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Clinical and Psychological Factors of Chronic Suicidal Behavior

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CONTENTS

INTRODUCTION

Research Relevance

Suicidal behavior is a pressing medical, social and psychological problem that includes both suicide attempts, self-harm, and completed suicides. Primary suicide attempts or self-harm often entail repeated auto-aggressive actions. Among suicides, repeated suicide attempts are made by 20% to 60% of people with a time interval of up to three years. A history of a suicide attempt is one of the most important factors increasing the risk of repeated suicidal actions (Beghi M., et al., 2013; Olfson M., et al., 2017). Every second person who attempted suicide within a year repeats their attempt, and every third person made a suicide attempt in the past (Kholmogorova A.B. et al., 2009), the number of incomplete suicides is several times higher than the number of suicides with a fatal outcome (Polozhiy B.S., 2010), and for every completed suicide there are from 10 to 40 suicide attempts (Semke V.Ya., 1988).

An important predictor of suicidal behavior is depression. The risk of suicide in people suffering from depression is 100 times higher than in healthy people (Kholmogorova A.B., 2013). Depressive disorders have a relatively large impact due to their high prevalence, despite the fact that the risk of completed suicide in this category of people is lower than in people suffering from schizophrenia or bipolar and unipolar disorder (Dikaya T.I., 2004; Runeson B. et al., 2010).

Social anxiety in combination with depression has a significant impact on the manifestation of suicidal and self-harming behavior (Kholmogorova A.B. et al., 2009). Social anxiety is also associated with the perception of the surrounding world as uncertain, alien and hostile, which leads to social isolation and, as a result, to a feeling of loneliness (Kholmogorova A.B. et al., 2009). Many authors describe the feeling of loneliness as a lack of social contacts or as an imaginary or real absence of close ties with significant others (Sheridan Rains L. et al., 2021; Ikhtabi S. et al., 2022).

There are many studies proving that chronic suicidal behavior is more characteristic of individuals with personality disorders, especially with borderline

personality disorder (BPD) (Akhtar S. et al., 1986; Shitov E.A., Merinov A.V., 2015; Paris J., 2019). According to research, 3/4 of people with borderline personality disorder attempt suicide, and 11% of outpatients and 19% of hospitalized psychiatric patients have diagnoses of BPD (Linehan M.M. et al., 2000; Söderholm J.J. et al., 2020). According to research, self-harming behavior is based on the need to restore "control over one's own state", which implies overcoming highly intense painful emotions caused by situational factors and conditioned by psychological difficulties in controlling emotions, low stress tolerance, and poorly developed self-regulation skills (Polskaya N.A., 2014; Polskaya N.A., Vlasova N.V., 2015; Shchelkova O.Yu., 2016; Fedunina N.Yu. et al., 2018; Shafti M. et al., 2021). Recurrent suicidal thoughts and behavior have been conceptualized as avoidant coping behavior, given that they often act as a way to avoid difficult, severe negative emotions and other stressors (Daly C. et al., 2020). The presence of such personality traits as perfectionism and narcissism also increases the risk of repeated suicide attempts (Gabbard G.O., 2022). Thus, many authors have identified a link between perfectionism and the presence of symptoms of anxiety, depression and suicidal thoughts and intentions (Garanyan N.G. et al., 2001; Kargin A.M. et al., 2009; Kholmogorova A.B., 2011; O'Connor, G.Portzky, 2018).

In suicides, in comparison with other causes of death, the largest share (37%) of total losses falls on the group of "youth and young adults" aged 20–29, which is 27.5% of the working-age population and necessitates not only considering the psychological and demographic aspects of this problem, but also analyzing it as a factor causing significant economic damage due to early mortality and loss of productive years of life (Lyubov E.B. et al., 2012). Many patients do not seek help after discharge from crisis units due to a number of factors: poor economic resources (no opportunity to see a private doctor), underdeveloped primary care structures for patients after a suicide attempt (crisis outpatient appointment, crisis room), negative attitudes towards treatment, negative past treatment experiences, a feeling of hopelessness about recovery or receiving support after a suicide attempt, culturally conditioned ideas about methods of treating mental disorders ("do not talk about problems", "do not seek help", "seek help only from family, not from specialists") (Sullivan S.R. et al., 2022).

Thus, there are many studies of repeated suicide attempts, but most of them take into account individual factors or predictors. There are several theoretical models aimed at identifying factors or mechanisms of repeated suicide attempts. For example, in the model of M. Linehan (Linehan M.M., 1993), based on the biopsychosocial theory, the dysfunction of the emotional regulation system in patients with chronic suicidal behavior is identified as the main mechanism.

The aim of this paper is to systematize the available data and conduct a comprehensive empirical study of the factors of chronicity of suicidal behavior based on a multifactorial psychosocial model of affective spectrum disorders, including macrosocial, personality, family and interpersonal factors (Kholmogorova A.B., Garanyan N.G., 1998; Kholmogorova A.B., 2011).

This model has already proven its effectiveness in studies of suicidal behavior factors in childhood and adolescence (Kholmogorova A.B., Volikova S.V., 2012).

Study Aim

The aim of this study is to identify the clinical and psychological factors contributing to the chronicity of suicidal behavior and, based on these findings, to determine the main targets for psychological assistance to patients with repeated suicide attempts.

Study Objectives

1. To analyze theoretical models of suicidal behavior and its chronicity.
2. To review empirical studies on the sociodemographic, clinical, and psychological factors involved in the chronicity of suicidal behavior.
3. To develop and test a methodological complex designed to diagnose clinical and psychological risk factors associated with suicidal behavior chronicity.
4. Using the developed methodological complex, conduct a comparative study of two groups of patients hospitalized after primary and repeated suicide attempts.

5. To describe the factors contributing to chronic suicidal behavior and identify targets for psychological assistance for individuals with repeated suicide attempts, based on a multifactorial psychosocial model of affective spectrum disorders.

Study Object

The object of the study is chronic suicidal behavior.

Study Subject

The subject of the study is sociodemographic characteristics and clinical and psychological (clinical, personality, cognitive-behavioral, interpersonal) factors of chronicity of suicidal behavior.

Main Study Hypothesis

The main hypothesis of the study: patients with chronic suicidal behavior, compared with patients with a single attempt, more often have signs of social maladjustment, serious mental disorders and more pronounced symptoms of anxiety and depression, as well as maladaptive personality traits, avoidance of cognitive-behavioral strategies for coping with difficult life situations, and a lack of social support.

