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ORIGINAL ARTICLE

Relationship between non-psychotic morbidity and substance dependence in male prisoners suffering from dissocial personality disorder

P. Sureka

Institute of Medical Sciences (IMS), BHU, MIG-42, Ratan Lal Nagar, Kanpur, UP 208022, India

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Abstract
Background and objectives: To study (1) comparative prevalence of non-psychotic morbidity (NPM) in male dissocial personality disorder (DPD) patients with or without psychoactive substance dependence (SD).
(2) Relationship of NPM with pattern and duration of SD.
Methods: This was a 20-month single blind cross sectional hospital-based study with a sample size of total 1036 male prisoners ≥18 years of age suffering from DPD (study = 518, control = 518). Participants in study group fulfilled further criteria of being suffering from SD.
Results: Majority of participants in both groups were unemployed, married individuals with occupational skills of less than skilled labour level and educational attainment of higher secondary level or lesser. Intensity of substance use was higher in study participants with NPM than those without NPM, and they started consuming substance at younger age, had a longer duration of substance use and dependence, and majority of them had onset of NPM after onset of SD. NPM was present in 350 (67.6%) of study participants against 159 (30.7%) in controls. Study participants had especially high prevalence of Major Depressive Disorder (MDD)/Recurrent Depressive Disorder (RDD) (24.9%) and Adjustment Disorder (13.3%). Among study participants, 203 (58%) participants with NPM used ≥3 psychoactive substances against 33 (19.7%) in those without NPM.
Conclusions: The results suggested that a higher burden of NPM exists in substance using DPD population than those without NPM and occurrence of NPM in turn leads to earlier onset and increased severity of SD in this population.

E-mail address: pankajsureka17@gmail.com

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Introduction

Personality disorder (PD) affects 6% of the world population, and the differences between countries show no consistent variation.[1] PD leads to a disturbance in functioning as great as that in most major mental disorders.[2]

Dissocial PD (DPD) is associated with high rates of separation and divorce; unemployment and inefficiency; and poor quality of life for the individual and his/her family.[3] Offenders with DPD are usually young, have a high suicide risk, high rate of mood, anxiety, substance use, psychotic, somatoform disorders, borderline personality disorder, Attention Deficit Hyperactivity Disorder (ADHD).[6] Health care utilization by DPD patients is excessive.[3]

In a study, 10% of male prisoners were found to be suffering from personality disorder.[7] More antisocial acts were perpetrated by alcohol and drug users than by nonusers and main risk factors for perpetrating antisocial acts were being male, using alcohol and other drugs.[8] Almost 47–63% of male prisoners and 21–31% of female prisoners had DPD.[9] Similarly, the prevalence of DPD is higher among patients in alcohol or other drug (AOD) abuse treatment programs than in the general population,[10] suggesting a link between DPD and AOD abuse and dependence. Offenders with DPD are more likely to have substance use disorder.[4,11–13] Since very few of these studies have employed standardized interviews; hence underestimation of PD prevalence cannot be ruled out. DPD is significantly associated with persistent alcohol, cannabis and nicotine use disorders (adjusted odd ratios 2.46–3.51) then general population.

Prisoners are several times more likely to have psychosis and major depression, and about ten times more likely to have DPD than the general population.[14]

Some of the problems in studying various clinical aspects related with DPD have been (a) it is only in recent times that a consensus has emerged for the definition of DPD. The studies carried out until recently have employed variable definition of DPD. (b) Other sources of variation include variable expertise of therapist, sampling techniques, geographical variations and time period of the study.

Although only about one-third of the world's prisoners live in western countries, about 99% of available data from prison surveys are derived from western populations, which underscores the need for greater forensic psychiatric research in non-western populations.[14] Literature from India in this area is scanty.

Objectives

To study (1) comparative prevalence of NPM in male DPD patient with or without SD (2) relationship of NPM with pattern and duration of SD.

Methods

This was a 20-month single blind cross sectional hospital-based study with a convenience sample size of total 1036 participants (study = 518, control = 518). This study was conducted at Central Jail Hospital (CJH), New Delhi which is largest prison hospital setting in India with both inpatient and outpatient departments. Prior to initiation of study approval in this regard was obtained from Ethical committee of CJH after protocol presentation.

Inclusion criteria

1. Prisoners diagnosed to be suffering from both substance dependence and DPD by ICD-10 (DCR) criteria in past one month.
2. Male participant.
3. Age 18 years or above.
4. Participant willing to give a written informed consent.

Exclusion criteria

1. Participants who were not co-operative for the interview for study purposes, as per the clinical judgement of the researcher. The rationales behind the clinical judgements of researcher were recorded.
2. Inability to speak sufficient English or Hindi.
3. Those participants with severe physical illness (like hepatic encephalopathy, severe debilitating illness) or severe cognitive illness (with Mini Mental Status Examination (MMSE) score < 23) that might have hampered the assessment process.
4. Lifetime diagnosis of psychosis and/or Bipolar Affective Disorder (BPAD).
5. Participants currently suffering from personality disorder except DPD as per International Personality Disorder Examination (IPDE).

Inclusion criteria for control participants

Participants found matching with study participants on socio-demographic and clinical parameters except presence of psychoactive SD.

Instrument used: (a) **International personality disorder examination (IPDE):** semi-structured interview using ICD-10 criteria has 67 set of questions and time required in its completion is 150 min.[15] In participants who were unable to understand English, North Indian Hindi translation which was standardized and used in previous studies was used.[16]

(b) **Basic socio-demographic Performa:** it included questions to obtain information regarding socio-demographic characteristics of SD. Socio-demographic characteristics such as age, sex, marital status, education, occupation, employment status, religion and residence were recorded.

(c) **The mini-mental state examination:** The MMSE is a 30-point questionnaire test designed by Folstein et al. that is used to screen for cognitive impairment. Each component is rated from 0 to 1. In the time span of about 10 min it samples various functions including orientation, memory, arithmetic skills, language use and comprehension and basic motor skills. Cognitive deficits in participants were ruled out using MMSE.[17]

(d) **Schedule for Clinical Assessment in Neuropsychiatry (SCAN):** the assessment of psychiatric morbidity in participants was performed by a SCAN-based clinical interview in which clinical interview.[18]

(e) **The Severity of Dependence Scale (SDS):** the SDS developed by Gossop et al. was used to rate severity of