The role of Clinical and Personological Features in Predicting High Lethality Suicide Attempts: A Study among Mood Disorder Patients.

Short Title

Risk factor for High lethality SA

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Abstract

Suicidal attempts (SA) represent heterogeneous behaviours ranging in their seriousness from fatal and near-fatal (high-lethality) cases to those that do not require medical attention (low lethality). These considerations stress the need to identify high-risk individuals for high lethality SA in order to target suicide preventive interventions. The present study aims at evaluating the role of sociodemographic and clinical variables and examining personality pathological features in predicting high lethality SA. The sample was composed by 94 patients who were consecutively admitted to the Mood Disorders Unit of the San Raffaele Turro Hospital in Milan. The results of binary logistic regression analyses showed that previous SA and current suicide ideation play a role in predicting serious SA. Considering the DSM-5 personality dysfunctional domains assessed by the Personality Inventory for DSM-5, our logistic regression analyses suggested that high lethality SA was associated with Detachment PID-5 domain. Finally, binary hierarchical regression analysis showed that Detachment domain remained a significant predictor of serious SA over and above the effect of previous SA and suicide ideation. As a whole, our results highlight the importance of a multidimensional approach to develop adequate assessment, effective treatments and prevention of high lethality SA risk.

Keywords

High lethality, Suicide Attempts, Personality, Clinical variables

Classification of the paper: research article.

Suicide is a global phenomenon that accounted for 1.4% of all deaths worldwide every year (WHO, 2019).

The predisposing factors for suicidality involve a range of components including mood disorders. Mood disorder patients are 30 times more at risk than the general population. Patients with major depression or bipolar disorder represent the 72–87% of completed suicides (Arsenault-Lapierre et al., 2004). Thus, examining suicide risk in mood disorders is a relevant issue.

Various suicide behaviours can be distinguished: attempted suicide (SA), completed suicide, single or multiple SA (Beautrais, 2001).

SA represents a complex behaviour with medical severity ranging from fatal and near-fatal (high-lethality) cases to medically irrelevant ones (low lethality). Features important to identify fatal SA are the probability of relevant medical outcomes and the risk of recidivism (Szanto et al., 2020). Several studies found that individuals who make high lethality SA showed risk factors similar to suicide completers (Beautrais, 2001), thus, they represent overlapping populations (Levi-Belz et al., 2019).

Distinguishing between suicide attempters who are at high or low risk for suicide is crucial. Different psychosocial factors, for example male gender (Irigoyen-Otiñano et al.,2019), old age (Morin et al., 2019) and lower educational achievement (Kumar et al., 2006) seem to promote higher lethality. The role of other socio-demographic characteristics as marital status, unemployment and low social support in predicting serious SA is still inconsistent (Irigoyen-Otiñano et al., 2019; Giner et al., 2013; DeJong et al., 2010).

Considering clinical variables, data suggested that high lethality SA are associated with mood disorders (Irigoyen-Otiñano et al., 2019). Previous SA (Szanto et al., 2020), repeated hospitalizations (DeJong et al., 2010; Irigoyen-Otiñano et al., 2019), psychiatric and positive family history for suicide (Giner et al., 2013) and suicide ideation (Szanto et al., 2020; Giner et al., 2013, DeJong et al., 2010) represent relevant risk factors.

Research emphasizes the association between personality, personality pathology and high lethality SA (Giner et al., 2013) allowing clinicians to identify factors indicating greater propensity to commit suicide. Up to now, most studies focused on Personality Disorders (PDs). Since there is poor evidence that PDs constitute discrete categories in nature and PD variation is more likely to occur along a continuum (Krueger et al., 2011), the dimensional approach could be more appropriate and clinically useful to investigate the individual differences in high lethality SA risk.

Few data focusing on the associations between adaptive and maladaptive personality traits and suicide risk distinguished between high and low lethality SA. Gvion (2018) showed that impulsivity combined with aggression constitute predictors of the severity of SA in individuals with repeated SA.

Considering suicide behaviours from a broader perspective, without taking lethality into account, several evidence showed the role of Five Factor Model (FFM) personality traits. Neuroticism, linked to depression and mood instability, represents a core aspect in suicide research (Bowen et al., 2011; Mousavi et al., 2015); it is considered a risk factor for SA (Mousavi et al., 2015; Orme et al 2020), serious intent (Statham et al., 1998) and Suicide Ideation (SI) (Velting, 1999; Duberstein et al, 2000; DeShong, et al., 2015; Tucker et al., 2016).