Specific Study Hypotheses

1. Sociodemographic characteristics such as low social income, lack of higher education, and unemployment are more frequently observed in patients with chronic suicidal behavior compared to those with single attempts.

2. Patients with chronic suicidal behavior exhibit higher rates of anxiety, depression, and suicidal readiness than patients who have made a primary suicide attempt.

3. Patients with chronic suicidal behavior show more pronounced maladaptive personality traits, including narcissism, perfectionism, and borderline personality characteristics, than those with a primary suicide attempt.

4. Patients with chronic suicidal behavior more frequently adopt unproductive cognitive-behavioral coping strategies for managing stress compared to those with a primary suicide attempt.

5. Patients with chronic suicidal behavior experience more significant difficulties in interpersonal interactions compared to patients with single attempts.

Theoretical and Methodological Basis of Study

The basis for systematizing the obtained data is the multifactorial psychosocial model of affective spectrum disorders (Kholmogorova A.B., Garanyan N.G., 1998; Kholmogorova A.B., 2011; Kholmogorova A.B., Volikova S.V., 2012). The proposed model includes a comprehensive consideration of various factors by combining them into blocks of different levels - sociodemographic or macrosocial (gender, age, education, place of residence, social status, religiosity, employment, availability of psychological assistance), as well as three blocks of psychological factors: family, personality and interpersonal. Various dysfunctional personality traits, as well as maladaptive strategies of thinking and behavior are considered as personality and cognitive-behavioral factors of chronic suicidal behavior, and various dysfunctions in relationships with people both inside and outside the family system are considered as family and interpersonal factors. It is also planned to consider such factors as clinical diagnosis and the severity of psychopathological symptoms in the form of depression and anxiety symptoms. Based on the multifactorial model of suicidal behavior, recommendations have been developed for providing comprehensive psychological assistance to patients with suicidal behavior with the aim of early intervention immediately after a suicide attempt and prevention of subsequent ones.

Research Methods

To assess sociodemographic characteristics or macrosocial factors (gender, age, education, social status, religiosity, availability of psychological assistance) the following were used:

1. Questionnaires;

2. Analysis of medical records (anamnesis, diagnoses).

To study clinical and psychological factors in the form of predominant diagnoses and severity of symptoms of mental disorders, dysfunctional personality traits, destructive cognitive and behavioral style, as well as dysfunctions in interpersonal relationships, the following blocks of methods were used.

To assess the role of clinical factors in the form of depression and anxiety symptoms, the following were used:

1. Retrospective analysis of medical records (diagnoses);

2. Beck Depression Inventory (Beck A.T. et al., 1961; adapted by Tarabrina N.V., 2001);

3. Beck Anxiety Inventory (Beck A.T. et al., 1988; adapted by Tarabrina N.V., 2001).

To assess the severity of dysfunctional personality traits as factors in the chronicity of suicidal behavior, the following were used:

1. Hypersensitive Narcissism Scale (Hendin H.M., Cheek J. M., 1997, the method is in the process of validation);

2. Three-factor Perfectionism Questionnaire (Garanyan N.G., Kholmogorova A.B., Yudeeva T.Yu., 2018);

3. Personality Belief Questionnaire for BPD PBQ-BPD (Beck A.T., Beck J.S., 1991; adapted by Konina M.A., Kholmogorova A.B., 2016).

To assess the severity of destructive cognitive style and coping strategies as factors in the chronicity of suicidal behavior, the following were used:

1. Alexithymia Scale (Toronto Alexithymia Scale, or TAS-20, – Taylor G. J. et al., 1985; adapted by Starostina E.G. et al., 2010);

2. COPE Questionnaire (Carver C.S. et al., 1989; adapted by Garanyan N.G., Ivanova P.A., 2010);

3. Rumination Scale (Treynor W., Gonzalez R., Nolen-Hoeksema S., 2003; adaptation by Pugovkina O.D. et al., 2021).

To assess the severity of dysfunctions in interpersonal relationships as factors in the chronicity of suicidal behavior, the following were used:

1. Loneliness Scale (Russell D., Pepla L. A., Cutrona C.E., 1980);

2. Empathy Test (Davis M.H., 1983; adapted by Karyagina T.D., Kukhtova N.V., 2016).

Statistical Methods

The statistical analysis of the data was performed using the IBM SPSS Statistics 27.0 software package. To analyze the differences between the samples with primary and repeated suicide attempts by sociodemographic indicators, Pearson's chi-square tests for 2xn tables, as well as Fisher's exact test and chi-square with continuity correction for 2x2 tables, were used. To study the differences between the samples with primary and repeated suicide attempts by psychological factors (personality, cognitive-behavioral and interpersonal), the Shapiro-Wilk test was used to study the normality of distributions, as well as the nonparametric Mann – Whitney test to study the significance of differences. In addition, measures of central tendency (medians) and quartiles for each quantitative parameter were calculated.

Study Design

The study was conducted from 2019 to 2023 at the State Budgetary Institution of Healthcare of the City of Moscow, "N.V. Sklifosovsky Research Institute of Emergency Medicine of Moscow Health Department".

Recruitment of participants (N = 119) began upon admission to the closed-type hospital in the departments of acute poisoning and somatopsychiatric disorders. The

examination was conducted 2–3 days after admission and included 2–3 sessions lasting 45–60 minutes each. *During the first session*, clinical histories and patient biographies were collected from patients who provided informed consent to participate. The anamnestic data collected by a psychiatrist, along with feedback from nursing staff and surgeons, was taken into account. Subsequently, interested patients were asked to complete a set of tests and methods. *During the second session*, patients were given feedback and provided with information about specialists and organizations they could contact after discharge. Interested patients were offered follow-up sessions upon request, using cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) methods (including crisis planning and distress tolerance training).

Empirical Basis of Study

The main group (patients who had made repeated suicide attempts) consisted of 59 individuals treated in the toxicology and somatopsychiatric departments for surgical patients at the State Budgetary Healthcare Institution "N.V. Sklifosovsky Research Institute of Emergency Medicine of Moscow Health Department," of whom 43 were women (73%) and 16 were men (27%). All patients had no intellectual disabilities. The majority of patients were of active working age (18 to 45 years), representing 92% of the total sample, with more than half being unemployed: 36 individuals (59%). A total of 42 patients (71%) were single or never married. 41 patients (69%) were under the influence of alcohol when they attempted suicide. Most patients (83%) did not have higher education: 17 individuals had secondary education, 25 had secondary specialized education, and 7 had incomplete higher education.

