Author's response to reviews

Title: In-depth study of personality disorders in first-admission patients with substance use disorders

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In-depth study of personality disorders in first-admission patients with substance use disorders

Dear Mr. Hesse,

Thank you for considering the publication of our paper “In-depth study of personality disorders in first-admission patients with substance use disorders” by AM Langås, UF Malt and S Opjordsmoen.

The reviewers’ suggestions for clarification have been most helpful in making the paper more informative and less prone to misunderstanding. The revised manuscript is hereby submitted.

The following is a list of changes or rebuttals to each suggestion from Referee 1:

1. Our intention was to study patients with SUDs who were entering treatment for the first time, and not to study PDs in subjects with SUD in the general population. The difference between population samples and treatment samples is discussed on page 14 (Berkson’s fallacy), and exemplified by the comparison with the study of the general population in Oslo. We agree that it would be preferable to have a control group of subjects with SUD and PD in the community to identify differences between treatment-seekers and those who do not seek treatment. This was beyond the scope of our study.

Our method of sample inclusion (all patients with SUD, 16 years and older, living in one catchment area, admitted to treatment for the first time, including all treatment modalities) is more stringent than those of most previous studies, and a strength of our study. Many previous studies have used convenience samples (for example, patients admitted to one or a few inpatient wards during a time period, irrespective of the characteristics of the patients, the profile of the wards, or the patients’ previous treatment histories).

In the original paper, we emphasized the small sample size and the risk of type II errors as the main limitations of the study. Referee 1 raises an interesting issue with the hypothesis that patients with SUD and avoidant PD also avoid treatment and therefore are underrepresented in clinical samples. Even if avoidant PD is the most common PD in the general population, it has not been found to be among the most prevalent PDs in subjects with SUD in population samples (Grant et al., 2004). Contrary to this, many clinical studies of patients with SUD and PD have found a high prevalence of patients with avoidant PD. In our study, it was the third most prevalent PD diagnosis. This does not support the hypothesis that patients with avoidant PD also
avoid treatment. As we did not have our own data from population samples of subjects with SUD and PD to compare with our clinical sample, we have not discussed this any further in the revised paper.

2. In the submitted paper, we chose to describe the objectives and not the hypotheses. The objectives of our study are outlined at the end of the Background section. The formulation of the respective hypotheses are as follows: 1) The only prevalent and clinical relevant PDs in SUD patients entering treatment for the first time are antisocial PD and borderline PD, and 2) There are no differences between first time admitted SUD patients with and without PDs in demographics, comorbidity, symptoms, and functioning. In the revised version, we included the null hypotheses and deleted the objectives.

3. As both the PDs and the SUDs were categorical variables that were not normally distributed, we used chi-square tests with continuity correction or Fisher’s exact test. In the paragraph discussing limitations, we have stated that we have not accounted for multiple testing.

4. As seen in Table 4, SUD patients with PDs had higher scores on the SCL-90-R, IDS, GAF-S and GAF-F than SUD patients without PDs. Not surprisingly, there is a statistically highly significant correlation between each of these scales and the number of PD criteria in total, and for each cluster of PDs, except for the correlation between cluster B and IDS or SCL-90R. We have chosen not to include the correlation table, as it shows similar information to that presented in Table 4.

5. The data regarding schizotypal PD and dependent PD were presented in Table 2. In the revised paper, they are also added in the text.

6. The information “not shown in tables” has been deleted, as requested.

7. The chapter about etiology has been deleted, as suggested.

8. For completeness, narcissistic PD is included in Table 2.

9. Incorrectly used abbreviations have been corrected. A list of abbreviations has been added, as recommended in the ‘Instructions for authors’.

