Personality traits, brief recurrent depression and attempted suicide

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This study investigated the relationship between attempted suicide, personality factors and brief recurrent depression.

Over a period of 1 year, the demographic and psychiatric factors of 307 patients who had attempted suicide and subsequently been hospitalised at H. F. Verwoerd Hospital and referred to its Department of Psychiatry were recorded. Their personality traits were evaluated clinically. After 5 years, 205 respondents were traced to complete a follow-up questionnaire and, where possible, a personality assessment was completed on clinical grounds. They were also evaluated for brief recurrent depression.

Among the men, antisocial, dependent and histrionic personality traits, in that order, were most commonly noted and among the women, histrionic, dependent and antisocial traits.

A clear relationship between suicidal behaviour and the syndrome of brief recurrent depression was established. The latter was also found to be related to histrionic personality traits in women. This underscores the relationship between suicide attempts and histrionic personality traits.

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Cases of overdosing and other forms of suicidal behaviour are a daily occurrence. It is noteworthy that certain traits and personality disorders are associated with this type of behaviour. Furthermore, certain personality traits are associated more frequently with brief recurrent depression than with other mood disorders. These relationships form the subject of this paper.

Several studies[1-4] have documented personality traits such as immaturity, egocentricity, dependency, animosity, anxiety, impulsiveness and inability to deal with frustration in people who attempt suicide. Unfortunately, personality scales such as the Minnesota Multiphasic Personality Inventory and the Eysenck Personality Inventory do not distinguish between suicidal and non-suicidal people.[5]

Borderline, antisocial and histrionic personality disorders are associated with non-lethal suicidal behaviour,[6,7] especially in the presence of comorbid conditions such as major depression, substance abuse and/or dependency, or other personality disorders. Although this type of behaviour is not usually indicative of serious suicidal intent, and although it displays a low degree of lethality, a considerable percentage of those affected eventually do commit suicide[8-10] or repeatedly attempt suicide.[11,12]

After the epidemiological study which they undertook in Switzerland, Angst *et al.*[13] proposed a subtype of mood disorder, viz. brief recurrent depression. The diagnostic criteria are identical to those for major depression in respect of mood and number of symptoms. The duration of the episode is limited, however, to less than 2 weeks, and the episodes must recur monthly over a period of 1 year. They found that the history of this group of patients revealed a higher incidence of attempted suicide than the group with a diagnosis of major depression. People with both these conditions had a markedly higher incidence of attempted suicide, with almost one-third having a history thereof. This relationship between brief recurrent depression and attempted suicide was also previously demonstrated by Montgomery *et al.*[14] The question which arises is whether a relationship exists between personality disorders and brief recurrent depression. In this study the relationship between, *inter alia*, attempted suicide, personality factors and brief recurrent depression is considered.

Method

All attempted suicides who had subsequently been hospitalised at H. F. Verwoerd Hospital and referred to its Department of Psychiatry were investigated over a period of 1 year by a psychiatrist. The following particulars were noted during an interview, usually within 24 hours of the incident: (*i*) demographic particulars; (*ii*) the role of alcohol; (*iii*) history of suicidal behaviour; (*iv*) psychiatric diagnosis; and (*v*) personality traits (clinically evaluated during the interview). One of the reasons for adopting this method of assessment is that, following a thorough psychiatric evaluation, the clinician makes a diagnosis on Axis II of the DSM-III-R,[15] fully knowing that this diagnosis may be modified later. Initially, however, this diagnosis influences the selection of a programme of treatment and assists in the description of the patient's prognosis. Such a diagnosis is, therefore, a variable which may also be investigated in a study of this nature.

The predominant personality trait in each case was subsequently classified as one of the following: dependent, antisocial, passive-aggressive, histrionic/narcissistic/borderline, chizoid/paranoid/schizotypical, avoidant, obsessive-compulsive, intellectually inadequate, inadequate (emotionally and conatively)/immature, manipulative, without being overtly antisocial, and adolescent. If no obvious traits were evident, this was noted too. Guidelines were compiled for the diagnosis of these personality traits (Appendix 1).