Suicide behaviours seem also related to other FFM dimensions. Stefa-Missagli and colleagues (2020) showed that Extraversion and Agreeableness represent protective factors against SI. Low Extraversion was also associated to SA (Duberstein et al., 2000). Kerby (2003) suggested an association between SI, low Extraversion, low Conscientiousness, and low Agreeableness and Velting (1999) highlighted a relationship between low conscientiousness and SI in females. On the contrary, Orme et al. (2020) suggested that high Conscientiousness was predictive of lifetime SI intensity and suicide-related behaviour.

To our knowledge, there is a lack of data on the relationship between high lethality SA and dysfunctional personality traits as presented in Section III of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5, American Psychiatric Association [APA], 2013). Since

AMPD traits represent dysfunctional variants of FFM traits (Krueger et al, 2012), it could be useful to detect individual dysfunctional differences in personality pathology associated to high lethality SA. Currently, studies investigated the associations between DSM-5 personality traits, suicide-related behaviours and SA, but they did not consider the severity of suicidal behaviour. Orme et al. (2020) analysed the associations between personality dimensions and suicide-related behaviours in individuals with psychiatric disorders using Personality Inventory for DSM-5 (PID-5, Krueger et al., 2012) domain scales and PID-5 borderline traits composite score. Lifetime SI was predicted by PID-5 Detachment domain and the Borderline traits composite score whereas lifetime suicide-related behaviour was predicted by Negative Affectivity and PID - 5 Borderline traits (Orme et al., 2020). Moreover, Somma et al. (2016) examined the relationship between SA and PID-5 scales in a sample of clinical adolescents finding that PID-5 traits of Anhedonia, Depressivity and Submissiveness were significantly associated to SA over and above mood disorders.

The current study aims at evaluating the role of sociodemographic and clinical variables and examining personality pathological features in predicting high lethality SA in individuals with mood disorders. The socio-demographic variables considered were age, gender, marital status, education, and employment. Concerning clinical characteristics, we investigated psychiatric and suicidal behaviour family history, suicidal ideation, previous SA and the number of hospitalizations.

To examine the associations between personality and serious SA, we relied on the DSM-5 personality dysfunctional domains. Finally, we evaluated if PID-5 domains predict severe SA over and above socio-demographic and clinical variables.

METHODS

Participants

One hundred and thirty-six patients who were admitted to the Mood Disorders Unit of the San Raffaele Turro Hospital in Milan, from May 2017 to March 2020 composed our sample.

Forty-two participants (30.8%) were excluded from the final sample because they yielded incomplete PID-5 questionnaire (if more than 10% of the items in any given scale were not answered). Participants that did not complete PID-5 did not differ from patients who yielded complete questionnaires on gender ($\chi^2(1) = 1.42$, $p>.23$), being employed ($\chi^2(1) = .97$, $p>.30$), being married or cohabiting ($\chi^2(1) = 2.96$, $p>.08$), or age (Mann-Whitney U-tests = 1729.50, p > .21, $r_{r\text{-}b} = .12$) and years of education (Mann-Whitney *U*-tests = 1836.00, p > .41, $r_{r\text{-}b} = .07$) A large number of participants could have failed to complete PID-5 because of the severity of their psychiatric condition or emotional difficulties during the test administration. The final sample was composed of 94 participants[1]. Thirty-nine (41.5%) participants were women and 55 (58.5%) were men. Participants' mean age was 52.10 years, SD=13.46 years. The sociodemographic and clinical characteristics of the sample are listed in Table 1.

The inclusion criteria were a) DSM-5 Major Depressive Disorder (MDD) or Bipolar Disorder (BD) and MDD or BD in comorbidity with Anxiety Disorders; b) age > 18 years; c) IQ > 75; d) ability to give informed consent.

Exclusion criteria included diagnoses (or comorbidity with) other psychiatric disorders such as Psychotic Disorders or Substance Use Disorders since they were referred to different Units of San Raffaele Hospital.

Procedures

Participation occurred on a voluntary basis subscribing a written informed consent.

The local ethical committee (IRCCS San Raffaele Hospital) provided approval for the study. No incentives were offered; all measures were administered as part of their clinical assessment during the participant's admission to the unit.