The comparison group (patients who had made a primary suicide attempt) comprised 60 individuals treated in the toxicology and somatopsychiatric departments for surgical patients at the State Budgetary Healthcare Institution “N.V. Sklifosovsky Research Institute for Emergency Medicine of Moscow Health Department", of whom 34 were women (57%) and 26 were men (43%). All patients had no intellectual disabilities. The majority of patients were of active working age (18 to 45 years),

representing 91% of the total sample, with more than half being unemployed: 36 individuals (60%). A significant majority were divorced or had never been married – 46 individuals (76%) – and did not have higher education (70%): 11 individuals had secondary education, 21 had secondary specialized education, and 10 had incomplete higher education. Additionally, most patients were intoxicated at the time of their suicide attempt: 41 individuals (68%).

Scientific Novelty

For the first time, a comprehensive study of macrosocial, clinical and various psychological factors of chronic suicidal behavior (personality, cognitive-behavioral, interpersonal) was conducted. In existing studies of chronic suicidal behavior, these factors were studied in isolation.

For the first time, differences in these factors were identified between patients with primary suicide attempts and those with chronic suicidal behavior. Psychological assistance targets for this patient category were developed to mitigate the risk of suicidal behavior becoming chronic.

Theoretical and Practical Implications of Study

The theoretical significance of the study lies in the systematization of existing theoretical approaches and empirical data, as well as a comprehensive study of various factors of the chronicity of suicidal behavior.

The practical significance of the study lies in identifying a system of targets for psychological assistance and prevention of chronic suicidal behavior based on a comprehensive study of its sociodemographic characteristics, clinical and psychological factors.

The study results are used in the educational process for courses such as "Personality Disorders" and "Personality Theories in Clinical Psychology". They also support the preparation of term papers, dissertations, and master’s theses by students at

the Faculty of Counseling and Clinical Psychology, Moscow State University of Psychology and Education.

Additionally, the findings have been integrated into the psychological services at the N.V. Sklifosovsky Research Institute of Emergency Medicine, Moscow Department of Health. They are applied in differential diagnostic psychological assessments and in providing psychotherapeutic and psychological assistance to patients following primary and repeated suicide attempts, with the aim of preventing the chronicity of suicidal behavior.

Reliability and Validity of Study Results

The reliability and validity of the study results are ensured by the theoretical analysis of the problem under study, the required sample size, the presence of a comparison group, a methodological complex that meets the goals and objectives of the work, statistical data processing methods selected in accordance with the characteristics of the sample and the objectives of the study.

Author’s Contribution

The author's contribution includes developing the study design based on a preliminary analysis of domestic and foreign literature and data obtained from the pilot study, as well as preparing the stimulus material. The empirical material was personally collected by the author, who independently conducted patient examinations, interviews with relatives and medical personnel, analyses of available archival documentation, and mathematical data processing. Based on the results obtained, conclusions were drawn, targets for psychological assistance to patients with primary and repeated suicide attempts were identified, and practical recommendations were developed for applying the scientific findings and thesis materials in psychological practice.

Presentation and Dissemination of Study Findings

The thesis materials and study findings are featured in seven publications, including seven articles published in peer-reviewed scientific journals approved by the Ministry of Education and Science of the Russian Federation. Additionally, six of these publications are indexed in the scientometric databases Web of Science and Scopus.

The study materials were discussed at the scientific and practical conference of young specialists of medical organizations of the Moscow City Health Department, "Topical Issues of Emergency Medicine" (2020); at the annual VII scientific and practical conference "Suicidology: Current Problems, Challenges and Modern Solutions" (2022); at the scientific and practical conference with international participation "Jubilee Luzhniki Readings: Stages and Prospects for the Development of Clinical Toxicology" (2020, 2023); and at the annual VIII scientific and practical conference "Suicidology: Current Problems, Challenges and Modern Solutions" (2023). The main ideas and scientific results are reflected in four publications.

Thesis Structure and Scope

The study is presented in Russian and English in two volumes, respectively. The English version of the text is presented on 119 typewritten pages. The thesis consists of an introduction, three chapters, a conclusion, findings, practical recommendations, a list of abbreviations and symbols, a list of references (237 titles), including 99 domestic and 138 foreign sources, and a list of illustrative material. The work contains 16 tables and two figures.

Key Research Contributions

1. Treatment characteristics of patients who committed suicidal acts in association with blood-borne viral infections – refer to the work by Zubareva O.V. and Chernaya M.I., 2015 (author's contribution: no less than 50%).

2. Social, psychological, and clinical aspects of suicidal behavior in alcohol-dependent and drug-dependent individuals with incomplete suicide attempts – refer to the work by Zhuravleva T.V., Enikolopov S.N., Chernaya M.I., et al., 2015 (author's contribution: no less than 35%).

3. Clinical and socio-psychological characteristics of individuals who have made repeated suicide attempts – refer to the work by Chernaya M.I., Kholmogorova A.B., Zubareva O.V., et al., 2016 (author's contribution: at least 90%).

4. Comparison of the severity of maladaptive personality traits and psychopathological symptoms in patients with primary and repeated suicide attempts – refer to the work by Kholmogorova A.B., Subotich M.I., Korkh M.P., et al., 2020 (author's contribution: at least 70%).

5. Clinical and psychological characteristics of patients who have attempted suicide by self-poisoning with antihypertensive and antiarrhythmic drugs – refer to the work by Kholmogorova A.B., Pugovkina O.D., Subotich M.I., et al., 2022 (author's contribution: at least 50%).

6. Review of studies on clinical, psychological, and sociodemographic factors of suicidal behavior and the risk of its chronicity – refer to the work by Subotich M.I., 2023 (entirely conducted by the author of the thesis).

7. Comparison of cognitive and behavioral strategies for coping with stress in patients with primary suicide attempts and chronic suicidal behavior – refer to the work by Subotich M.I. and Kholmogorova A.B., 2023 (author's contribution: at least 90%).

Thesis Statements to Be Defended

1. Patients with chronic suicidal behavior, compared to patients with single attempts, are more likely to have diagnoses of personality disorders and more severe forms of depressive disorders, and also have more pronounced depressive and anxiety symptoms. They are more likely to live alone and have a lower level of education than patients with a primary suicide attempt.

2. Patients with chronic suicidal behavior, compared to patients with single

attempts, are more likely to have maladaptive personality traits: distrust of people, impulsivity and low level of autonomy, socially prescribed perfectionism and hypersensitive narcissism.

3. Compared to patients with single attempts, patients with chronic suicidal behavior have more pronounced difficulties recognizing feelings, a tendency to focus on past mistakes and failures, as well as destructive coping strategies in the form of ruminative thinking and avoidance of active ways of solving problems.