After 5 years had elapsed, attempts were made to contact as many of the respondents of the original study as possible. Initially telephonic contact was made by using patients' clinical records. (Telephone numbers of patients and those of their next of kin are recorded on admission.) Telephone directories were also used. Subsequently an interview was arranged to complete a follow-up questionnaire at this evaluation. Where possible, a personality assessment was completed on clinical grounds. At this interview, criteria for brief recurrent depression were evaluated systematically according to those proposed by Angst *et al.*[13] and Montgomery *et al.*[14] (Appendix 2).

Results

Initial assessment

Initially, 307 respondents were assessed over a period of 12 months. After 5 years, 205 respondents were located, of whom 59 were men and 146 women. Several aspects of attempted suicide were investigated in this 5-year study. This paper concerns itself with one aspect of this study only, namely the relationship between personality traits, brief recurrent depression and suicidal behaviour. Personality traits observed during the initial assessment are listed in Table I.

Table I. Personality traits observed during initial assessment

	Men		Women		Total	
	No.	%	No.	%	No.	%
Dependent	10	11,9	22	10,1	32	10,6
Antisocial	15	17,9	11	5,1	26	8,6
Histrionic etc.	12	14,3	53	24,4	65	21,6
Schizoid etc.	0	0	4	1,8	4	1,3
Avoidant	0	0	1	0,5	1	0,3
Obsessive-compulsive	1	1,2	2	0,9	3	1,0
Intellectually inadequate	4	4,8	14	6,5	18	6,0
Inadequate/immature	7	8,3	31	14,3	38	12,6
Manipulative	2	2,4	2	0,9	4	1,3
Adolescent	4	4,8	20	9,2	24	8,0
No obvious traits	27	32,1	52	24,0	79	26,3

Follow-up assessment

It was assumed that the personality traits recorded according to DSM-III-R criteria[15] in the follow-up assessment (in relaxed circumstances) would be more reliable, when compared with those observed during the initial assessment (Table II).

Table II. Personality traits observed during the follow-up assessment

	Men		Women		Total	
	No.	%	No.	%	No.	%
Schizoid	2	3,8	1	0,8	3	1,6
Schizotypal	0	0	1	0,8	1	0,5
Paranoid	0	0	0	0	0	0
Histrionic	5	9,4	28	21,5	33	17,7
Narcissistic	0	0	1	0,8	1	0,5
Borderline	2	3,8	4	3,0	6	3,2
Antisocial	14	26,4	11	8,3	25	13,4
Passive-aggressive	1	1,9	0	0	1	0,5
Dependent	9	17,0	17	12,8	26	14,0
Obsessive-compulsive	0	0	1	0,8	1	0,5
Avoidant	0	0	0	0	0	0
Mixed-NOS	2	3,8	6	4,5	8	4,3
Intellectually inadequate	1	1,9	8	6,0	9	4,8
No obvious traits	17	32,1	55	41,4	72	38,7

NOS = not otherwise specified.

Subsequently, for statistical reasons the traits were grouped into categories in accordance with the DSM-III-R, viz. cluster 'A' (schizoid, schizotypal, paranoid), 'B' (histrionic, narcissistic, borderline, antisocial) and 'C' (avoidant, dependent, passive-aggressive, obsessive-compulsive). This classification is shown in Table III.

Table III. Categories of personality traits observed during the follow-up assessment

	Men (%)	Women (%)	Total (%)
Cluster A	3,8	1,6	2,1
Cluster B	39,6	33,6	34,8
Cluster C	18,9	13,6	15,0
Mixed	3,8	4,5	4,3
Intellectually inadequate	1,9	6,0	4,8
No obvious traits	32,1	41,4	38,7

The vast majority of respondents who had attempted suicide more than once fell into cluster 'B'. Among the men, antisocial traits were commonest (26,4%), with histrionic traits forming a sizeable percentage (9,4%). This relationship was virtually reversed among the women, with histrionic traits representing 21,5% of the total and antisocial traits 8,3%.

The only other significant contribution was in cluster 'C', where dependent traits characterised 17% of men and 12,8% of women. It would appear, therefore, that dependent traits constitute a bigger risk for parasuicide among men than among women.

