Author's response to reviews

Title: Psychotic and schizotypal symptoms in non-psychotic patients with obsessive-compulsive disorder

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Author's response to reviews: see over
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Editor
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Dear Editor

We are thankful for the opportunity to revise our article. Below you will find our response to the reviewers’ comments. We hope that the revised manuscript could be found suitable for publication in your journal.

Sincerely,

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Response to reviewers

Reviewer #1
1. In the Methods section the authors need to add a statement as to whether the study underwent ethical approval and was an informed consent obtained from patients
Reply: We now mention that the study was approved by a local ethics committee.

2. The authors need to show the flow of OCD patients and the general psychiatric outpatient group (controls) from various studies using a simple flow diagram. It would also be good to indicate the instruments used for assessments in various arms.
Reply: Unfortunately the university clinic has not kept track of patient flow so we cannot address patient flow in the control group. The control group consists of treatment completers from the clinic. In the revised manuscript we now more accurately describe patient flow. A total of 49 patients were excluded from the OCD group. We chose not to include a patient flow diagram as this is not a randomized controlled study and the revised manuscript more clearly describes patient flow and the case of missing data at post-treatment.

3. The authors must clearly indicate why patients were excluded. OCD patients are indicated as 133 in line 118 and then authors state that 7 were excluded due to psychotic disorders. However Table 1 states that n=103. Can the authors clarify?
Reply: We agree that differences in sample sizes may have been unclearly described. The reason for the different sample size is due to missing data at post-treatment. We had SCL-90 data on 133 OCD patients at pre-treatment and 103 at post-treatment. We now describe more accurately the number of treatment seeking patients and the number of excluded patients in the manuscript. We also mention missing post-treatment data in the revised manuscript.

4. Why were the 20 patients with no psychiatric diagnosis included in the analyses? Would it not be better to exclude them?
Reply: We chose to include the 20 patients with no diagnosis as they were treatment seeking patients and they were given treatment at the clinic. The 20 patients with no psychiatric diagnosis did have lower scores on SCL-90 compared to the 90 diagnosed patients. However, this difference was not significant with regard to paranoia or psychoticism. We have added the following to the revised manuscript: “They were still included in the study as they were treatment seeking and received treatment at the clinic.”

5. How many patients in the ‘control’ arm were assessed by SCID-II and how was the decision made to screen these patients with SCID-II. Were personality disorders identified only in those whom SCID-II was done?
Reply: We have added the following to the revised manuscript: “The number of patients assessed with SCID-II is unknown. SCID-II was not used as a routine procedure, but administered when the therapist had a hypothesis that the patient suffered from a personality disorder.”
6. This seems to be one of the first studies that had used SCL-90-R in OCD patients to assess for schizotypal symptoms. Was the validity of the scale assessed in any way?  
Reply: We have added the following to the limitation section: “The validity of the SCL-90-R in assessing schizotypal symptoms in OCD is unclear.”

7. The authors found a correlation of psychotic and schizotypal symptoms with BDI. Did they carry out any partial correlations? This finding should be discussed in further detail in the discussion.  
Reply: We have now included partial correlations also for BDI in table 2. The relationship between psychotic and schizotypal symptoms and BDI is addressed in the discussion. In line with the recommendation from the reviewer, we also added the following: “Scores on psychotic and schizotypal symptoms were moderately correlated with depressive symptoms. There may be considerable overlap between depressive symptoms and some of the SCL-90-R items assessing psychotic and schizotypal symptoms.”
Reviewer #2

1. In general, the description and measurement of psychotic symptoms should be improved. Regarding description, the authors write that psychotic symptoms “constitute more general symptoms that are prevalent in several other emotional disorders” on Page 3. I do not view psychotic symptoms as “general” symptoms as they are described here. The authors should provide further evidence and rephrase this description. Also on page 3, I would like more information as to what the authors mean when they write that “there might not be a clear distinction between delusions and obsessions.”

Reply: We agree that ‘general’ is an unfortunate term and have deleted it in the revised manuscript. We also attempt to explain the delusions vs. obsessions comment: “Furthermore, there might not be a clear distinction between delusions and obsessions as OCD patients describe varying degrees of overvalued ideas [2].”