4. Compared to patients with single attempts, patients with chronic suicidal behavior have more pronounced empathic distress in contacts with other people and less developed mature forms of emotional self-regulation. They are also more likely to experience loneliness and isolation from other people.

5. The main targets of psychological prevention of chronic suicidal behavior are overcoming socially prescribed perfectionism and narcissism in the form of fixation on one’s own imperfections, overcoming the focus on avoiding problems and developing constructive cognitive and behavioral strategies for coping with stress, developing emotional self-regulation and the ability to understand the emotional states of other people and developing social connections.

CHAPTER 1. THEORETICAL MODELS OF SUICIDAL BEHAVIOR: HISTORY AND CURRENT STATE

1.1. Early Theoretical Models of Suicidal Behavior

Suicide is a complex concept that encompasses cultural, ethnic, moral, and historical aspects. The perception of suicide and attitudes toward it have varied across historical periods, with each culture exhibiting its own distinct characteristics.

The issue of suicide has concerned and fascinated many philosophers, whose perspectives are analyzed in numerous contemporary works (e.g., Avanesov S.S., 2013; Schopenhauer A., 2020). The voluntary and intentional act of ending one's life has long been a subject of debate. In ancient times, altruistic suicide and self-sacrifice were often encouraged. This attitude was evident among Greek philosophers and medieval Vikings, who saw suicide for the state or noble causes as honorable. Stoic philosophers regarded suicide as a right of individual freedom, while Plato and Socrates considered the implications of suicide for society and condemned it. With the advent of Christianity, suicide came to be viewed as a profoundly negative act that opposed divine principles (Lyaschenko M.N., 2013).

Debate about the permissibility of voluntary death continues today. For instance, assisted suicide is legal in several countries, allowing patients with terminal illnesses to end their lives with medical assistance. The U.S. media often frame this as a democratic right to choose death (Claire A., Velasquez M., 2015). Regulations in some jurisdictions permit euthanasia for individuals over 18 with terminal illnesses expected to result in death within six months, contingent upon their competence to make decisions and voluntary requests for assistance. Countries such as the United Kingdom, Switzerland, Spain, Germany, the Netherlands, and other European countries have also legalized euthanasia for terminally ill patients suffering unbearable pain (Gamondi C. et al., 2022). However, it is quite difficult to determine who makes decisions and on what basis, how long a person has left to live. This procedure can also be dangerous for patients who do not plan euthanasia. For example, a doctor may mistakenly determine that a person has less than six months to live. Or, for example, the state may benefit from euthanasia by

saving money that is spent on a terminally ill patient.

Proponents argue for a distinction between assisted dying for terminally ill individuals and suicide in general, asserting that there is a difference between helping a terminally ill person die and helping an unhealthy person die. Assisted suicide allows a terminally ill person to choose the manner and timing of their inevitable death. Receiving assistance in dying enables an individual who is not terminally ill to choose death over life (Mroz S. et al., 2021). However, research highlights challenges in regulating euthanasia, with Switzerland reporting that approximately 15 out of every 1,000 deaths are due to assisted suicide (Borasio G.D. et al., 2019). Most of these occur at the patient's home, with 9% of home deaths classified as suicides (Hurst S.A. et al., 2018). Another problem highlighted by modern researchers is the difficulty of separating the concepts of suicide and euthanasia in clinical practice as well as the experiences of medical personnel involved in assisted suicide (Reiter-Theil S. et al., 2018; Gerson S. M. et al., 2019). Thus, according to Stoic philosophers, under certain conditions, a person is granted the right to choose to end their life. However, it seems impossible to separate the concepts of “euthanasia” and “suicide”. A person who is terminally ill may suffer from both depression and other mental health conditions, which are often associated with an increased risk of suicide. It is worth noting that it is difficult to completely control euthanasia, which can be a dangerous tool in the hands of unscrupulous people. Euthanasia also has a negative impact on medical personnel themselves, with many doctors and nurses suffering personal consequences after this act. Therefore, euthanasia is a dangerous and unacceptable end-of-life solution.

Suicidal behavior in the "pre-scientific" period was viewed through the lenses of religion, moral-ethical principles, and legal perspectives. Later, a typology of suicides was introduced, and the causes of this behavior were examined. Thus, Emile Durkheim, a representative of the French sociological school, examined the phenomenon of suicide from various perspectives: social, moral-psychological, religious, and ethnic. Durkheim defined suicide as "all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result" (Durkheim E., 1998). He differentiated completed suicides from attempted ones, noting

that an "attempted suicide is a homogeneous act, albeit incomplete" (Durkheim E., 1998). In examining suicide, he distinguished between suicide resulting from "madness" or psychopathology, where a person might suffer from hallucinations and delusions, and suicide among individuals without mental illness, attributing their actions to external social factors. He also introduced a typology of suicides:

– **Egoistic.** This type is characterized by a state of depression and apathy, resulting from exaggerated individualism. It is more commonly observed among the intelligentsia and those engaged in mental work. The individual no longer values their life because they cease to sufficiently value the only mediator connecting them with reality: society. Durkheim noted that this type of suicide tends to develop during periods of societal prosperity.

– **Altruistic.** This type is associated with the subordination of the individual to the group. Durkheim considered this form of suicide "a necessary act of collective discipline" and noted the close connection between the practice of suicide and the moral order of society. If depersonalization is prevalent in the environment – such as the military spirit that encourages self-renunciation – then this "inevitably opens the way to suicide".

– **Anomic.** This type is more frequently observed in the world of commerce and industry. It is characterized by feelings of alienation and insufficient societal closeness to the individual. Anomic suicide becomes more common during socio-economic crises and arises from the difficulties individuals face in adapting to change.

Consequently, egoistic suicide results from individuals' inability to find meaning in life; altruistic suicide occurs when an individual perceives the meaning of life as existing outside of themselves; and anomic suicide is determined by disorderly, unregulated human activity and the suffering that accompanies it (Durkheim E., 1998).

Later, the topic of suicide began to be examined not only from the perspectives of sociology, philosophy, and politics but also from the standpoint of psychiatry. Z. Freud viewed suicide through the lens of his theory of the two driving forces within humans: Eros – the life instinct – and Thanatos – the death instinct. By 1910, he identified several important clinical features: 1) a feeling of guilt for wishing death upon others, especially parents; 2) identification with a suicidal parent; 3) loss of libidinal satisfaction or refusal

to accept such a loss; 4) an act of revenge, particularly for the loss of satisfaction; 5) escape from humiliation; 6) a message or cry for help; and, finally, 7) Freud acknowledged the close connection between death and sexuality.