Comparison of the two assessments

1. Antisocial personality traits were commonest among men in both assessments, viz. 17,9% in the initial assessment and 26,4% in the follow-up assessment.

2. Histrionic personality traits were commonest among women, viz. 24,4% in the initial assessment (combined with narcissistic and borderline traits) and 21,5% in the follow-up assessment.

3. The 'B' cluster personality traits were present in 34,6% of the male population in the initial assessment and 39,6% in the follow-up assessment. The corresponding percentages for women were 33,6% and 31,3%. In both assessments, the 'B' cluster accounted for most of the personality traits observed in the respondents. Furthermore, in both assessments a comparable proportion of 'no obvious pathological personality traits' was noted (32,1% of men in both assessments, and 24% of women in the initial assessment and 41,4% in the follow-up assessment). The figures for dependent personality traits displayed the same trend. This implies that personality traits were identified with a reasonable degree of accuracy in this study, also during clinical interviews soon after an unsuccessful suicide attempt, despite the view expressed in this regard by, among others, Hirschfeld and Davidson.[1] In neither of the assessments were cluster 'A' personality traits associated with non-fatal suicidal behaviour.

Brief recurrent depression

The criteria for this condition were specifically investigated in the follow-up assessment. The findings are given in Table IV.

Table IV. Incidence of brief recurrent depression

	Men		Women		Total	
	No.	%	No.	%	No.	%
Present	8	14,8	42	32,1	50	27,0
Absent	46	85,2	89	67,9	135	73,0

This condition was found to occur more often in women than in men, viz. 32,1% as opposed to 14,8%. Since the study population had been selected on the basis of suicidal behaviour, and since this behaviour had been found to occur in such significant percentages, it would appear that the findings of this study support the claims of Angst *et al.*[13] and Montgomery *et al.*[14]

A two-way table was compiled matching personality traits of the men and women with the absence or presence of this syndrome. Because of the low frequencies found in some subgroups, certain categories were combined, as before, in clusters 'A', 'B' and 'C'. Among the men, no statistical interaction was observed, whereas among the women the significance of the interaction was found to have a *P*-value of 0,2610. Although not statistically significant, brief recurrent depression is associated with histrionic/narcissistic/borderline/antisocial traits. When the original categories are examined, it can be seen that 15 of the 20 female respondents who were originally grouped in cluster 'B' fell into the group with histrionic personality traits. It can, therefore, be deduced that this follow-up study revealed a clear relationship between women with histrionic personality traits and brief recurrent depression. The absence of this relationship among men may be ascribed to the small number of men in this study, viz. 8, who suffered from this syndrome. More comprehensive studies and epidemiological studies should provide further insight into this subject.

Discussion and conclusions

These findings indicate, firstly, that this study's clinical assessment of personality traits in the acute situation was reasonably reliable.

Secondly, among the men in this study population, antisocial, dependent and histrionic personality traits, in that order of importance, were found, and among the women, histrionic, dependent and antisocial personality traits. These traits can therefore be associated with attempted suicide.

In people who displayed suicidal behaviour a clear relationship was established with the syndrome of brief recurrent depression, which in turn was found to be related to histrionic traits in women. This underscores the relationship between suicidal behaviour and histrionic personality traits.

Finally, it should be taken into account that although personality traits have been discussed here in isolation, they can only be evaluated properly in conjunction with other factors. These factors include, for example, psychiatric diagnoses and recent quarrels with key figures in the patient's life, which also, to a greater or lesser extent, affect this complex pattern of behaviour.

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Appendix 1. Guidelines for the diagnosis of personality traits at the initial assessment

The schizoid/paranoid/schizotypal group

To distinguish accurately between these groups after a clinical interview is difficult especially if the emphasis is on characterising personality traits and not the diagnosis of personality disturbances. For this reason they were grouped together. The most obvious personality traits combined in this group were: (*i*) a tendency to ascribe malicious motives to others; (*ii*) an isolated existence without a need for others; (*iii*) a lifestyle characterised by multiple peculiarities, eccentric behaviour, thought, affect, speech and appearance.