2. Regarding measurement of psychotic symptoms, why wasn’t a measure specifically designed to assess psychotic symptoms used in this study? The SCL-90-R is often used as a self-report measure that assesses personality traits rather than symptoms of psychosis. Likewise, for schizotypal traits, why was the SCL-90-R used as opposed to a measure like the Wisconsin Schizotypy Scales or the Schizotypal Personality Questionnaire? Although there is some evidence presented here for ‘schizotypal signs’ and ‘schizophrenia nuclear symptoms’, the authors do not present rationale for using the ‘psychoticism’ or ‘paranoid ideation’ subscales. The authors should provide evidence as to why the SCL-90-R was used and justify the use of all scales.

Reply: We agree that other measures could be used that are more appropriate with regard to assessing psychotic and schizotypal symptoms. The main reason for choice of instruments is that the university clinic wanted to ease burden on patients with regard to using different self-report instruments. Thus the clinic chose SCL-90-R which consists of several different subscales including measures of psychoticism and paranoid ideation. We also mention the use of SCL-90-R in the limitation section. Justification for the use of this measure is included in the description of the measure in the method section.

3. The third paragraph of the Introduction discusses how some have proposed that schizotypal OCD is a distinct OCD subtype. However, the evidence they provide in the following sentences does not present a convincing argument that this should be a distinct subtype of OCD.

Reply: We agree with the reviewer and have rewritten the sentence: “There have been proposals of a distinct subtype of schizotypal OCD [3, 6, 12], as OCD patients with schizotypal symptoms have poorer insight and lower functioning than OCD patients without such symptoms. However, there are discrepant findings…”

4. ERP is first mentioned as the last word of the Introduction. This abbreviation is not defined in the main text and the therapy is not discussed in the Method section. Further, one of the primary findings of the manuscript is that psychotic and schizotypal symptoms improved after ERP in both groups. However, no rationale for why ERP is used, how improvement occurred, or what the treatment entailed is provided. All of these are necessary to justify these analyses and allow the reader to judge how this intervention might have helped improve symptoms.

Reply: We now define the ERP abbreviation in the introduction. We did mention ERP in the method section: “Patients received either ERP-based group therapy over a period of 12 weeks [19] or individual ERP based on the manual by Foa [23].” ERP was chosen as treatment as it
is an evidence based treatment for OCD. A closer description of the treatment is now included: “The main ingredients of ERP were in the first session to formulate a case-conceptualization, present a habituation rationale, and use of self-registration of rituals for homework. The second session involved creating the exposure hierarchy and introducing the rules for ritual prevention. The following sessions were similar in structure and consisted mainly of checking homework assignments, in vivo and imaginary exposure delivered in a sequence as specified by the hierarchy and agreeing on homework assignments. Focus turned to relapse prevention when treatment was approaching termination.”

5. Regarding ERP, it was administered differently to participants in this study. In the OCD group, some received individualized ERP while others received 12 weeks of group ERP. The general psychiatric outpatient group all received “15 weekly sessions of eclectic psychotherapy delivered by graduate psychology students.” This brings up several questions: 1) how many received group vs individual ERP in the OCD group?; 2) Were there differences in psychotic/schizotypal improvement based on the type of therapy received?; 3) Did the general outpatient group receive individual or group therapy? and; 4) What did this eclectic psychotherapy entail?

Reply:
5.1. A total of 65 received group treatment and 68 had individual ERP treatment.
5.2. Independent t-tests found no significant difference between people in group and individual treatment with regard to changes in symptoms of paranoia ($p = .19$), psychoticism ($p = .36$), schizotypal signs ($p = .17$), and schizophrenia nuclear signs ($p = .17$).
5.3. The general outpatient group had individual treatment only.
5.4. Description of “Eclectic therapy” is now more detailed: “Supervisors had different backgrounds with training in CBT or psychodynamic therapies. Supervisors were to ensure that treatment should be based on good clinical research practice. Choice of treatment was made in agreement between therapists and supervisors.” These details are now included in the revised manuscript.

6. Although the authors mention it as a limitation, justification for combining the different types of psychopathology into one ‘general’ group should be provided. Did the presence of psychotic and/or schizotypal symptoms differ based on the different problems faced in this group?