[1] This sample includes patients from a previous study (Brioschi et al., 2020); the results constitute a new employment of the data.

Mood disorder diagnosis according to DSM-5 criteria, sociodemographic and clinical variables and the lethality of SA were assessed by a senior psychiatrist through the standardized clinical chart used in the Mood Disorder Unit.

A self-destructive behaviour with at least some intention to die (O'Carroll et al., 1996) was considered as SA. The clinicians asked the participants if they had attempted suicide in the last year and/or in their life, how many times they attempted suicide, the methods used and the medical consequences. Following Beautrais' criteria (2001), SA that required over 48 hours of health care in the general hospital and/or in intensive care unit were considered high-lethality SA.

Measures

Beck Scale for Suicide Ideation (SSI, Beck et al., 1979)

SSI is a semi-structured interview that quantifies the intensity of suicidal intent giving importance to the different thought dimensions and self-harm domains.

SSI is composed of 19 items and the total score varies in the range of 0-38, obtainable with the sum of items. SSI is one of the most commonly used instruments to evaluate SI even in Italian samples.

Consistent with Duberstein et al. (2000), we relied on positive answers to SSI item 4 ("passive suicidal desire") or SSI item 5 ("desire to make an active suicide attempt") as marker of suicide ideation. Based on responses, two categories were identified: suicide ideators and non-suicide ideators. In the present study, we relied on this distinction as suicide ideation is considered a clinical risk factor for high lethality SA (Szanto et al., 2020). SSI was admnistered during the participant's intake and was included in the standardized clinical chart.

Personality Inventory for DSM–5 (PID-5, Krueger et al., 2012*)*.

The PID-5 is a 220-item questionnaire with a 4-point response scale designed to measure the proposed DSM-5 personality traits. The PID-5 has 25 primary scales that load onto 5 higher-order dimensions. We used Krueger and colleagues' (Krueger et al., 2012) algorithm for scoring PID-5

domains. PID-5 showed adequate psychometric characteristics also in its Italian translation (Fossati et al., 2013). In the present study, we relied on the domain scale scores. Cronbach's coefficient values were .93, .94, .94, .88, and .93 for PID-5 Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism domain scales, respectively.

Data analysis

The Shapiro-Wilk Test was employed to examine normal distribution of the variables. Considering the sample size and the non-normal distribution for two PID-5 domains (*Shapiro-Wilk Test* = .90, $p < .001$ for Antagonism and .95 $p < .001$ for Psychoticism), we relied on non-parametric analyses.

To identify the predictors to enter in the logistic regression analyses, chi-square analyses were used to test the associations between demographic or clinical variables and high lethality SA. We performed chi-square tests of independence with Yates's correction for continuity on 2x2 contingency tables, and we computed odds ratios. Mann–Whitney U test was used to evaluate the associations between high lethality SA and continuous measures; rank biserial *r* coefficient was used as an effect size measure for Mann–Whitney *U* test. Nominal significance level (i.e., $p < 0.05$) was corrected according to the Bonferroni procedure for multiple comparisons.

Logistic binary analyses were performed to analyse the effect of clinical variables and PID-5 domain scores on the high lethality SA group.

To evaluate if the PID-5 domain scales were able to predict high lethality SA over and above the clinical variables, we tested a hierarchical binary logistic regression model in which the predictive clinical variables were entered in Step 1 and the PID-5 domain scales were entered in Step 2.

We then carried out a sensitivity power analysis using the G* Power program to detect critical χ^2 required for .80 power in a sample of 94 participants.

RESULTS

In our sample, 43 (45.7%) participants attempted suicide in their life (M=0.86, DS= 1.23). Among this group, 18 participants (41.9%) attempted suicide within the last year. Twenty-four (25.5%) participants enacted high lethality SA. Thirteen (54.2%) patients used drugs overdose, 6 (25%) threw themselves from the window, 2 (8.3%) tried to hang themselves, 2 (8.3%) participants stabbed themselves and 1 (4.2%) tried to suffocate himself/herself with gas. Twenty (83,3%) participants needed at least 48 hours of hospitalization after SA and 4 (16,7%) were admitted to intensive care unit. Two (8,3%) patients later died for another SA.