The histrionic/narcissistic/borderline group

For reasons stated previously, these personality traits were combined. The most obvious were: (*i*) a dramatic emotional presentation; (*ii*) a preoccupation with the impression created; (*iii*) a pattern of grandiosity and over-concern with physical attractiveness and extraordinary abilities; (*iv*) a pattern of unstable and intense interpersonal relationships; (*v*) affective instability; (*vi*) inappropriate intense anger; (*vii*) recurrent suicide threats and/or behaviour; (*viii*) self-mutilating behaviour.

Dependent

The most prominent personality traits include: (*i*) a dependent and submissive attitude; (*ii*) an inability to make daily decisions; (*iii*) a prominent fear of rejection; (*iv*) difficulty in initiating projects and doing things alone; (*v*) an avoidance of situations which entail being alone; (*vi*) feelings of devastation and helplessness when close relationships are terminated.

Passive-aggressive

The person demonstrates covert causation of obstruction, is obstinate, ineffective and procrastinates.

Avoidant

The person is shy, bashful, timid and tends to avoid interpersonal contact.

Antisocial

The person's behaviour is maladaptive, does not regard the rights of others, exhibits a history of conduct disorder which starts before the age of 15 years, is irresponsible as demonstrated by, e.g., having no constant job; is not law-abiding; repeatedly becomes involved in physical fights; repeatedly tells lies and is reckless. His/her life shows no premeditation.

Manipulative without obvious antisocial traits

The person's way of life and behaviour exhibit an obvious manipulation of others for self-gain.

Intellectually inadequate

The person is not mentally retarded to the extent that it can be recorded on Axis I of the DSM-III, but his/her intellectual capacities range from low-normal, through borderline intellectual functioning to mild mental retardation. The individual thus shows a marked inability to make progress in areas where intellectual functioning is essential.

Inadequate (emotionally and conatively)/immature

The person is no longer an adolescent but continues to act like one, and exhibits an inability to maintain him/herself emotionally and conatively — interpersonally, socially, financially, etc.

Adolescent

This is a developmental stage described by some as a period of storm and stress. It usually lasts from 12 to 18 years. In this study we included persons who were still dependent on others (usually parents for financial assistance), but who at the same time had started experimentation with alternative lifestyles. Persons in this

category were creating a career and/or building a relationship and/or working toward financial independence, and their emotional reactions to stressors were excessive, impulsive and thoughtless.

Appendix 2. Diagnostic criteria for brief recurrent depression

- Dysphoric mood or loss of interest or pleasure.
- Duration less than 2 weeks.
- Four of the following symptoms: (*i*) poor appetite or significant weight loss (when not dieting); (*ii*) insomnia or hypersomnia; (*iii*) psychomotor agitation or retardation; (*iv*) loss of interest or pleasure in usual activities, or decrease in sexual drive; (*v*) loss of energy, fatigue; (*vi*) feelings of worthlessness, self-reproach, or excessive or inappropriate guilt; (*vii*) diminished ability to think or concentrate, slowed thinking, or indecisiveness; (*viii*) recurrent thoughts of death, suicidal ideation or a suicide attempt.
- Impairment in usual occupational activities.
- At least 1 - 2 episodes per month over 1 year.

Dokter en digter

Neurotiese depressie

Gebore in 'n donker land
langs heining waar die doodsroos rank.

Die lewe moeilik te verduur
teen hemelhoë klaemuur.

Die siek son met sy dowwe straal
wat nooit die oog se fokus haal.

Die wolke sonder silwer rand
wat kronies hang oor swart verstand.

Die kos wat in die mond vergal
terug weer in die bord wil val.

En o, die taaie hardlywigheid
onmeetbaar in ons Greenwichtyd.

Die hart wat met sy bokkesprong
die einde afwag soos 'n ghong.

Die longe wat die asem sug
dit weer teruggooi in die lug.

Die seksdrang van sy seks ontdaan
nog voor geboorte, het gaan staan.

En raak die klagtes uitgeput
gaan ons vir nuwe klagtes bid.

C. J. v. d. M. Pretorius