THE PREVALENCE OF PERSONALITY DISORDERS IN A KENYAN INPATIENT SAMPLE

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DSM-IV Axis I and II comorbidities and the pattern of Axis II diagnoses in patients admitted at Mathari (Psychiatric) Hospital, Nairobi, Kenya are unknown.

To determine DSM-IV Axis I and II comorbidities and patterns of Axis II diagnoses in patients admitted at Mathari Hospital.

Cross-sectional study on 148 randomly sampled patients.

Twenty percent of the patients were confirmed for an Axis II diagnosis. Eighty-seven percent of the Axis II disorders were Cluster B Personality Disorders of various types. Using \( \chi^2 \) tests, significant associations were found between Axis I and II diagnoses and substance use/dependence (\( \rho < 0.001; 66.7\% \)), mood disorder (\( \rho = 0.002; 46.7\% \)) and schizophrenia (\( \rho < 0.001; 23.3\% \)).

The prevalence of personality disorders was lower than that reported in psychiatric patients in USA and Europe. The results are likely to be a true reflection of the actual clinical epidemiological situation, but cannot be generalized to outpatient or general populations.

BRIEF COMMUNICATION

There are no data on the prevalence of personality disorders (PDs) in psychiatric in-patients in Kenya in particular and in Africa in general. Prevalence rates for PDs in psychiatric hospital patients elsewhere have been reported at 45% in Germany (Heun & Maier, 1993), 66% in the USA (Kenan et al., 2002) and 50% in Italy (Marinangeli et al., 2000). This study aimed to fill the gap in the overall cross-cultural data on PDs.

This study was conducted at the Mathari Hospital, the national referral and teaching psychiatric hospital in Kenya. The hospital receives patients referred from facilities all over the country and mainly admits those who...
cannot be managed by relatives at home or cannot afford private psychiatric facilities. A predetermined sample of 148 patients was achieved by including into the study every fifth patient on the admission register for non-forensic wards. Clinical data and information on PDs were collected using the Structured Clinical Interview for DSM-IV (the Diagnostic and Statistical Manual Fourth Edition) Axis I disorders (Clinical Version; SCID-I CV; First, Spitzer, Gibbon, & Williams, 1996) and the SCID Axis II personality disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997), respectively.

Nearly two-thirds of the patients aged between 18 and 64 years (mean 31 years) were male. More males ($n = 39$) than females ($n = 6$) were abusing substances ($\rho^* \leq 0.001$) and more females ($n = 18$) than males ($n = 18$) were diagnosed with mood disorders ($\rho^* = 0.013$). The difference in gender distribution of schizophrenics (70 males against 29 females) was marginal ($\rho^* = 0.06$).

Eighteen (60%) out of the 30 (20.3%, $N = 148$) patients with PDs were aged between 25 and 34 years. Thirteen percent of them had a family history of mental illness which was significantly associated with the positive and negative scores for the PDs ($\rho^* = 0.034$). There were also significant associations between PDs and substance abuse dependence, $n = 18$; 66.7%; $\rho^* < 0.001$ (mainly alcohol 33%, cannabis 31% and 24% both cannabis and alcohol), mood disorder ($n = 14$; 46.7%; $\rho^* = 0.002$) and schizophrenia ($n = 7$, 23.3%; $\rho^* \leq 0.001$). More than half of the 30 patients were diagnosed with an antisocial PD (males 14/20; females 2/10). Twice as many females as males were diagnosed with borderline PDs (males 4/20; females 4/10). The other PD diagnoses were dependent (2 cases), PDNOS (2 cases), narcissistic (1 case), and histrionic (1 case).

This is the first report on PDs in a psychiatric hospital in Kenya and the findings cannot be generalized to other situations or populations. The cross-cultural impact on the reliability, validity or false positives related to the use of the SCID have not been documented in Kenya although the SCID has been shown to be a standardized diagnostic tool with demonstrated utility in cross-cultural research settings (Gorman et al., 2004). The DSM-IV Axis II 20.3% prevalence rate of PDs in this study is lower than those reported elsewhere using the SCID II. The low rate could be a reflection of the true epidemiological pattern, the different reasons for admission into a psychiatric hospital, the cultural inappropriateness of the SCID II in the Kenyan context, a low threshold for SCID II, or a combination of all the aforementioned. In Kenya where community psychiatric services are generally unavailable, disturbed behavior that cannot be tolerated in the society and in particular, by the families, is the more probable precipitant for admission rather than a PD that does not cause intolerable disruption in the support system. Hence, it is possible that these patients were phenomenologically different from those who end up in psychiatric hospitals in other countries. The net effect of this is that patients with PDs are less likely to find their way to in-patient admissions. This
difference in admission procedures rather than real cultural differences could be an explanation for the low prevalence of PDs found in this sample.

The significant association found between mood disorders and cluster B PDs is similar to findings in the West (Jackson & Burgess, 2002) and is comparable to the highly significant association with substance disorders \( p^* < 0.001 \) reported in the USA (Zanarini et al., 1998), Europe (Verheul, van den Brink, & Hartgers, 1995), Australia (Moran, Coffey, Mann, Carlin, & Patton, 2006) and, in the UK (Khan, Jacobson, Gardner, Prescott, & Kendler, 2005). The similarities in socio-demographics, substance abuse disorders, mood disorders, and PDs would suggest that it is not the constructs of the instruments that account for the low prevalence of PDs in the Kenyan population but, that the differences in prevalence most likely reflect the actual epidemiological patterns.

These Kenyan findings should increase awareness on PDs and improve appropriate management, since it has been shown that the outcome of patients with a dual diagnosis of a severe mental illness and a PD is worse than that of single diagnoses (Newton-Howes, Tyrer, & Johnson, 2006). This study is important for the reason that it adds to cross-cultural information on the prevalence of PDs among hospitalized psychiatric patients in a setting with sparse literature.

REFERENCES