The comparisons between high lethality SA group and low lethality SA group on demographic and clinical variables are summarized in Table 2. High lethality SA was associated with suicide ideation ($\chi^2(1) = 13.21$, $p < .001$, odds ratios = 6.67, 95% CI [2.42 – 18.36]) and with previous SA ($\chi^2(1) = 12.15$, $p < .005$, odds ratios = 6.79, 95% CI [2.34 – 19.62]). After Bonferroni correction (.05/4=.012), the co-occurrence of high lethality SA and these clinical variables remained significant.

We conducted a binary logistic regression analysis predicting high lethality SA; we entered as covariates into the model the presence of previous SA and SI. Previous SA and SI were significant predictors of the high lethality SA group (Wald's $\chi^2(1) = 8.24$ $p < .005$, Exp (B)= 5.35, 95% CI [1.70 – 16.83] for previous SA and Wald's $\chi^2(1) = 9.55$, $p < .005$, Exp (B)= 5.45, 95% CI [1.86 – 15.99] for SI). The Hosmer-Lemeshow goodness of fit test indicated a satisfactory fit ($\chi^2(2) = .59$, $p = .74$). The variance explained by the model was 32% (Nagelkerke's R^2.32).

The descriptive statistics of PID-5 domain scales are listed in Table 3. Negative Affectivity and Detachment showed bivariate associations with high lethality SA (Mann-Whitney *U*-tests = 450.00, $p < .001$, r_r-$_b$ = .46 for Negative Affectivity and Mann-Whitney *U*-tests = 428.00, $p < .41$, r_r-$_b$ = .49) for Detachment); thus, we entered them as predictors in the regression analysis.

When we entered Negative Affectivity and Detachment as covariates in the logistic regression model, the Hosmer-Lemeshow goodness of fit test indicated a satisfactory fit ($\chi^2(2) = 6.50$, $p = .59$). The variance explained by the model was 25% (Nagelkerke's $R^2 = .25$). In particular, Detachment represents a significant predictor of high lethality SA (Wald's $\chi^2(1) = 4.14$, $p < .05$, Exp (B)= 5.16, 95% CI [1.06 – 25.06].

In the next hierarchical regression model, Detachment resulted a significant predictor of high lethality SA adjusting for the effect of previous SA and of SI (Wald's $\chi^2(1) = 5.86$, $p < .01$, Exp (B)= 4.95, 95% CI [1.36 – 18.08]). When clinical variables were entered in the regression equation in Step 1 predicting high lethality SA, the value of Nagelkerke's R^2 was .32; when PID-5 domains were added as predictors in the equation in Step 2, the value of Nagelkerke's R^2 was .40.[2]

Power analysis results showed that a χ^2 coefficient value $\geqslant .3.84$ is needed in a sample of 94 participants in order to achieve a power of .80 (which is usually considered acceptable).

DISCUSSION

The present study aimed at investigating the relationship between high lethality SA and socio-demographic, clinical variables and dysfunctional personality traits as listed in the DSM-5 Section III in a sample of mood disorder adult patients.

In our sample, we found a lifetime prevalence of SA (44.7%) aligned with data on mood disorder samples reporting values ranging from 30 – 40% in MDD to 50% in BP (Su et al., 2018). When we considered high lethality SA, 24 (25.5%) participants enacted high lethality SA, in line with available research (Levi-Belz et al., 2019).

The results of binary logistic regression analyses showed that previous SA play a role in predicting serious SA in patients with mood disorders consistent with available research (Gvion,

[2] Considering Detachment and Negative Affectivity traits, Anxiousness and Depressivity showed significant associations with high lethality SA (Wald's $\chi^2(1) = 4.28$, $p < .05$, Exp (B)= 4.61 95% CI [1.07 – 13.46], Nagelkerke's $R^2 = .24$ for Anxiousness; Wald's $\chi^2(1) = 5.63$, $p < .05$, Exp (B)= 4.61 95% CI [1.30 – 16.27], Nagelkerke's $R^2 = .27$ for Depressivity). Depressivity remained a significant predictor of high lethality SA over and above the clinical variables (Wald's $\chi^2(1) = 4.47$, $p < .05$, Exp (B)= 2.41 95% CI [1.08 – 5.46], Nagelkerke's $R^2 = .37$).