Freud identified the necessary conditions for suicide: firstly, by committing this act, a person simultaneously kills the object with which they identified; secondly, they turn the death wish directed at another onto themselves. Freud explained suicide through the concept of narcissistic identification with a lost object that is both ambivalently loved and hated (Sultanov A.B., Kazhimova K.R., 2022).

K. Horney and G. Sullivan, representatives of social psychoanalysis, sought the causes of suicidal behavior in relationships and within macro- and microsocietal contexts.

K. Horney studied the structure of personality, emphasizing childhood experiences and the surrounding environment. She highlighted the environment as a critical factor in the formation of neuroses. The child's relationship with significant adults plays a crucial role in shaping how the child perceives the world. For instance, if parents behaved unreliably, the outside world might be perceived as alarming and threatening, resulting in "basic social anxiety." Hostility toward the world may then be directed inward by the individual. These internalized personal beliefs about oneself and the world manifest as feelings of inferiority and inadequacy compared to others, potentially leading to suicidal actions (Horney K., 2008).

G.S. Sullivan, the author of the interpersonal theory in psychiatry, considered personality in terms of the interactions that characterize a person's life. Unlike Freud, Sullivan asserted that the need for interpersonal relationships is as important as biological needs. He attributed the need for affection and tenderness to biological needs and linked the need for security to interpersonal communication, which he termed "human." Sullivan identified experiences such as social anxiety and loneliness and posited that mental illnesses are caused by inadequate relationships with significant others. A person's self-esteem, according to Sullivan, arises from the attitudes of others toward them. If others' attitudes provide a sense of security, an individual develops an image of the "Good Self"; if they evoke social anxiety, the "Bad Self" forms. The latter becomes a source of mental discomfort and, if persistent, transforms into the "Not-I" image, which ultimately leads

to auto-aggressive behavior as the only means to alleviate suffering (Sullivan G.S., 1999; Morev M.V. et al., 2012).

Within the existential approach, the problem of suicide was viewed as a lack of meaning and value in life.

Viktor Frankl (1905–1998), the founder and prominent figure of logotherapy, used his experience working with suicidal patients to assess suicidal risk based on whether a patient perceives meaning in life. He created a questionnaire for patients being discharged to determine their suicide risk. If a patient provided monosyllabic answers to questions about their reasons for living rather than detailed responses, this indicated potential risk. Frankl reasoned that "suicide can never be justified" because there is always a way out of any situation. Suicide, he argued, exacerbates problems rather than solving them and removes any opportunity for resolution. He described fatigue with life as a feeling that should be countered with reliance on facts and reason rather than emotions. Frankl highlighted the loss of life's meaning as a significant predictor of suicide, emphasizing the importance of helping such patients rediscover purpose and goals. He famously quoted Nietzsche: "He who has a why to live can bear almost any how," emphasizing that while it is impossible to shield patients from crises, hardships, and stress, it is possible to guide them toward purpose and spiritual development in the face of life's challenges (Frankl V., 1999).

R. May also believed that suicide could result from a lack of meaning in life, occurring when individuals no longer see or find value in their existence. The loss of one's sense of self, combined with experiences of loneliness and contempt for life, fosters the idealization of death and suicidal intentions (May R., 2001).

The emergence of suicide as a subject of scientific research – suicidology – can be attributed to Edwin Shneidman, the founder of the American Association of Suicidology, in 1968. Shneidman first encountered this issue when he found suicide notes in an archive. Fascinated by the idea of comparing these notes with similar fake notes written by patients without suicidal tendencies, Shneidman began his work in the field of suicidology. He later proposed the creation of a journal titled *Bulletin of Suicidology*. He emphasized the importance of focusing on the psychological aspects of suicide, rather than solely on

sociodemographic and physical factors. Shneidman identified the main cause of suicide as unbearable mental pain, stemming from unmet psychological needs. He described helplessness and hopelessness as the primary emotions involved in suicide, with ambivalence representing the internal struggle: the desire for death on one hand, and the hope that someone will recognize their suffering and help. He also introduced the concept of egression, defining it as "a deliberate desire of a person to leave the disaster zone or the place where he experienced misfortune" (Shneidman E., 2001). He proposed viewing suicide as "the perception of insane mental pain and the unwillingness (inability) to bear it," paired with "lethality" – the belief that this pain can only be permanently ended by death. In 1986, Shneidman presented his “cubic” model of suicide, illustrating three sides of the cube: “Pain – Perturbation”, created by the cognitive constriction and the urge to act, and “Press”. To assist a patient with suicidal intent, Shneidman believed it was necessary to make changes to at least one of the cube's sides: reduce mental pain, mitigate confusion, or relieve environmental pressure.

Shneidman was among the first to study suicide predictors, which he termed suicide precursors. "Precursors are observable phenomena that precede (and, in a sense, predict) the event of interest to us." He categorized precursors into two types: verbal and behavioral. Verbal precursors include statements or hints about the desire to end one’s life. Shneidman asserted that suicidal individuals often provide signals of their intentions, which are frequently ignored or overlooked by relatives and friends. He emphasized that if a doctor or relative does not understand or finds the patient’s statements strange, and suspects they might be referring to suicide, the best course of action would be to directly ask: "Are you talking about suicide?"

The second type of precursors involves behaviors similar to those of someone saying goodbye or preparing for a prolonged departure. Patients may begin to return belongings, repay debts, write farewell letters, etc. In the 1950s, Shneidman and colleagues conducted a study and found that 90% of people who attempted suicide exhibited verbal or behavioral precursors during the week before their attempt (Shneidman E., 2001). This research revealed that precursors accompany the vast majority of suicides.

Suicidology as a scientific discipline in Russia began to develop in the mid-20th century. Studies of suicidal behavior as a biopsychosocial phenomenon provided a scientifically evidence-based foundation for the original concept of suicidogenesis by A.G. Ambrumova (Lyubov E.B. et al., 2017). Ambrumova introduced the concept of "suicidal behavior" and considered it not only as an individual act but also in relation to its societal context. The fundamental prerequisite for suicidal behavior is the socio-psychological maladjustment of the individual within a microsocial conflict (Chistopolskaya K.A. et al., 2013). A breakup with the usual social environment or insufficient social connections can provoke loneliness, which has been noted by many scholars as an important predictor of suicide (Ambrumova A.G., 1981). Suicidal behavior was viewed as an “avoidance” reaction. Ambrumova highlighted suicide as a consequence of experiencing a breakup and the loss of significant loved ones; as a reaction to conflict with the social environment; as avoidance of emotional experiences and difficult emotions; and as a reflection on the meaning of life. A.G. Ambrumova identified various types of reactions in suicidal patients (Ambrumova A.G., 1996):

– Emotional imbalance (presence of negative affects);

– Pessimism (“everything is bad,” “there is no way out of the situation,” “there is nothing good in the future”);

– Negative balance (rational and supercritical “summing up one’s life”);

– Demobilization (withdrawal from social contacts and activities due to feelings of loneliness and rejection);

– Opposition (an aggressive stance with accusations directed at others, turning into auto-aggressive behavior, often demonstrative);

– Disorganization (a state of social anxiety accompanied by pronounced somatovegetative disorders).

