PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Euthanasia Requests, Procedures and Outcomes for 100 Belgian Patients Suffering from Psychiatric Disorders: A Retrospective, Descriptive Study
AUTHORS	Thienpont, Lieve; Verhofstadt, Monica; Van Loon, Tony; Distelmans, Wim; Audenaert, Kurt; De Deyn, Peter-Paul

VERSION 1 - REVIEW

REVIEWER	A D (Sandy) Macleod University of Canterbury Christchurch New Zealand
REVIEW RETURNED	26-Jan-2015

GENERAL COMMENTS	The authors need to be commended having the courage to submit on such a controversial subject. Euthanasia and psychiatric illness is a critical issue and we are reliant upon Belgium (and Holland) to address this within their legislation this topic. I obviously have major concerns about allowing personality disordered and autistic persons to be 'euthanised', whether resistant depressive disorders had been assertively treated (ECT, pharmacology, psychosurgery, ketamine etc). I am presuming in the future another paper on the specific psychiatric diagnoses and treatment of this cohort. This paper is a demographic introductory presentation and very informative in this regard. They rightly raise the issue of the definition of unbearable suffering and comment upon the risk of suicide with this group pf very sick persons. Determining 'terminality' in chronic psychiatric disease needs to be addressed by the profession and hopefully this article may initiate such discussion (and many other heated discussions). well done to the authors!

REVIEWER	Michael Cholbi California State Polytechnic University, Pomona, US
REVIEW RETURNED	31-Jan-2015

GENERAL COMMENTS	This study was carefully conducted and is, as authors note, virtually unique in investigating the determinants for seeking euthanasia among psychiatric patients. Its methodology appears sound and its conclusions justified. My primary criticism is that the conclusions are rather modest, and I would encourage authors to perform additional analysis to derive more specific and probative conclusions regarding euthanasia (and the requests thereof) among the psychiatrically disordered.

	Three possibilities suggest themselves: 1. Authors could compare the study population to the overall populations seeking euthanasia. For instance, it would be worthwhile to know whether those with psychiatric disorders ended up participating in euthanasia, engaging in suicide, etc., to a greater or lesser degree than those in the non-psychiatrically disordered populations that request euthanasia. (I would assume such data about the general euthanasia-seeking population is available.) Are the psychiatrically disordered individuals more (or less) determined in their commitment to euthanasia? 2. Authors could analyze the relation between patient diagnoses and participation in euthanasia, suicide, etc. For instance, it would be valuable to learn which psychiatric diagnoses were most strongly correlated with euthanasia, suicide, etc., in this population. 3. Authors could analyze suicide prevalence among the study population whose requests for euthanasia were denied by clinicians. This would clearly bear on the justifiability of euthanasia for the psychiatrically disordered In other words, although this is one of the few studies of its kind, Authors nevertheless have data available to them that would seem to support more substantive inferences about euthanasia requests and behaviors within and among psychiatrically disordered populations. I would welcome their using their very valuable data to extract other patterns that would (arguably) be more informative about the specific features of euthanasia among the psychiatrically disordered.

REVIEWER	Malcolm Parker School of Medicine, University of Queensland. Australia
REVIEW RETURNED	01-Feb-2015

GENERAL COMMENTS	Thankyou for the opportunity to review the paper. This is an important study which reflects developments in assisted dying practice in Belgium which need to be disseminated as an important contribution to continuing clinical/philosophical/political debate. I suggest only minor revisions as follows: 1. This is the first such report of assistance in dying for patients with psychiatric conditions (to my knowledge). Although it is an empirical report, it describes a practice that has been the subject of debate in the bioethical and related literature for some time. A brief account of this debate, beyond stating that the assisted dying debate is fierce and even fiercer in relation to psychiatric cases (paragraph 5 of introduction) would enhance the paper by providing background to the empirical material reported. Many readers may also find the step from individual case reports (eg such as the well known Chabot case) and the subsequent debates, to what is presented as routine practice, somewhat puzzling, despite the fact that the law concerning the granting of euthanasia requests covers both somatic and psychiatric disorders. 2. It is somewhat unclear whether author LT is the "second, independent, consulting physician" as stipulated in the law and described in paragraph 6 of the introduction. A more explicit