The following is a list of changes or rebuttals to each suggestion from Referee 2:

1. Detailed information about the different SUDs has been added under the SUDs subheading in the Results section: “Of the total sample, 53 patients (87%) had AUD and 33 patients (54%) had DUD. Twenty-eight patients (46%) had AUD only and eight patients (13%) had DUD only. Twenty-five patients (41%) had both AUD and DUD. The 33 patients with DUD abused or were dependent on the following substances (number of patients in parentheses): cannabis (28), sedatives (13), stimulants (10), cocaine (9), opioids (2), and other substances (2). Of the polysubstance users, 10 patients had two SUDs, 10 patients had three SUDs, three patients had four SUDs, and four patients had five SUDs.”
2. To clarify our terminology, we have added the following under the *Measurements* subheading in the *Methods* section: “According to the DSM-IV, SUD is a term that includes disorders connected to the use of all types of substances: alcohol, drugs, medication and toxins. AUD and DUD are the subgroups of SUDs included in our study, where DUD covers abuse of or dependence on illicit drugs or prescribed medications with misuse potential. We use the terms ‘AUD only’ to refer to AUD without DUD, and ‘DUD only’ to refer to DUD without AUD.”

3. Information about inpatients/outpatients has been added under the *Participants* subheading in the *Methods* section: “Because most SUD patients in Norway are assessed as outpatients before they are referred to inpatient treatment, most of the sample patients were outpatients. Only five were inpatients, and three of these participated only during parts of the assessment period.” The group of inpatients was too small to make a meaningful comparison with outpatients.

4. In the revised paper, we have omitted the third digit in percent values in the tables.

5. As SUDs are Axis I disorders, we wanted to differentiate between comorbid SUDs and SUDs comorbid with other Axis I disorders. We accept that this was ambiguous and have changed “Any non-SUD Axis I” to “Any Axis I” and defined the term in the table note.

Because we applied the PRISM, we have assessed all diagnoses as either independent or substance induced (S-I). Almost all the anxiety disorders in our sample were independent disorders. Of other disorders that may be categorized as either independent of substance use or S-I, only major depressive disorders (MDD) were of high enough prevalence to be relevant to this paper. There were no differences between SUD patients with and without PDs on the prevalence of independent and S-I MDD respectively. We have added the following to the *Results* section, at the end of the material under the *Axis I comorbidity* heading: “The distribution of independent and substance-induced MDD did not differ between groups.”

6. We do not have any data to prove that one disorder has caused another disorder. However, social phobia is probably not caused by PDs, as the mean age of onset of social phobia is lower than the age at which one usually starts to diagnose personality features. We have added the following to the discussion of Axis I comorbidity: “The mean age at onset of social phobia was 10.4 years in the patients with PD and 13.2 years in the patients without PDs. The mean age of onset of SUDs in these two groups was 20.4 and 41.0 years respectively, a difference which was statistically significant (p = 0.018). The results suggest that social phobia may contribute to the development of a PD. The combination of social phobia and PD seems to increase the risk of early onset SUD.”

7. In the *Methods* section, we have added arguments for the inclusion of subthreshold disorders: “By including the subthreshold cases, we wanted to explore whether the severity or dimensional aspect of PDs, measured by the number of PD criteria, influenced the results.”

In the *Results* section, we have added more details of the effects of including subthreshold cases: “This caused a higher increase in the prevalence of some of the
PDs (obsessive-compulsive, paranoid, dependent, and avoidant) than in others, and cluster C became as prevalent as cluster B. In general, the differences between patients with and without PDs decreased, but there were still statistically significant differences concerning age, education, employment, number of SUDs, SCL-90-R, GAF-S, and GAF-F.”

In the Discussion section, we have further commented on the results when including the subthreshold diagnoses: “The decrease in differences between patients with and without PDs when subthreshold diagnoses are included implies, as expected, that the patients with subthreshold diagnoses have somewhat better functioning and fewer comorbid disorders than patients who meet the full criteria. This supports the suggestion that the DSM-5 should include dimensional aspects of PD assessment.”

We hope that this added information meets with your approval.

With kind regards on behalf of the authors,

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