Thus, the understanding of suicide evolved over time. Initially, suicide was considered from the perspectives of philosophy, law, and morality. During periods of conquest, altruistic suicide was approved by leaders. Later, suicide came to be viewed as an individual’s right to die, and the concept of freedom of choice was supported. However, from an economic standpoint, suicide was not seen as beneficial to society,

which contributed to a negative attitude toward voluntary departure from life. Subsequently, suicide began to be examined from sociological, medical, and psychiatric perspectives. Statistical data on the gender, age, and race of people who committed suicide were studied. Psychiatrists also noted the presence of mental disorders in many cases of suicide. In 1968, it was reported that suicide ranked third after cardiovascular and oncological diseases as a cause of death for people aged 15 to 45 (Shelekhov I. L. et al., 2011), which further spurred the development of suicidology as a science in the mid-20th century. Various models, types, and predictors of suicidal behavior began to emerge, emphasizing the need to consider the risks of suicidal behavior and repeated suicide attempts.

1.2. Contemporary Models of Suicide Behavior and Its Chronicity

Research has shown that suicide attempts are significant predictors of repeated suicides. Suicidal behavior is a complex phenomenon encompassing suicidal thoughts, intentions, and actions. These actions do not always result in death and can evolve into chronic suicidal behavior. Among individuals who attempted suicide, 20% to 60% have made repeated attempts within a three-year period (Lapitsky M.A. et al., 2004). Additionally, half of those who attempt suicide will make another attempt within a year, and one-third have previously attempted suicide (Starshenbaum G.V., 2005).

To understand contemporary models, it is essential to define a suicide attempt as a nonfatal, self-directed, potentially harmful act performed with the intent to die, even if the act does not result in injury. Suicidal ideation refers to thinking about, considering, or planning suicide (Klonsky E.D. et al., 2016). The terms "parasuicide" and "self-harm" are used to describe self-injurious behavior without suicidal intent (Polskaya N.A., 2014; Polskaya N.A., Vlasova N.V., 2015). However, many authors argue that it is difficult, if not impossible, to clearly differentiate between "self-harming" and "suicidal" behavior in clinical practice. Patients experiencing intense emotional distress may exhibit suicidal thoughts and intentions, and both behaviors can coexist or alternate in the same individual (Davidovsky S.V., Igumnov S.A., 2020). Notably, self-harm among patients with

borderline personality disorder (BPD) may not always be harmless. The percentage of completed suicides among individuals with BPD varies but averages around 9% (Barrash J. et al., 1983; Paris J. et al., 1987; Stone M., 2016; Soderholm J.J. et al., 2020).

A.T. Beck's Cognitive-Behavioral Model of Suicidal Behavior. A.T. Beck initially conceptualized depression as stemming from cognitive distortions, introducing the cognitive triad, which includes a negative view of the world, the self, and the future. Hopelessness and pessimism can result from the expectation of negative outcomes and belief in perpetual failure (Beck A.T. et al., 1993). The experience of hopelessness, a negative attitude toward the future, and a diminished ability to anticipate positive events are identified by the author as important factors in depression and suicidal behavior. These factors are also key targets of cognitive-behavioral therapy (CBT) in the treatment of suicidal behavior. As A. B. Kholmogorova notes in her work, during the 1970s and 1980s, A.T. Beck and his followers actively advanced therapy for depression (Kholmogorova A.B., 2013). The effectiveness of cognitive-behavioral therapy (CBT) for depression was subsequently confirmed by numerous studies. However, therapy specifically for suicidal patients was only developed in the 1990s, when researchers recognized that suicidal behavior is not always a symptom of depression and can exist independently. Increased excitability of the nervous system and maladaptive coping styles for managing stress, which can be symptomatic of many mental disorders – particularly personality disorders – have also come to be regarded as causes of suicidal behavior. In cases of personality disorders, suicide attempts are often repeated as an avoidant coping mechanism, potentially developing into chronic suicidal behavior. In 2003, a protocol for cognitive psychotherapy targeting suicidal patients was developed, with key focuses on impulsivity, deficits in problem-solving skills, and perfectionism (Kholmogorova A.B., 2016).

M. Linehan's Dialectical-Behavioral Model of Suicidal Behavior. Later, M. Linehan, building on CBT, mindfulness techniques, and a dialectical approach, created her own method for working with patients with BPD, where chronic suicidal behavior became the focus of research and the development of assistance programs – dialectical behavior therapy (DBT). DBT is based on biopsychosocial theories, with the

fundamental idea being that BPD is a dysfunction of the emotional regulation system. Emotional dysregulation occurs due to the interaction and mutual influence of biological (innate) factors and a dysfunctional environment. An invalidating environment prevents a child from developing effective emotional regulation and coping skills and from trusting their emotional responses and interpretations of events. Such an environment is characterized by variable, inadequate, and extreme reactions to a person's expression of emotions. The individual's feelings are not acknowledged, are ignored, or are met with punishment. An invalidating environment has two main characteristics:

1. The individual is led to believe they are mistaken in both the description and analysis of their own experiences, especially regarding the causes of their emotions, beliefs, and actions;

2. Experiences are attributed to socially unacceptable characteristics or personality traits of the individual.

In such an environment, personal achievement is highly valued, often involving emotional control and limiting demands on others. There is great emphasis on maintaining happiness despite difficulties, believing in one’s ability to achieve any goal, and sustaining confidence and a "positive attitude" in overcoming obstacles, echoing traits of perfectionism. Failure to meet these expectations results in censure and criticism.