	description of how the study aligned with the legal requirements in Belgium would be helpful. 3. Greater clarity is required in relation to the status of the study as retrospective or prospective. The development of the approach to the study suggests a prospective aspect, with the abstract talking about "Interventions", whereas it is also described as a "Retrospective analysis of data obtained through medical file review" in the abstract. This ambiguity is repeated in the Methods section. For example, was the "four-track approach" developed for the patients who were followed prospectively, and then their charts audited? Or was there a different approach? Phrases such as "At the time of the intake consultation ... " do not align with the description of the study as a retrospective chart audit. 4. One of the limitations of the study is said to be the fact that some important determinants, such as personal and social background, and the details of the psychiatric evaluation, were not systematically collected. It should be made more explicit that these things were not collected as part of the study, while they (presumably) were routinely collected in the clinical work-up of these patients. This is linked to (2) and (3) above: just where and how did the psychiatric evaluations occur, in relation to the study as opposed to the clinical management of the patients. The boundary between the study and the clinical management of the patients is not clearly marked in the paper. 5. The authors state that the "unbearable" and "untreatable" aspects of psychological suffering "have not, as yet, been precisely defined". This suggests that they might be precisely defined in the future, and readers may be left thinking that the authors may be thinking of trying to do this. However, in the results section, the authors have stated that "In all patients, the suffering was chronic, constant and unbearable without prospect of improvement, due to treatment resistance". This suggests that some measure or criterion of suffering was met. This dissonance merits some further clarification. 6. The authors, correctly in my view, mark a distinction between suicidality that is symptomatic of psychiatric disorder, and well considered euthanasia requests. They, again correctly in my view, identify that a euthanasia request must be scrutinized as a request for effective and far-reaching treatment, and that any request demands exploration of all implications and clarification of alternatives. Here the authors might contrast this approach which, by implication, allows for rational euthanasia requests, with the approach of some other authors (eg Kissane) which defines all euthanasia requests as irrational and necessarily based in psychopathology. Alternatively, this contrast might figure in the background material as suggested in (1) above.

VERSION 1 – AUTHOR RESPONSE

Reviewer Name A D (Sandy) Macleod
Institution and Country University of Canterbury
Christchurch New Zealand
Please state any competing interests or state ‘None declared’: None declared

COMMENT
The authors need to be commended having the courage to submit on such a controversial subject. Euthanasia and psychiatric illness is a critical issue and we are reliant upon Belgium (and Holland) to address this within their legislation this topic. I obviously have major concerns about allowing personality disordered and autistic persons to be 'euthanised', whether resistant depressive disorders had been assertively treated (ECT, pharmacology, psychosurgery, ketamine etc). I am presuming in the future another paper on the specific psychiatric diagnoses and treatment of this cohort. This paper is a demographic introductory presentation and very informative in this regard. They rightly raise the issue of the definition of unbearable suffering and comment upon the risk of suicide with this group pf very sick persons. Determining 'terminality' in chronic psychiatric disease needs to be addressed by the profession and hopefully this article may initiate such discussion (and many other heated discussions). well done to the authors!

ANSWER
Thank you for the positive comments. The authors are indeed very committed to further research on the vulnerable group of autistic persons, for example. We are very much concerned about the underdiagnosis of ASD and the high suicide risks of patients with ASD. We definitely agree that further research is very much needed.

(We refer for example to the research of Raja, Michele, Antonella Azzoni, and Alessandra Frustaci: "Autism spectrum disorders and suicidality." Clinical practice and epidemiology in mental health: CP & EMH 7 (2011): 97. AND Raja, Michele: "Suicide risk in adults with Asperger's syndrome." The Lancet Psychiatry 1.2 (2014): 99-101.)

Reviewer Name Michael Cholbi
Institution and Country California State Polytechnic University, Pomona, US
Please state any competing interests or state ‘None declared’: None declared

COMMENT
This study was carefully conducted and is, as authors note, virtually unique in investigating the determinants for seeking euthanasia among psychiatric patients. Its methodology appears sound and its conclusions justified.

My primary criticism is that the conclusions are rather modest, and I would encourage authors to perform additional analysis to derive more specific and probative conclusions regarding euthanasia (and the requests thereof) among the psychiatrically disordered.
Three possibilities suggest themselves:

COMMENT 1
Authors could compare the study population to the overall populations seeking euthanasia. For instance, it would be worthwhile to know whether those with psychiatric disorders ended up participating in euthanasia, engaging in suicide, etc., to a greater or lesser degree than those in the

non-psychiatrically disordered populations that request euthanasia. (I would assume such data about the general euthanasia-seeking population is available.) Are the psychiatrically disordered individuals more (or less) determined in their commitment to euthanasia?

