCD) and bipolar disorder in psychological distress subscales (depression, anxiety, stress) and parenting styles (authoritative, authoritarian, permissive). Although the OCD group reported higher mean scores in psychological distress and the bipolar group reported higher scores in authoritative parenting, the multivariate (Wilks' Lambda) and univariate (ANOVA) analyses did not reveal statistically significant differences.

The aim of the present study was to examine differences between individuals with obsessive-compulsive disorder (OCD) and bipolar disorder in indices of depression, anxiety, and stress. The findings indicated that individuals with OCD reported higher mean scores in depression, anxiety, and stress compared to those with bipolar disorder; however, these differences were not statistically significant. These results are consistent with the findings of Yapıcı Eser et al. (2020), Hassoulas et al. (2023), Davoudian et al. (2022), and Ameri and Najafi (2022), which suggest that different clinical disorders may exhibit similar overall levels of psychological distress due to shared underlying mechanisms such as deficits in emotion regulation and heightened cognitive sensitivity. The present findings are also in line with studies by De Prisco et al. (2023) & Olivine (2025), which emphasize the existence of common mechanisms underlying psychological symptoms across diverse psychiatric conditions. Conversely, the findings of this study are inconsistent with research such as Cheng et al. (2025) and Durdurak et al. (2025), which reported that bipolar patients, particularly during manic or hypomanic episodes, display distinct patterns of emotion regulation and psychological distress compared to individuals with OCD. Systematic reviews, including De Prisco et al. (2025) have further highlighted that comorbidity of OCD and bipolar disorder creates a complex and distinct clinical profile that requires specialized treatment approaches. The lack of statistically significant differences in the present study may be explained by several factors. First, the limited sample size may have reduced the statistical power necessary to detect differences. Second, symptom overlap between OCD and bipolar disorder likely contributed to similarities in reported levels of depression, anxiety, and stress. Third, the sensitivity of measurement instruments may not have been sufficient to capture subtle distinctions between the two groups. Fourth, within-group heterogeneity, reflecting the variability in symptom severity and presentation across individuals, may have attenuated between-group differences. Fifth, the presence of comorbid disorders such as generalized anxiety or major depressive disorder could have confounded the results. Finally, cultural and social factors may influence how symptoms are experienced and reported, potentially leading to greater

similarities between the two groups (Strom, 2024).

The aim of the present study was to examine differences between individuals with obsessive-compulsive disorder (OCD) and bipolar disorder in perceived parenting styles. The results indicated that the bipolar group reported higher levels of authoritative parenting, whereas the OCD group reported higher levels of permissive parenting; however, these differences were not statistically significant. The present findings are consistent with the studies of Chen et al. (2022), Sudhir et al. (2021), Zolali Kordgheshlaghi and Nadermohammadi (2022), and Jamei and Zarbakhsh (2021), which have demonstrated that parenting styles play a crucial role in shaping psychological outcomes. Recent studies conducted in Iran have similarly shown that authoritarian and permissive parenting styles are positively associated with obsessive-compulsive symptoms, while authoritative parenting is negatively associated (Mostafavi, 2024). These findings also align with classical parenting theories, which associate authoritative parenting with better emotional adjustment and permissive parenting with anxiety-related and obsessive difficulties (Baumrind, 1971; Wang et al., 2021). In contrast, the present results diverge from some previous studies that reported clear differences between clinical groups. For example, the systematic review by De Prisco et al. (2025) highlighted that comorbidity of OCD and bipolar disorder creates a complex and distinct clinical profile requiring specialized interventions. Similarly, studies such as those conducted at the Okasha et al. (2024) reported that adolescents with psychiatric disorders more frequently perceived authoritarian parenting and low parental care, whereas healthy groups reported authoritative parenting. These findings suggest more pronounced differences between groups and therefore stand in contrast to the non-significant results of the present study. Contrary to the initial hypothesis, which anticipated significant differences between the groups, the lack of statistical significance may be explained by several factors. Children's perceptions of parenting styles may be influenced more by their current emotional state than by actual parental practices (Kalaman et al., 2023). Furthermore, cultural and social contexts may moderate the impact of parenting styles on psychological outcomes; in collectivist societies such as Iran, parenting styles may exert different effects on mental health compared to individualist contexts (Lu et al., 2024). Overlapping family and clinical experiences between the two groups may also contribute to similarities in perceived parenting styles. In addition, self-report instruments may lack the sensitivity to detect subtle differences, and the presence of comorbid disorders such as generalized anxiety or major depression may further confound the results.

Like other studies, the present research also had certain limitations. For instance, self-reporting tools were used to measure the research variables, and although these instruments had adequate validity and reliability, the responses may have been influenced by the participants' emotional state at the time of answering. Therefore, it is

suggested that future studies employ additional methods such as interviews and observations to obtain more comprehensive data. Moreover, variables such as personality traits, as well as social and cultural characteristics, were beyond the researcher's control and may have affected the findings. Another important limitation is that this study was restricted to participants from the city of Ardabil. Consequently, caution should be exercised when generalizing the results to other populations. Future research is recommended to include samples from different cities and regions to enhance the external validity and generalizability of the findings. Based on the results, it is further suggested that therapeutic interventions targeting cognitive biases be designed, and other psychological factors such as worry and guilt be investigated. In addition, meetings with the presence of psychologists should be organized to educate families about OCD and bipolar disorder, provide problem-solving skills, and rebuild social support systems so that family dynamics can return to a healthier state.

5. Conclusion

Overall, the findings revealed that although OCD patients reported higher levels of depression, anxiety, and stress, and bipolar patients reported more authoritative parenting, these differences were not statistically significant. Thus, psychological distress and parenting styles appear to share common patterns across the two disorders, suggesting that the type of disorder alone does not account for substantial differences in these variables.

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Conflict of interest

The authors report no potential conflicts of interest

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