Consequently, individuals with BPD rely not on their own emotions but on the emotions of those around them to interpret the external world. This reliance can lead to dissatisfaction with oneself, setting unattainable goals, self-punishment, and repeated suicidal behavior as a means to cope with acute emotional states due to the lack of effective coping mechanisms. M. Linehan considers suicidal behavior to be maladaptive, occurring as a response to uncontrollable and painful affect. For instance, many patients report feeling relief after acts such as cutting or burning themselves. Suicidal behavior may also serve as a way to seek help from others to alleviate emotional pain.

Thus, patients with chronic suicidal behavior often possess innate sensitivity and impulsivity but lack adaptive coping strategies for handling difficult life situations. They struggle to manage distress and face challenges in interpersonal communication. Repeated suicide attempts, in turn, become a maladaptive problem-solving method,

functioning as an attempt to “escape from life situations that seem unbearable and insoluble” (Linehan M., 2007).

As M. Linehan relies on the biopsychosocial model, she considers the interaction of multiple factors:

1. Biological factors (innate impulsivity, sensitivity);

2. Demographic factors (gender, race, and age);

3. Environmental factors, specifically the invalidating environment and the individual's relationship with it (social learning of self-invalidation, self-punishment, and self-criticism based on the behavior of significant adults);

4. Psychological factors (emotional dysregulation, lack of effective coping skills for distress, and difficulties in interpersonal interactions) (Brown M. Z., 2006).

Model of Suicidal Behavior by A. Spirito. Another cognitive-based model is A. Spirito’s model of suicidal behavior in adolescents. It is rooted in the diathesis-stress model and considers the predisposition of adolescents to psychopathology, paying particular attention to the influence of family relationships on the development of suicidal thoughts and intentions. A. Spirito and colleagues discussed deficits in an individual’s ability to regulate external (e.g., facial expressions) and internal (e.g., cognitive functions) manifestations of emotions. Their studies revealed a relationship between a lack of emotional clarity (awareness and understanding of emotional experiences, leading to emotional dysregulation) and dysfunctional family communication (Pavlova T.S., Bannikov G.S., 2013; López R. Jr. et al., 2022).

Based on M. Linehan's theory (Linehan M. M., 1993), A. Spirito explains that some individuals are biologically predisposed to more intense emotional experiences and are more sensitive to emotional signals in their environment. A social (e.g., family) environment that fails to promptly recognize communicated desires and/or needs can exacerbate difficulties with emotional regulation in young people with such heightened sensitivity. If an adolescent’s needs are not met, it can contribute to heightened emotional escalation. The combination of intense emotional experiences and a lack of emotional regulation, along with the desire to suppress emotions, can lead adolescents to suicide attempts as a means of alleviating emotional pain. Choosing suicide attempts as a

behavioral strategy to cope with mental pain can contribute to the chronicity of suicidal behavior in youth, becoming ingrained as a dysfunctional coping mechanism (Linehan M.M., Wilks C.R., 2015). Thus, disruptions in affect regulation, cognitive issues, and behavioral dysfunctions can result in initial suicide attempts and the chronicity of suicidal behavior in adolescents (Spirito A. et al., 2011).

Interpersonal Theory of Suicidal Behavior by T.E. Joiner. Following the research of E. Shneidman and his followers, who focused more on personal experiences in suicidal behavior, T.E. Joiner's interpersonal theory was the first to emphasize the importance of interpersonal communication (Syrokvashina K.V., 2017). This model of suicide is based on the "ideation-to-action" framework, later expanded upon by authors such as O'Connor and E.D. Klonsky. Joiner highlighted the significance of frustrated interpersonal needs: thwarted belongingness and perceived burdensomeness, as well as the acquired capacity for suicide, or fearlessness in the face of death. When basic interpersonal needs are unmet, the risk of suicidal intentions increases. Specifically, feelings of thwarted belongingness and perceived burdensomeness are frequently associated with a higher prevalence of suicidal ideation (Menshikova A.A. et al., 2016).

Joiner posited that suicidal behavior is triggered by the simultaneous presence of two interpersonal constructs:

1. Thwarted belongingness and perceived burdensomeness (accompanied by hopelessness related to these conditions;

2. An acquired capacity for suicidal behavior that develops through repeated exposure to physical or mental pain.

T.E. Joiner identified various risk factors for suicide and its chronicity, including mental disorders, previous suicide attempts, social isolation, experiences of childhood maltreatment, combat exposure, physical illnesses, impulsivity, heightened nervous system excitability, poor sleep, nightmares, and serotonergic dysfunction. The "acquired capacity" is considered a significant risk factor for the chronicity of suicidal behavior (Zubareva O.V., Chernaya M.I., 2015). With repeated suicide attempts or self-harming actions, tolerance to physical pain may increase, fear of death may decrease, and auto-aggressive behavior may become normalized (suicide attempts may no longer be

perceived by the individual as unhealthy). Numerous studies indicate that individuals who have experienced childhood maltreatment, combat exposure, homelessness, and incarceration are at an increased risk for suicidal behavior and its chronicity. Figure 1 shows a scheme combining various factors of suicidal risk and acquired suicidal ability.

Joiner also emphasizes the importance of satisfying the need to belong to a group. This need may remain unmet due to isolation, difficulties in building communication, or the loss of a spouse or significant other. Failure to meet this need leads to what Joiner refers to as "thwarted belongingness," which can contribute to the development of suicidal thoughts and intentions. Thwarted belongingness includes two factors: experiencing a sense of loneliness and a lack of mutual care. It is assumed that the need for belonging has two components: “there is a need for frequent, affectively pleasant interactions with a few other people, and these interactions must take place in the context of a temporally stable and enduring framework of affective concern for each other's welfare“ (Baumeister R.F. et al., 2002). According to Joiner's theory, in the context of modern conflicts, adolescents may develop the concept of "perceived burdensomeness," which is also an important risk factor for suicidal behavior (Van Orden K.A. et al., 2010).