ANSWER
Unfortunately it is not possible for us to pursue this option because such data do not exist for large or national study populations. As mentioned in the Introduction, the national FCEC data report on patients who have died by euthanasia, not the larger group of patients who have ever requested euthanasia. In response to another reviewer comment, this point has also been clarified in the 'Strengths and weaknesses' section of the Discussion, as follows:
It is not possible to estimate how representative this sample is of the entire population of similar patients. Comparing characteristics and outcomes of our sample with the national data is not helpful since the FCEC only reports data from patients who died by euthanasia, not from patients who requested euthanasia. Moreover, FCEC does not differentiate between specific determinants of patients suffering predominantly from neurological and psychiatric disorders.

COMMENT 2.
Authors could analyze the relation between patient diagnoses and participation in euthanasia, suicide, etc. For instance, it would be valuable to learn which psychiatric diagnoses were most strongly correlated with euthanasia, suicide, etc., in this population.

ANSWER
We really would have liked to do this also, but unfortunately the sample size was not large enough. As described in the findings, out of 100 cases, 48 had their euthanasia requests accepted but only 35 went through with the procedure, while 6 patients in total (4 women and 2 men) committed suicide, including 2 whose requests were approved. As also mentioned, 90 of the 100 patients had more than one diagnosis, so it is not as simple as if they only had one diagnosis each. So it is not possible to formulate any meaningful or significant analysis of correlations or associations between these outcomes and their diagnoses or other characteristics.

For your information, the following table presents more detail on the nature of diagnoses from the total patient sample size, patients with positive responses to their requests, patients who received positive responses but changed their minds/postponed the procedure, patients who died by euthanasia and by suicide. However, we do not believe this data will support further formal analysis of the kind you have suggested. We could include this table in the report if you would like.

Table 1: Total sample and patient outcome groups by diagnosed disorder
Disorders Total sample size (intake)
N = 100 Positive responses to requests
N = 48 Positive response but requests
postponed
N = 8 Deaths by euthanasia N = 35 Deaths by suicide

N = 6
Depressive disorder 47a 23 2 19 5 (2 pos.resp.)
Bipolar disorder 10b 5 2 3 1
Personality disorder 49c 23 6 16 1 (pos. resp.)
Post traumatic stress disorder 13 6 2 4 0
Schizophrenia and other psychotic disorders 14d 6 1 5 2
Anxiety disorders 11 5 0 5 0
Eating disorders 10 3 1 2 0
Substance use disorders 10 4 2 2 0

Somatoform disorders 9 5 1 4 0
ASD 7 2 0 2 0
ADHD 1 0 0 0 0
Obsessive–compulsive disorders 7e 2 0 1 1 (pos. resp.)
Dissociative disorders 7 2 0 2 0
Complicated grief 6 4 0 4 0
Chronic fatigue syndrome and/or fibromyalgia 8f 6 0 4 1 (pos. resp.)
Other chronic somatic suffering 15g 9 1 7 1 (pos. resp.)

COMMENT 3.
Authors could analyze suicide prevalence among the study population whose requests for euthanasia were denied by clinicians. This would clearly bear on the justifiability of euthanasia for the psychiatrically disordered

ANSWER
This is an important point, and one that we can indeed address, although of course the numbers again are too small to obtain statistically significant results. For further information, we have added age and sex details to the information included in the results section about the 6 suicide cases as follows:
In the six suicide cases, one (female, age 51) experienced the procedure for obtaining the approval for euthanasia to be unbearably long, one (female, 74) found the waiting time after the approval unbearably long, and one (female, 42) committed suicide because her family resisted the option of euthanasia, even though the request had been approved. Two patients (both male, 33 and 44) committed suicide after breaking off communication (after requesting euthanasia), and one (female, 55) committed suicide after staying in a psychiatric ward to which she had been referred.

Furthermore, in the Discussion section where suicide is discussed, we have added the proportions and further explanation as follows:
Accordingly, the authors note that the fact that their euthanasia request was being considered could not prevent suicide in six patients, including two of the 48 patients (4.2%) whose euthanasia requests had been approved and four of the 52 patients (7.7%) whose requests had not yet been approved. Moreover, the modes of suicide were dramatic, but we cannot provide further details due to respect for patient confidentiality.

COMMENT
In other words, although this is one of the few studies of its kind, authors nevertheless have data available to them that would seem to support more substantive inferences about euthanasia requests and behaviors within and among psychiatrically disordered populations. I would welcome their using their very valuable data to extract other patterns that would (arguably) be more informative about the specific features of euthanasia among the psychiatrically disordered.

