Author's response to reviews

Title: Perceived quality of life in obsessive-compulsive disorder: Related factors

Authors:

Beatriz Rodriguez-Salgado (beatriz.rodriguez@hrc.es)
Helen Dolengevich-Segal (edolen@ya.com)
Manuel Arrojo-Romero (manuel.arrojo@hrc.es)
Paola Castelli-Candia (paola.castelli@ucm.es)
Mercedes Navio-Acosta (mercedes.navio@hrc.es)
Maria M Perez-Rodriguez (merperez@yahoo.com)
Jeronimo Saiz-Ruiz (jeronimo.saiz@hrc.es)
Enrique Baca-Garcia (ebacgar2@yahoo.es)

Version: 2 Date: 13 January 2006

Author's response to reviews: see over
January 13th 2006

BMC Psychiatry
BioMed Central Ltd, Middlesex House,
34-42 Cleveland Street,
London W1T 4LB, UK.

Ref.: 7068171257915167: Perceived quality of life in obsessive-compulsive disorder: Related factors

Dear editor:

Thank you for the opportunity to revise our paper. We appreciate the reviewers’ comments and have used them to make improvements in the revised manuscript. The following is our response to each of the reviewer’s comments. We described in italics the revised text copied from the article.

Reviewer comments:

Reviewer 1 comments:
This manuscript examines correlates of quality of life in 64 adult OCD patients. It a solid paper that builds on others' findings that will likely be cited often given its relevance.

Thank you.

Major compulsory Revisions (that the author must respond to before a decision on publication can be reached):

1. I do not believe that Pearson correlations are correct for correlating a continuous measure with a dichotomous variable. Point biserial would be appropriate.

Thank you. We realize that the statistical methods were not properly explained in the methods and results sections. We used 2-tailed Student’s t-tests (for dichotomous variables) and Analysis of Variance (ANOVA, for variables with more than 2 categories) to compare SF-36 subscales scores among the categories of sociodemographic variables. We used Pearson’s correlation to evaluate the correlations among the SF-36 subscales and the scale scores (global Y-BOCS, compulsions subscale, obsessions subscale and Hamilton’s Depression Scale). We have rephrased the following paragraph in the Methods section:

(page 6, paragraph 3): “The statistical analysis was performed with the computer program SPSS 11.5. We used 2-tailed Student’s t-tests (for dichotomous variables) and Analysis of Variance (ANOVA, for variables with more than 2 categories) to compare SF-36 subscales scores among the categories of sociodemographic variables. We used Pearson’s correlation to evaluate the correlations among the SF-36 items and the test
scores (global Y-BOCS, compulsions subscale, obsessions subscale and Hamilton’s Depression Scale).”

2. I found the tables to be somewhat difficult to read due to their inconsistency. Please reformat per the journal guidelines in a more consistent fashion.

Following the reviewer’s suggestions and the journal guidelines, we have reformatted the tables in order to make them more consistent and easier to read (see tables 1, 2, 3, and 4 on pages 17, 18, 19 and 20).

3. Please provide a rationale for examining the correlation between the YBOCS and individual SF36 items. It might be best to focus solely on subscales rather than individual items.

We are sorry, this was a typographical mistake. We examined the correlation among the SF-36 subscales scores and the test scores (global Y-BOCS, compulsions subscale, obsessions subscale and Hamilton’s Depression Scale). We did not examine the correlation among the YBOCS scores and individual SF36 items. We have corrected this in the Methods (page 6, paragraph 3) and Results (page 7, paragraph 4 and page 8, paragraph 1) sections:

(page 6, paragraph 3) “We used Pearson’s correlation to evaluate the correlations among the SF-36 subscales scores and the test scores (global Y-BOCS, compulsions subscale, obsessions subscale and Hamilton’s Depression Scale).”

(page 7, paragraph 4) “Y-BOCS global scores and Hamilton scale scores correlated negatively to all SF-36 subscales scores. The Y-BOCS obsessions subscale was negatively correlated to all SF-36 subscales. The Y-BOCS compulsions subscale was only negatively correlated to the social functioning, emotional role, mental health and vitality subscales of SF-36 (table 4). The SF-36 subscales that showed the weakest correlation to the Y-BOCS obsessions subscale (those related to physical functioning: physical function, physical role and pain) showed no correlation at all to the compulsions subscale.”

4. The discussion, while appropriate in its conclusions, could be shortened considerably.

Following the reviewer’s suggestion, we have shortened the length of the Discussion (pages 8-10) and Conclusions sections (page 11):

Discussion (pages 8-10): “Previous studies [17] have shown that patients with anxiety and depressive disorders have higher levels of physical, social and emotional impairment than other medical or psychiatric patients. The results of the present study are consistent with previous findings showing that OCD patients have significantly decreased mean QOL scores for every SF-36 subscale except those related to physical health and pain in comparison to the general population. However, in a recent study Moritz et al [18] observed that OCD also affected SF-36 subscales related to physical wellbeing. We found a correlation among Hamilton scale scores and all SF-36 subscales. This is consistent with the results of other studies [18]. However, bad QOL perception in our
sample may not be attributable to depressive symptoms, since the average Hamilton scale score was approximately 10 points. Sociodemographic factors, age of onset, and years of evolution of the disorder did not significantly affect QOL perception. This is consistent with the results of some studies [19]. However, other studies suggest that the delay in OCD diagnosis [20] and the length of illness [18] worsen QOL perception. Other studies corroborate the impact of OCD on academic and work performance, social functioning and QOL [18, 20, 21, 22]. We found that being employed was related to better scores in the SF-36 subscale of physical role. This stresses the importance of employment status on QOL in OCD patients. We only found one study that assessed QOL perception in Spanish OCD patients [10], and concluded that QOL perception was worse in OCD patients than in the general population. The most affected SF-36 subscales were social functioning, emotional role and mental health. Their results agree with ours and with other recent studies [18] in that not all SF-36 subscales were equally affected.

