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Comorbidity within Axis-II Disorders: The Unending Issues

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Authors' contributions:

This work was carried out in collaboration between both authors. Author NSE designed the study, wrote the protocol and wrote the first draft of the manuscript. Author EIN-E managed the analyses and data interpretation of the study. Both authors read and approved the final manuscript.

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Commentary

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ABSTRACT

Personality Disorders have since the 19th century been known and established as psychiatric diagnosis, yet till date, issues of definition still remain unresolved. With a prevalence of 10-15% of the general population, and it's associated extreme disruption in the lives of the patients and the communities, it is still not a principle focus of treatment. It's assessment and diagnosis have been restricted to clinical settings and drug treatment and rehabilitation centres. A study in a Nigerian prison community has revealed a comorbidity prevalence rate of 70% with substance use disorder, a 25% comorbidity prevalence within the personality disorders and a strong association between personality disorders and criminality.

Keywords: Axis-2 comorbidity; DSM-5; ICD-10; prison inmates; substance use disorders.

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1. INTRODUCTION

Throughout humankind and modern psychiatry, psychiatrists have sought to explain behaviours that are difficult to understand, unacceptable to people, but accommodated in the communities from those who constantly display them [1]. By 1923, the concept of personality disorder (PD) has been accepted and recognised in all cultures, leading to its full recognition by World Health Organization (WHO) in 1988 and its classification in the Diagnostic and Statistical Manual of Mental Disorder (DSM-111-R) and the International Classification of Diseases (ICD-10) in 1991 [2,3]. Although the concept is well established, it hasn't remained easy to define. This is particularly not surprising considering the problems involved in defining normal personality. The definitions by the 5th edition of the DSM and the ICD-10, acknowledged by WHO, provides an in-depth knowledge of the concept and an acceptable definition to the clinicians.

The DSM-5 recognises ten basic types of PD and groups them into three different clusters based on descriptive similarities. Cluster A includes Schizotypal, Schizoid, and Paranoid personality disorders, which share oddity, aloofness and eccentricity as common symptoms. Cluster B includes Narcissistic, Borderline, Antisocial, and Histrionic personality disorders, with common features of being dramatic, impulsive and erratic. Cluster C which includes Obsessive Compulsive, Dependent, and Avoidant personality disorders, are usually anxious and fearful. [4,5]. The ICD-10 recognises eight different types which includes Paranoid, Schizoid, Dissocial, Impulsive, Histrionic, Anankastic, Anxious and Dependent. Both instruments agree with the basic concepts in the definitions and highlight their behaviours as ingrained, inflexible, ego syntactic and alloplastic, and tending to represent significant deviation from normal personalities. A comparative analysis of both instruments administered on prison inmates in a study in Nigeria, reported that the ICD-10 is more sensitive in diagnosing PD. , that both instruments have good concordance for schizoid, Histrionic, and Dependent PD., and that both instruments also showed poor concordance for Obsessive and borderline PD and very poor concordance for avoidant PD.[6]

Personality disorders are common, affecting 10-15% of the normal population, very prevalent in clinical settings, but are nearly always assessed as comorbid to other disorders [7-12]. Patients are rarely admitted into treatment centres based on the diagnoses of PD, even in their various exciting phases. Personality disorders can and should be a principal focus of treatment because the patients are unable to adapt to changes and demands of life. They fail to make optimal social, occupational, and personal decisions leading to severe stress in their lives. Most reports and studies on PD have come from clinical settings and drug treatment and rehabilitation centres. Studies on PD outside these two settings are scanty. Surprisingly, there are few systematic studies of the health of prison inmates, but those carried out have indicated a high level of mental disorders [13].

A study of 213 prison inmates in a prison community in Nigeria on PD and substance use disorder (SUD) using ICD-10 criteria revealed that, 36% of the inmates had SUD and 52% had PD, with impulsive, Dissocial, and Anankastic PD having the highest prevalence of comorbidity of 70% [14]. As reported by Widiger et al. [15], the co-occurrence of PD revealed an average across four studies to be 2 and 4, meaning that one patient may have two to four diagnoses of personality disorders. In a similar study in a Nigerian prison community, Enyidah et al. reported 18 of the 213 inmates as having two diagnoses of PD, six inmates having three diagnoses and one inmate as having five diagnoses, so 25% of the inmates studied had multiple diagnoses of PD.

2. CONCLUSION

If a patient with one PD diagnosis could have so much personal and social disruption in life, what will be the outcome of multiple diagnoses on one patient? Could this explain the extreme behaviours seen in certain settings and communities? Could this also explain the strong association established between criminality and PD [16] and, more still, the recidivism seen in prison inmates? We sure have an unfinished business with personality disorders.

CONSENT

It is not applicable.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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