ANSWER
Thank you. We hope the above responses clarify the extent of what we can present, interpret and conclude based on this set of data.

Reviewer Name Malcolm Parker
Institution and Country School of Medicine, University of Queensland.
Australia
Please state any competing interests or state ‘None declared’: None declared

COMMENT

Thank you for the opportunity to review the paper. This is an important study which reflects developments in assisted dying practice in Belgium which need to be disseminated as an important contribution to continuing clinical/philosophical/political debate. I suggest only minor revisions as follows:

COMMENT 1.
This is the first such report of assistance in dying for patients with psychiatric conditions (to my knowledge). Although it is an empirical report, it describes a practice that has been the subject of debate in the bioethical and related literature for some time. A brief account of this debate, beyond stating that the assisted dying debate is fierce and even fiercer in relation to psychiatric cases (paragraph 5 of introduction) would enhance the paper by providing background to the empirical material reported. Many readers may also find the step from individual case reports (eg such as the well known Chabot case) and the subsequent debates, to what is presented as routine practice, somewhat puzzling, despite the fact that the law concerning the granting of euthanasia requests covers both somatic and psychiatric disorders.

ANSWER

Overall, euthanasia remains a very rare medical intervention in all patients and in particular in patients with psychiatric suffering. Given the complexity and specific skills required in this very delicate and sensitive area of assisting patients who want to end their lives, there is a trend towards specialized health care and currently there are only a limited number of health-care providers with dedicated training and skills. Therefore, this specialized health care is very concentrated but still rare. In Belgium euthanasia for psychiatric patients accounts for less than 3% of all cases of completed euthanasia (FCEC report 2010-2011).

COMMENT 2.
It is somewhat unclear whether author LT is the "second, independent, consulting physician" as stipulated in the law and described in paragraph 6 of the introduction. A more explicit description of how the study aligned with the legal requirements in Belgium would be helpful.

ANSWER
As we explained in the introduction, according to the Belgium's expanded Euthanasia Law (2013) the euthanasia criteria must always been confirmed by two consulting physicians in the case of non-terminally ill patients. At least one of these physicians must be a psychiatrist in the case of psychiatric patients. The first author LT is a psychiatrist and was involved as a consultant physician in all cases. We have now clarified this in the text as follows.

Adjusted text in the methods section:
LT was involved in the counselling, referring and evaluation of all patients, as a consultant physician.

COMMENT 3.
Greater clarity is required in relation to the status of the study as retrospective or prospective. The development of the approach to the study suggests a prospective aspect, with the abstract talking about "Interventions", whereas it is also described as a "Retrospective analysis of data obtained through medical file review" in the abstract. This ambiguity is repeated in the Methods section. For example, was the "four-track approach" developed for the patients who were followed prospectively, and then their charts audited? Or was there a different approach? Phrases such as "At the time of the intake consultation ... " do not align with the description of the study as a retrospective chart audit.

ANSWER
We have removed the 'Interventions' section from the Abstract now, as that was misleading. The four-

track approach was applied in all cases, it was developed by the group of four authors as mentioned before the time frame of the study, for the management of patients with euthanasia requests (and in the absence of specific guidelines for implementation in Belgium); a manuscript about this approach is being prepared for publication separately. We have clarified this in the methods section.

Adjusted text in methods section:

…authors…developed a four-track approach based on the guidelines of the Dutch Psychiatric Association (NVvP)7, which were issued in 2004 and revised in 2009, and also adapted to the requirements of the Belgian Euthanasia Law.
…
For all patients in the sample, the four-track approach has been used. Further details about this approach are being prepared for publication separately.

COMMENT 4.
One of the limitations of the study is said to be the fact that some important determinants, such as personal and social background, and the details of the psychiatric evaluation, were not systematically collected. It should be made more explicit that these things were not collected as part of the study, while they (presumably) were routinely collected in the clinical work-up of these patients. This is linked to (2) and (3) above: just where and how did the psychiatric evaluations occur, in relation to the study as opposed to the clinical management of the patients. The boundary between the study and the clinical management of the patients is not clearly marked in the paper.

ANSWER
This is a retrospective case file study, which implies that all data related to clinical management, such as personal and social background, and the details of the psychiatric evaluation, were recorded in the medical files, mostly in a narrative way. No standardised validated questionaires were used for data collection for research purposes as this was a clinical setting.

Adjusted text in strengths and weaknesses:
Some potentially important determinants, such as personal and social background and the details of the psychiatric evaluation were collected as part of the clinical file but not in a systematic way, as would have been applied in a prospective study.

