BJPsych | The British Journal of Psychiatry (2017) 210, 167–168

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

Contents

Personality disorders and suicide in China

In October 2016, Tong *et al*[1] published a study that aimed to describe the prevalence of Axis II personality disorders in suicides and suicide attempts in China, and to estimate risks for these outcomes associated with personality disorders. The authors found that personality disorders as defined by DSM-IV are much less prevalent in mainland China compared with other countries. Another finding that was not emphasised was that cluster B personality disorders did not confer increased risk relative to the other clusters, which is in contrast to other studies mostly conducted in Europe and North America.

The authors provide possible explanations for the low prevalence of personality disorders, including that they may be obscured by Axis I disorders, and that individuals with personality disorders do not seek treatment or get referred for treatment. This appears to imply that there may be a higher prevalence of personality disorders in China, which was not detectable owing to the sensitivity of measurements and lack of mental health awareness.

Although this is possible, the authors do not adequately explore possible environmental reasons for their findings, or question the validity of their approach. The theory and diagnosis of mental illnesses, including personality disorders, occur within prevailing cultural expectations.[2] While the cultural differences between 'East' and 'West' are stereotyped and crude, they nonetheless provide hints as to why DSM-IV personality categories may not be appropriate tools for understanding suicidal behaviour in China. Social norms, cultural attitudes towards suicide and motivations for suicidal behaviour can differ markedly compared with the West. For example, although suicide as a result of shame is most commonly associated with Japan, the Chinese have also typically viewed suicide out of loyalty to the family or to 'save face' as acceptable.[3]

Socio-economic factors can also explain why strategies designed in high-income countries may not be appropriate to use in low- or middle-income countries. The rural areas of China still face challenges such as relative poverty compared with urban areas and limited health services.[4] As well as creating different pressures on individual lives compared with the West, a lack of available mental health interventions may hamper any meaningful diagnostic findings.

The authors use the findings from this study to advocate for using a dimensional model of personality traits to understand suicidal behaviour. The validity of this approach was not clearly explained: could it adequately distinguish between fixed traits and the states of an underlying Axis I disorder, for example, and does it also risk obscuring the environmental influences on behaviour? It is clearly important to try to understand suicidal behaviour in China, but a focus on personality without a social context and cultural narrative may limit the scope of inquiry.

1 Tong Y, Phillips MR, Conner KR. DSM-IV Axis II personality disorders and suicide and attempted suicide in China. *Br J Psychiatry* 2016; **209**: 319–26.

2 Summerfield D. The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ* 2001; **322**: 95–8.

3 Lester D. The role of shame in suicide. *Suicide Life Threat Behav* 1997 **27**: 352–61.

4 Milner A, De Leo D. Suicide research and prevention in developing countries in Asia and the Pacific. *Bull World Health Organ* 2010; **88**: 795–6.

Kathy Y. Liu, ST4 in Old Age Psychiatry, King's College London; Email: kathy.liu@kcl.ac.uk

doi: 10.1192/bjp.210.2.167

Authors' reply: We appreciate Liu's interest in our case–control study of DSM-IV Axis II personality disorders and suicidal behaviour in China; however, the commentary does not accurately represent the purpose of the report or our conclusions.

Liu was critical of our focus on personality disorders, stating that 'the authors do not adequately explore possible environmental reasons for their findings [. . .] DSM-IV personality categories may not be appropriate tools for understanding suicidal behaviour in China'. One possible explanation for the much lower reported prevalence of mental disorders in suicide and attempted suicide in China compared with high-income countries[1,2] is the failure to consider Axis II personality disorders in the relevant studies. One of the goals of this study was to test this hypothesis by examining the relationship between personality disorders and suicidal behaviour in China using case–control methodology. We did not make an *a priori* assumption about the role of such disorders in suicidal behaviour. In fact, as stated in the introduction of the paper, 'The purpose of the current study is to address the gaps in data on personality disorders and suicidal behaviour in China'.

We found that a low percentage of suicide decedents (7%) and suicide attempters (6%) in China had one or more Axis II personality disorders, and that a very low percentage of living community controls (1%) had such a disorder. Despite some concerns about the sensitivity of available instruments for measuring personality in China and about respondents' reluctance to report negative traits, our conclusion was that 'personality disorders as defined by DSM-IV are much less prevalent in mainland China'. This result confirms our initial impression that failure to consider the categorically defined DSM-IV personality disorders is *not* the main reason for the previously reported low prevalence of mental disorders among individuals with suicidal behaviour in China.[3] Of course, it remains possible that using dimensional measures of personality traits (rather than the categorical classification of personality disorders) could identify personality characteristics that are important predictors of suicidal behaviour in China. Prior research on the relationship of dimensional measures of impulsivity to suicidal behaviour in China[4,5] is an example of the type of work needed to assess this possibility.

Liu suggested other targets for research and prevention that should take precedence over the examination of Axis II personality disorders, including environmental influences, culture and economic factors. We agree that these are potentially important foci, but they were intentionally not considered in the current report that focused on the relative importance of Axis I and Axis II mental disorders as predictors of fatal and non-fatal suicidal behaviour. These other factors will be addressed in subsequent reports on this study.

1 Yang GH, Phillips MR, Zhou MG, Wang LJ, Zhang YP, Xu D. Understanding the unique characteristics of suicide in China: national psychological autopsy study. *Biomed Environ Sci* 2005; **18**: 379–89.

2 Jiang CL, Li XY, Phillips MR, Xu YC. Matched case-control study of medically serious attempted suicide in rural China. *Shanghai Arch Psychiatry* 2013; **25**: 22–31.

3 Phillips MR. Rethinking the role of mental illness in suicide. *Am J Psychiatry* 2010; **167**: 731–3.

4 Zhang J, Xiao S, Zhou L. Mental disorders and suicide among young rural Chinese: a case-control psychological autopsy study. *Am J Psychiatry* 2010; **167**: 773–81.

5 Ai M, Chen JM, Wang MJ, Gan Y, Shen Y, Li DQ, et al. The impulsiveness and aggression among suicide attempters in college students (in Chinese). *Chin J Nerv Ment Dis* 2011; **37**: 650–5.

Yongsheng Tong, MD, PhD, Beijing Suicide Research and Prevention Center, Beijing Hui Long Guan Hospital, Beijing, China; WHO Collaborating Center for Research and Training in Suicide Prevention, Beijing, China. Email: timystong@pku.org.cn; **Michael R. Phillips**, MD, MA, MPH, Shanghai Mental Health Center, Shanghai Jiao Tong University School of Medicine, Shanghai, China; Departments of Psychiatry and Public Health, Emory University, Atlanta, Georgia, USA; and Beijing Suicide Research and Prevention Center, Beijing Hui Long Guan Hospital, Beijing, China; **Kenneth R. Conner**, PsyD, MPH, Department of Emergency Medicine and Psychiatry, University of Rochester Medical Center, Rochester, New York, USA.

doi: 10.1192/bjp.210.2.167a

https://doi.org/10.1192/bjp.210.2.167a Published online by Cambridge University Press