2018) showing that previous suicide behaviours represent the best predictor of future high lethality SA. Repeated SA could increase habituation to pain and fear, and this could facilitate the following serious SA. Similar to previous data (DeJong et al., 2010; Giner et al., 2013), suicide ideation represents a significant risk factor for high lethality SA suggesting a progression from ideation to lethal gestures. We did not find significant associations between previous hospitalizations, psychiatric and suicidal behaviour family history and serious SA. This could be linked to our sample characteristics; in particular, the small size of patients that enacted high lethality SA.

In the study, socio-demographic features did not show significant associations with high lethality SA. The socio-demographic predictors for suicide behaviours in inpatient psychiatric population remain controversial (Madsen et al., 2017). Some studies found that higher education (Madsen et al., 2017), high income (Szanto et al., 2020), marital status and being employed (Giner et al., 2013) were associated with an increased risk of completed suicide in psychiatric population. These controversial data could be discussed considering the fear of social isolation and losing income or employment due to the psychiatric disorder in well-functioning individuals when they are facing a stressful situation as a mood disorder.

We did not find associations between gender and high lethality SA. This result is inconsistent with previous studies showing a significant relation between male gender and high lethality SA in mood disorder patients (Murphy, 1998) and in other clinical samples (Irigoyen-Otinano et al., 2019). However, men often do not require professional mental health assistance for severe psychiatric symptoms (Murphy, 1998) and they may be less represented in our mood disorder sample. In our sample, no significant impact of age on high lethality SA has been reported. The debate in literature on age as a predictor of suicidal behaviours remains open (Morin et al., 2019; Madsen et al., 2017).

Our data suggest that personality dysfunctional dimensions are associated with serious SA in a sample of mood disorder inpatients. To our knowledge, this study represents the first attempt to evaluate the role of DSM-5 personality domains in predicting high lethality SA. Our bivariate

analyses showed that serious SA is significantly associated with both Negative Affectivity and Detachment PID-5 domains. However, when we entered Negative Affectivity (the dysfunctional variant of high Neuroticism) in a regression model, it did not predict high lethality SA. Previous studies underlined the role of Neuroticism in suicidal behaviour, although they did not specifically consider high lethality SA. Our findings may suggest that the tendency to experience frequent and intense high levels of negative emotions does not represent a specific risk factor for high lethality SA.

Detachment seems to play a significant role in predicting high lethality SA, consistent with data on the relationship between history of life-threatening behaviours and Detachment personality domain (Somma et al., 2016). Our results could suggest that individuals high in Detachment (the dysfunctional variant of low Extraversion) may engage in less interactions with others, receiving less social support and losing a protective factor against suicide risk. Consistent with Levi-Beltz et al. (2019) avoidance of social and emotional experiences and hopelessness represent risk factors for high lethality SA.

Binary hierarchical regression analysis showed that Detachment remained a significant predictor of high lethality SA over and above the effect of clinical variables. These findings suggest the relevance to carefully assess the propensity to avoid socioemotional experiences in individuals with several past suicide attempts and ideation to evaluate and prevent high lethality suicide risk in mood disordered patients. Moreover, our data support a multidimensional approach to suicide risk assessment consistently with existing literature (Brioschi et al., 2020).

Considering the small sample, to support our findings we carried out a sensitivity power analysis. All our Wald's χ^2 values were higher than critical χ^2 improving the power of our results.

Our results should be considered in light of several limitations. First, our sample was composed of inpatients who voluntarily participated in the study and the sample size of the high lethality SA group was small; the generalizability of our results could be limited by these sample characteristics. The small sample size is also linked to our strict exclusion criteria for incomplete

PID-5. We used this criterion since it investigated our main research variables. Further investigation will be necessary.

Considering the high lethality SA operationalization, we did not rely on a standardized instrument. However, we investigated high lethality SA using the standardized clinical chart employed in the Mood Disorder Unit. Further studies could use validated instruments to assess lethality or investigate if subjective expectations of lethality may be a better indicator of the seriousness of SA than medical lethality, since people often do not know the real medical seriousness of their chosen method.

Regarding the SI assessment, we relied on SSI measure because it is part of the clinical evaluation and management of inpatients in the mood disorder unit. Recently, McCall and colleagues (2021) showed that the most common disagreement of dichotomized SI evaluation occurred when SSI was administered compared to other two measures. The authors stated that all measures available were equally able to identify low and high levels of SI and the choice of the SI instrument may be related to time and contextual variables.