COMMENT 5.
The authors state that the "unbearable" and "untreatable" aspects of psychological suffering "have not, as yet, been precisely defined". This suggests that they might be precisely defined in the future, and readers may be left thinking that the authors may be thinking of trying to do this. However, in the results section, the authors have stated that "In all patients, the suffering was chronic, constant and unbearable without prospect of improvement, due to treatment resistance". This suggests that some measure or criterion of suffering was met. This dissonance merits some further clarification.

ANSWER
The first reviewer also asked us to define unbearable and untreatable if possible. In response we added the following text to the introduction:
“Unbearable” suffering can be understood as a subjective term. By its nature, the extent to which the suffering is unbearable must be determined from the perspective of the patient him- or herself, and may depend on his or her physical and mental strength and personality.6 According to the Law, a physician has to come to a level of mutual understanding with the patient about the extent of his or her unendurable suffering.1

“Untreatable” is a more objective term. According to the 2009 guidelines of the Dutch Psychiatric

Association (NVvP), any therapeutic option for a particular condition must meet the following three requirements: (i) it must offer a real prospect of improvement, (ii) it must be possible to administer adequate treatment within a reasonable period of time, and (iii) there must be a reasonable balance between the expected treatment results and the burden of treatment consequences for the patient.7

As seen in practice, unbearable suffering seems to be the result of combined elements in a very complex interaction of symptoms of the disease itself, but also enhanced or rooted in some major traumatic life events, existential background or social issues. As our findings show, patients do present themselves with a combination of (dissimilar) disorders associated with various types and levels of suffering.

COMMENT 6.
The authors, correctly in my view, mark a distinction between suicidality that is symptomatic of psychiatric disorder, and well considered euthanasia requests. They, again correctly in my view, identify that a euthanasia request must be scrutinized as a request for effective and far-reaching treatment, and that any request demands exploration of all implications and clarification of alternatives. Here the authors might contrast this approach which, by implication, allows for rational euthanasia requests, with the approach of some other authors (eg Kissane) which defines all euthanasia requests as irrational and necessarily based in psychopathology. Alternatively, this contrast might figure in the background material as suggested in (1) above.

ANSWER

Thank you for this remark and for the very careful wording, which we would like to use and elaborate on in the text as follows.

New text for discussion section (end of 'interpretation and implications):
Therefore we wish to underline that each euthanasia request must be scrutinized as a request for effective and far-reaching treatment, and that any such request demands exploration of all implications and clarification of alternatives. The four-track approach implies that patients are compos mentis – ie they can make a rational choice; under the Euthanasia Law it is required that patients are legally competent and so their capacity for discernment is thoroughly assessed before any request for euthanasia is considered.

Please also refer to our answer to comment 1 above.

VERSION 2 – REVIEW

REVIEWER	Michael Cholbi California State Polytechnic University, Pomona US
REVIEW RETURNED	02-Apr-2015

GENERAL COMMENTS	I believe this manuscript passes muster as it is. The authors acknowledge (and I heartily agree) that there are many more factors relating euthanasia requests to various factors concerning psychiatric patients to be studied, but such investigations can safely be addressed in subsequent research and manuscripts. My only substantive question at this point is why authors speak in a generic way of patients with "personality disorder" rather than referring to more specific diagnoses. Of course, the various classificatory schemes used by the international psychiatric community vary in precisely how they understand these disorders.

	Nevertheless, given how broad a category personality disorder is, it would be of great use to the clinical community to have more insight into these patients and the specifics of their conditions (whether the disorders are schizoid, paranoid, antisocial, narcissistic, etc.). This problem is further compounded by authors listing as "other" diagnoses (p. 8) conditions standardly understood as personality disorders. Was it not possible to extract more specific disorders from the patient data? If it was possible, then I would suggest either disaggregating the data on personality disorders to reflect the diversity of this diagnostic family or providing some rationale for counting personality disorders as a homogeneous category.