We found that patients with medical comorbidity scored lower in the subscales of general health and social functioning. Other researchers have reported similar findings in OCD populations without medical comorbidity [10, 22]. In our sample, patients with psychiatric comorbidity had worse scores in the subscales of pain, general health, vitality, social functioning and mental health. Koran et al [22] only found differences in mental health perception. The discordance in the results may be related to the low psychiatric comorbidity in Koran’s sample (20%) and to the fact that all patients in our sample (but not in Koran’s) [22] were receiving treatment at the time of the study. Psychiatric comorbidity may be a confounding factor since it may influence QOL perception. Previous studies have reported a negative effect of psychiatric disorders on QOL perception [23, 24, 25, 26]. The severity of OCD was correlated with all SF-36 subscales and with the highest scores in Hamilton’s scale. The obsessions subscale was correlated to all SF-36 subscales, while the compulsions subscale was correlated only to social functioning, emotional role, mental health and vitality. Other authors have pointed out the positive correlation between social impact and severity of the clinical manifestations of the disorder [22]. It is noteworthy that the scores in the compulsions subscale in our sample were not negatively correlated with all SF-36 subscales. Masellis et al [27] obtained similar results. This might be related to the fact that compulsions are strategies to reduce the anxiety generated by the obsessions [28]. Obsessions are perceived as intrusive and uncontrollable, generate marked uneasiness and have a greater impact on QOL than compulsions, which may be considered necessary for controlling the anxiety and discomfort. Evidence-based psychological therapies for OCD pay more attention to decreasing the compulsions than the obsessions [29], and may be less useful for patients with predominantly obsessive manifestations. Between 17% and 44% of OCD patients only experience obsessions [30]. This suggests that treatments specifically aimed at reducing the anxiety related to the obsessions may improve global QOL perception in OCD patients, particularly in those with predominant obsessive symptoms. Cognitive therapy [30, 31, 32, 33] has been shown to be effective in patients with only obsessive symptoms, though no studies have reported an improvement in perceived QOL.

There are some limitations in our study. First, the sample size makes it difficult to control for gender and comorbidity. Second, the study design is transversal, meaning that perceived QOL may be determined by multiple punctual factors. This is magnified
by the lack of control group. Third, the use of general scales (instead of specific scales for psychiatric patients) to measure perceived QOL may bias the results. Further research is needed on perceived QOL in OCD patients, with bigger samples and control groups. Another line of investigation should be to determine the degree to which psychotherapies and pharmacological treatments make emphasis on health perception and how these treatments can improve the adaptation of OCD patients in family, social and work environments.”

Conclusions (page 11): “In this sample, OCD had a clear negative repercussion on perceived QOL except in the SF-36 subscales related to physical health and pain. This suggests that not all areas of the scale were altered by the disorder. There was a correlation among Hamilton scale scores and all SF-36 items. The severity of OCD was correlated with all SF-36 areas and with the highest scores in Hamilton’s scale. The obsessions subscale was correlated to all SF-36 items, while the compulsions subscale was correlated only to social functioning, emotional role, mental health and vitality. This suggests that treatments aimed at reducing the anxiety related to obsessions may improve global QOL perception in OCD patients, particularly in those with predominant obsessive symptoms. Sociodemographic characteristics, age of onset and years of evolution of OCD did not affect QOL perception. However, being employed was related to better scores in the area of physical role. Patients with medical comorbidity scored lower in general health and social functioning. Patients with psychiatric comorbidity had worse scores in the areas of pain, general health, social functioning and mental health.”

5. The Discussion notes that OCD usually starts in the first 2–3 decades of life. Other data suggests an earlier onset (in childhood) or a bimodal onset (childhood, early adulthood).

We have removed the paragraph mentioning the age of onset of OCD (page 8, paragraph 2) in order to shorten the length of the Discussion and Conclusions (see item 4, reviewer 1).

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

1. The information in the 1st paragraph in the Measures section of the Results should all be included in Table format.

Following the reviewer’s suggestion, we have included the information in the first paragraph in the Measures subsection of the Results section in Table format (See table 2, page 18).

Reviewer 2 Comments:

Quality of Life (QoL) is increasingly targeted as an important outcome criterion in psychiatric disorders, including obsessive-compulsive disorder (OCD). The authors report a timely study employing a sizable sample of individuals suffering from OCD. The results show that OCD is associated with low QoL, particularly in patients with a diagnosis of comorbid depression. The article is concerned with a timely topic and its claims are embedded well in the existing literature. I also like that the impact of comorbid diagnoses is investigated.
Thank you.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached):

1. The authors should report more data on OCD subtypes since washers and checkers may differ on QoL.

As we explain in the limitations, this is a modest sample and unfortunately we can not report more data on OCD subtypes.

In addition, the authors may take into consideration a new article by Moritz et al. (2005, Comprehensive Psychiatry) which fits well to the reported findings.

Following the reviewer’s suggestion, we have added statements comparing our results with those presented by Moritz et al in the Conclusion section (see item 4, reviewer 1) and we have included a new reference (Reference number 18, page 15):


Sincerely yours,

Enrique Baca-Garcia, M.D.
Corresponding author
Fundación Jiménez Díaz, Servicio de Psiquiatría
Avda. Reyes Católicos, 2
28040 Madrid, Spain
(00 34) 91-550-4987, phone; (00 34) 91-550-4987, Fax
ebacgar2@yahoo.es