Despite these limitations, our study highlights the relevant role of PID-5 Detachment personality domain in identifying maladaptive personality risk factors for high lethality SA over and above clinical variables. These findings stress the need of a multidimensional approach to develop adequate assessment, effective treatments and prevention/safety plans of high lethality SA risk.

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Table 1. Clinical and Sociodemographic Variables of the Whole Sample (n=94).

Characteristics	All patients, n 94
Socio-demographic features	
Age (years), mean (s. d.)	52.11 (13.47)
Gender, n (%)	
Male	55 (58.5)
Female	39 (41.5)
Married or cohabiting, n (%)	42 (44.7)
Employed, n (%)	68 (72.3)
Education (years), mean (s. d.)	12.89 (3.71)
Psychiatric diagnosis	
Major Depressive Disorder, n (%)	45 (47.9)
Bipolar Disorder, n (%)	29 (30.9)
Mood Disorder and Anxiety Disorder, n (%)	20 (21.3)
Clinical history	
Age of onset (years), mean (s. d.)	31.85 (13.34)
Number of episodes, mean (s. d.)	6.87 (6.85)
Depressive episodes, mean (s. d.)	5.36 (5.38)
Manic episodes, mean (s. d.)	1.51 (2.91)
Number of hospitalizations, mean (s. d.)	3.16 (2.32)
Total time in depression/mania (weeks), mean (s. d.)	32.74 (38.04)
History of suicidal behavior	
Suicide Ideation, n (%)	29 (30.9)
Previous Suicide Attempts, n (%)	21 (22.3)
Family history	
Suicidal behaviors family history, n (%)	12 (12.8)
Psychiatric family history, n (%)	65 (69.1)

Table 2. Demographic Variables, Family and Clinical History of the Participants in the High Lethality SA Group (n = 24) and in the Low Lethality SA Group (n = 70).

	High lethality SA group (*n* = 24)		Low lethality SA group (*n* = 70)			
	N/M	*%/SD*	*N/M*	*%/SD*	$\chi^2(df)$/ Mann-Whitney *U(df)*	Effect size
Socio-demographic features						
Age (years)	55.83	15.48	50.83	12.57	660.00	.21
Gender					.55	-.10
Male	12	50.00	27	38.57		
Female	12	50.00	43	61.43		
Marital Status					.34	-.09
Partner	9	37.50	33	47.14		
Single	15	62.50	37	52.86		
Education (years)	11.75	4.73	13.29	3.23	670.50	.21
Occupation					2.29	-.18
Unemployed	10	41.67	16	22.86		
Employed	14	58.33	54	77.14		
Family history						
Suicidal behaviors family history	2	8.33	10	14.28	1.15	-.14
Psychiatric family history	14	58.33	51	72.86	0.16	-.08
Clinical history						
Number of hospitalizations	4.00	3.01	2.87	1.98	656.50	.22
Suicide ideation	15	62.50	14	20.00	13.21(1)*	.40*
Previous Suicide Attempts	24	55.8	19	44.2	35.35(1)*	.64*

Note: Phi coefficient was used as an effect size measure for χ^2 tests of independence; rank biserial *r* coefficient was used as an effect size measure for Mann-Whitney U tests.
**p<.001*

Table 3. *Descriptive Statistics, Group Comparisons between the High Lethality SA Group and the Low Lethality SA Group and Effect Size Estimates for Group Comparisons for Personality Inventory for DSM-5 Domain Scales (N = 94).*

	Whole sample (N = 94)		High lethality SA group (N = 24)		Low lethality/no SA group (N = 70)		
PID-5 Domain Scales	M	SD	M	SD	M	SD	$r_{r\text{-}b}$
Negative affectivity	1.35	0.39	1.58	0.37	1.26	0.37	.46*
Detachment	1.19	0.48	1.52	0.46	1.08	0.44	.49*
Antagonism	0.60	0.46	0.65	0.47	0.59	0.42	.00
Disinhibition	1.18	0.30	1.18	0.25	1.18	0.32	.04
Psychoticism	0.71	0.50	0.86	0.57	0.66	0.46	.20

PID-5: Personality Inventory for *DSM-5*; SA: Suicide Attempts; $r_{r\text{-}b}$: rank biserial r coefficient. Statistical significance for $r_{r\text{-}b}$: was based on Mann-Whitney U-test
*p<.001