Reply: We now include a justification for combining the different types of psychopathology into on general group: “For the non-psychotic control group, a one-way ANOVA revealed no significant difference between five different diagnostic groups with regard to scores on psychoticism, $F(4,102) = 2.113, p = .085$, or schizotypal symptoms, $F(4, 102) = 2.148, p = .08$. The five diagnostic groups consisted of; depressive disorders ($n = 28$), anxiety disorders ($n = 39$), personality disorders ($n = 8$), several comorbid disorders ($n = 12$), and no diagnosis ($n = 20$).”

7. More information is needed on the Y-BOCS. What is the measure, is it reliable/valid, why was the general psychiatric group not administered this measure? Further, why was the BDI not administered to the general psychiatric group?

Reply: More details on the Y-BOCS is now included: “Y-BOCS is considered the gold standard for measuring OCD severity. Obsessions and compulsions are rated on a 0-4 scale with regard to frequency, distress, interference, resistance, and control.” The clinic wanted to ease burden on patients with regard to the use of self-report instruments. Thus the clinic chose SCL-90-R which consists of several different subscales including measures of depression and OCD.
8. Bottom page 3: I believe the authors are referring to Schizotypal Personality Disorder when they mention ‘schizotypal disorder’. This should be clarified.  
Reply: The reviewer is correct. The revised manuscript reads schizotypal personality disorder.

9. Pg. 5: Why would psychiatric and/or schizotypal symptoms be “specific” to an OCD population?  
Reply: We agree that using the term ‘specific’ is unfortunate and have removed it from the manuscript.

10. Pg. 5: Were any individuals from the general group excluded due to psychosis?  
Reply: Unfortunately the university clinic has not kept records of excluded patients. We now mention this in the method section.

11. Pg. 14: How could the limitation of using a general outpatient group instead of specific diagnostic groups affect the results observed in this study? In other words, why is it a limitation?  
Reply: It is a possibility than the results could be different for different specific diagnostic groups. However, as mentioned previous in this reply letter we did not find any differences between the major diagnostic groups. This could however be due to sample size. We now specify this in the limitation section: “Another limitation is the use of a general psychiatric outpatient sample instead of sub-samples of different specific diagnostic groups. There is a possibility that psychotic and schizotypal symptoms differ across disorders. We did not find any evidence of such differences within our non-psychotic control group, but that could be due to small sample sizes”. We also mention the result of comparing diagnostic groups in the control group.
Reviewer #3
1. Is the question posed by the authors well defined? The research question is well-defined in the ms.
2. Are the methods appropriate and well described? Method are appropriate. 3. Are the data sound? Data appear to be sound.
4. Do the figures appear to be genuine, i.e. without evidence of manipulation? Figures appear to be appropriate.
5. Does the manuscript adhere to the relevant standards for reporting and data deposition? Yes.
6. Are the discussion and conclusions well balanced and adequately supported by the data? Well-written discussion with connection to the current literature.
7. Are limitations of the work clearly stated? Yes.
8. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished? Yes.
9. Do the title and abstract accurately convey what has been found? Yes.
Reply 1-9: We are very grateful for the kind review.

10. Is the writing acceptable?
I would suggest that the authors use “non-psychotic” when they describe the OCD group and the control group and use it consistently throughout the ms for clarity. For example, “OCD non-psychotic patients” and “general non-psychotic psychiatric outpatient sample.”
Please explain ERP when it is first introduced on pg. 5. After that it is fine to refer to ERP. Explain what the “eclectic psychotherapies” were. It still needs a thorough review to correct minor grammatical errors. The above would be considered minor essential revisions.
Reply: We agree with the reviewer and have changed the text accordingly.

We now consistently describe the groups as non-psychotic. ERP is now defined when it is introduced in the introduction.

Description of “Eclectic therapy” is now more detailed: Supervisors had different backgrounds with training in CBT or psychodynamic therapies. Supervisors were to ensure that treatment should be based on good clinical research practice. Choice of treatment was made in agreement between therapists and supervisors.”

With regard to minor grammatical errors, the revised manuscript has been proofread by two native English speaking professors.