REVIEWER	Malcolm Parker School of Medicine University of Queensland Australia
REVIEW RETURNED	30-Mar-2015

GENERAL COMMENTS	I have answered "No" to the question concerning reviewing the manuscript as this is a response to the revised version. I think the manuscript can be accepted, subject to the editor's satisfaction with the reviewers' comments on the authors' answers to comments and the revised version of the paper. I have restricted the current comments to the authors' answers to MY initial comments only. I am happy with the answers to my comments, with the exception of the answer to comment 1. Comment 1 requested the authors to provide a brief account of the debate concerning assisted dying in relation to psychiatric cases as background to the empirical material reported. The authors' answer points to the fact that there is a limited number of health-care providers with dedicated training and skills in this area and that in Belgium euthanasia for psychiatric patients accounts for less a very small percentage of cases of euthanasia. I do not consider this answer to be relevant to the comment. I would restate my request to the authors that they provide at least some brief summary of the theoretical debate concerning assisted dying in relation to psychiatric cases as background to the empirical material reported.

VERSION 2 – AUTHOR RESPONSE

Reviewer Name Malcolm Parker
Institution and Country School of Medicine
University of Queensland
Australia

I am happy with the answers to my comments, with the exception of the answer to comment 1. Comment 1 requested the authors to provide a brief account of the debate concerning assisted dying in relation to psychiatric cases as background to the empirical material reported. The authors' answer points to the fact that there is a limited number of health-care providers with dedicated training and skills in this area and that in Belgium euthanasia for psychiatric patients accounts for less a very small percentage of cases of euthanasia. I do not consider this answer to be relevant to the comment. I

would restate my request to the authors that they provide at least some brief summary of the theoretical debate concerning assisted dying in relation to psychiatric cases as background to the empirical material reported.

New/adjusted text for the introduction

In 2002, the Belgian legislator had foreseen the possibility of life-ending assistance for psychiatric patients, following long political debates on the issue of self-determination.

Delbeke has briefly summarized the arguments as follows.6 The main argument in favour of providing life-ending assistance to psychiatric patients is that their suffering can be equally unbearable as the somatic suffering of other patients. The main argument against providing such assistance is that suicide prevention is a primary purpose of psychiatric care and a key focus of training for psychiatrists. From the psychiatrist's perspective, if the psychiatric patient has no further prospect of improvement, continues to suffer unbearably and persists with his or her wish to die, the psychiatrist finds him- or herself in the position of having to accept the validity of this wish, if all legal requirements can be fulfilled and all possibilities of mistakes and abuses can be carefully avoided. Some opponents reject this particular point of view because termination of life for non-terminally-ill patients is unacceptable and incompatible with their views that life has to be protected at all costs.

Furthermore, it should be borne in mind that the suffering associated with somatic disorders can also induce psychological suffering, such that there often exists a combination of physical and psychological suffering, which is called multi-causality of suffering, and which may imply presence of mental illness. Not only the nature and origin of the suffering, but also the longer life expectancy make euthanasia for psychiatric patients more problematic and less acceptable for opponents.

The specific complexity of this category of patients therefore requires the application of stricter conditions and criteria. "The Belgian legislature has registered a stricter approach for non-terminally-ill patients. Because unbearably suffering patients with a psychiatric condition are not suffering from a life-threatening (somatic) disease, they will generally fall under these stricter procedural conditions" 8.

(8) Pans, E. (2012). De normatieve grondslagen van het Nederlandse euthanasierecht. (The Normative Context of the Dutch Euthanasia Law), Nijmegen, Wolf legal Publishers, 2006, 36.

Reviewer Name Michael Cholbi
Institution and Country
California State Polytechnic University, Pomona US
Please state any competing interests or state 'None declared': None declared

My only substantive question at this point is why authors speak in a generic way of patients with "personality disorder" rather than referring to more specific diagnoses. Of course, the various classificatory schemes used by the international psychiatric community vary in precisely how they understand these disorders. Nevertheless, given how broad a category personality disorder is, it would be of great use to the clinical community to have more insight into these patients and the specifics of their conditions (whether the disorders are schizoid, paranoid, antisocial, narcissistic, etc.). This problem is further compounded by authors listing as "other" diagnoses (p. 8) conditions standardly understood as personality disorders. Was it not possible to extract more specific disorders from the patient data? If it was possible, then I would suggest either disaggregating the data on personality disorders to reflect the diversity of this diagnostic family or providing some rationale for counting personality disorders as a homogeneous category.

Answer

We apologize for the misinterpretation of your comment.
We do have that kind of specific information, but were not convinced that making any distinction between the personality disorders, would contribute more to the understanding of this patient population, due to the comorbidity.

New/adjusted text for the results section

The 50 patients with personality disorders included borderline personality disorder (27), dependent personality disorder (3), histrionic personality disorder (2), avoidant personality disorder (1), narcissistic personality disorder (1), paranoid personality disorder (1), cluster B personality disorder (1) and personality disorders not otherwise specified (14).