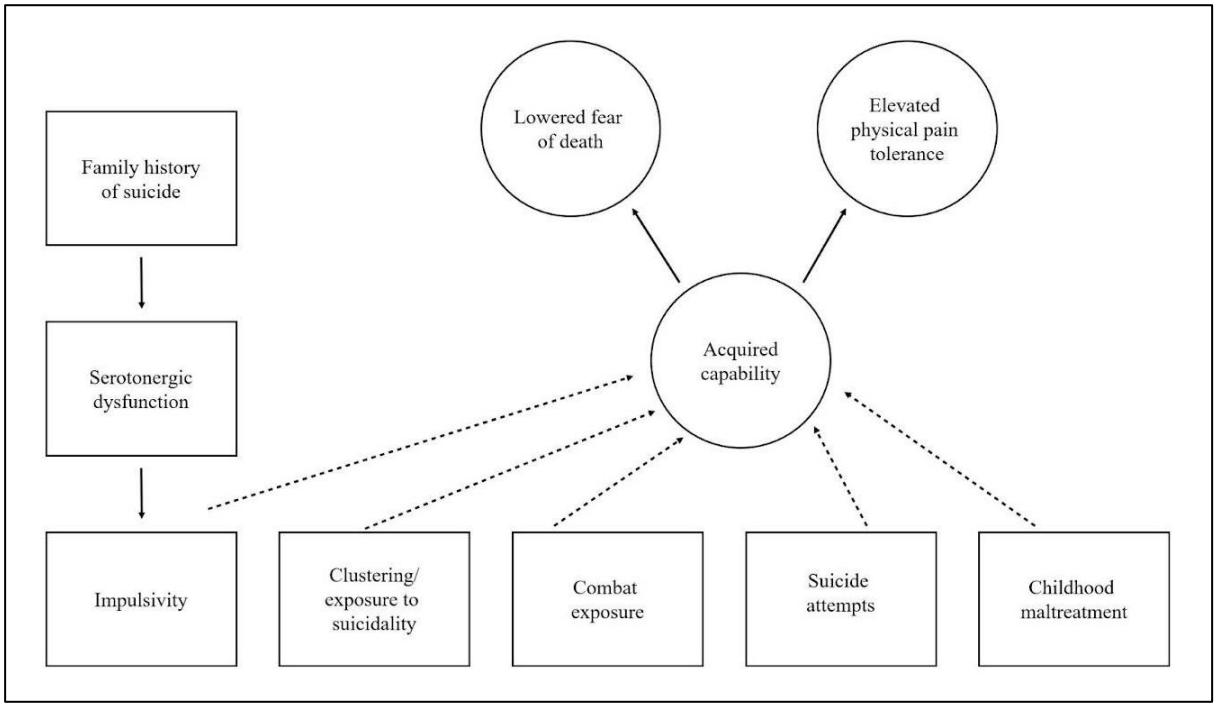

Figure 1 – Illustration of various risk factors for suicide
and the concept of acquired capability for suicide

O'Connor's Integrative Motivational-Volitional Model. O'Connor's Integrative Motivational-Volitional Model illustrates the relationship between background factors and triggering events, the development of suicidal thoughts and intentions, and subsequent suicidal behavior. Like A.T. Beck, this model focuses on the formation of a sense of hopelessness, entrapment, and despair, where suicide appears to be the only solution (O'Connor R. C., Kirtley O.J., 2018; O'Connor R.C., Portzky G., 2018). O'Connor emphasizes the importance of cognitive and biological vulnerability factors, which become particularly harmful when activated by stress (O'Connor R. C. et al., 2012). According to O'Connor's model of suicidal behavior, ruminative thinking, combined with a lack or underdevelopment of constructive problem-solving skills, plays a significant role in suicidal behavior (O'Connor R.C. et al., 2012; Dhingra K. et al., 2015).

O'Connor's Integrative Motivational-Volitional Model comprises three phases of suicidal behavior: pre-motivational, motivational, and volitional. This model depicts the progression from background factors and triggering events that "activate" suicidal ideation and intentions, ultimately leading to a suicide attempt in a state of hopelessness – referred to as "entrapment." It is the combination of ruminative thinking and inadequate problem-solving skills that serves as a primary mechanism during the motivational phase and is a crucial target for suicide prevention.

The pre-motivational phase involves factors such as childhood experiences (e.g., deprivation, vulnerability) and life events (e.g., relationship crises), which form the biopsychosocial context where suicidal ideation and behaviors may emerge.

The motivational phase details the factors linked to the emergence of suicidal thoughts and intentions. The intention is characterized by a feeling of being "trapped," where suicidal behavior becomes the only perceived solution to life’s circumstances. This entrapment results from experiences of defeat or humiliation, frequently associated with chronic or acute stressors. The volitional phase, in contrast, involves behavioral activation and factors that heighten the likelihood of a suicide attempt (O'Connor R.C., Portzky G., 2018). Consequently, ruminative thinking combined with maladaptive coping strategies can contribute to feelings of entrapment during the motivational phase, leading to the chronic nature of suicidal behavior.

O'Connor and colleagues, while studying the differences between adolescents who attempt suicide and those with suicidal thoughts, found no significant differences in personality variables during the pre-motivational and motivational phases (e.g., socially prescribed perfectionism, self-esteem, obsessive thoughts, and optimism). However, differences were evident in the volitional phase variables (e.g., history of self-harm within the family or among friends and impulsivity), as well as in the experience of life stress. Adolescents who face stressful situations without constructive coping strategies, but instead have examples of maladaptive coping (such as suicide attempts within their immediate environment), are more likely to exhibit suicidal behavior compared to those with constructive problem-solving methods. The chronicity of suicidal behavior, according to this model, stems from the presence of impulsivity, a history of previous suicide attempts, and an inability to develop adaptive coping strategies.

E.D. Klonsky's Three-Stage Model. E.D. Klonsky's three-stage model, similar to the models of O'Connor and T.E. Joiner, is based on the ideation-to-action framework. Klonsky and his colleagues emphasized the importance of distinguishing between suicidal thoughts and suicidal actions.

From this perspective, (a) the development of suicidal ideation and (b) the transition from suicidal ideation to a suicide attempt should be regarded as separate processes, each with distinct predictors and explanations. The key constructs of Klonsky's three-stage model are pain and hopelessness, connectedness, and suicidal capacity (see Figure 2).

Step 1. The first step toward suicidal ideation begins with mental pain (psychological or emotional). According to earlier researchers (Shneidman E. S., 1985), mental pain can diminish one's desire to live.

Causes of mental pain can include physical suffering (Ratcliffe G. E. et al., 2008), social isolation (Durkheim E., 1998), burdensomeness and "thwarted belongingness" (Joiner T. E., 2005), defeat and entrapment (O'Connor R. C. et al., 2011), and negative self-perception (Baumeister R. F., 1990), among other distressing thoughts, emotions, and experiences. The initial step toward suicidal ideation is triggered by pain, regardless of its source. An important complement to pain is hopelessness, a concept first discussed

by A. T. Beck. Pain alone does not lead to suicidal ideation (Hallensleben N. et al., 2019). If someone suffering from pain hopes that their situation can improve and that the pain can be reduced, they will strive to achieve a future with less pain rather than consider suicide. For this reason, hopelessness is necessary for the development of suicidal thoughts. It is the combination of pain and hopelessness that leads to suicidal ideation.

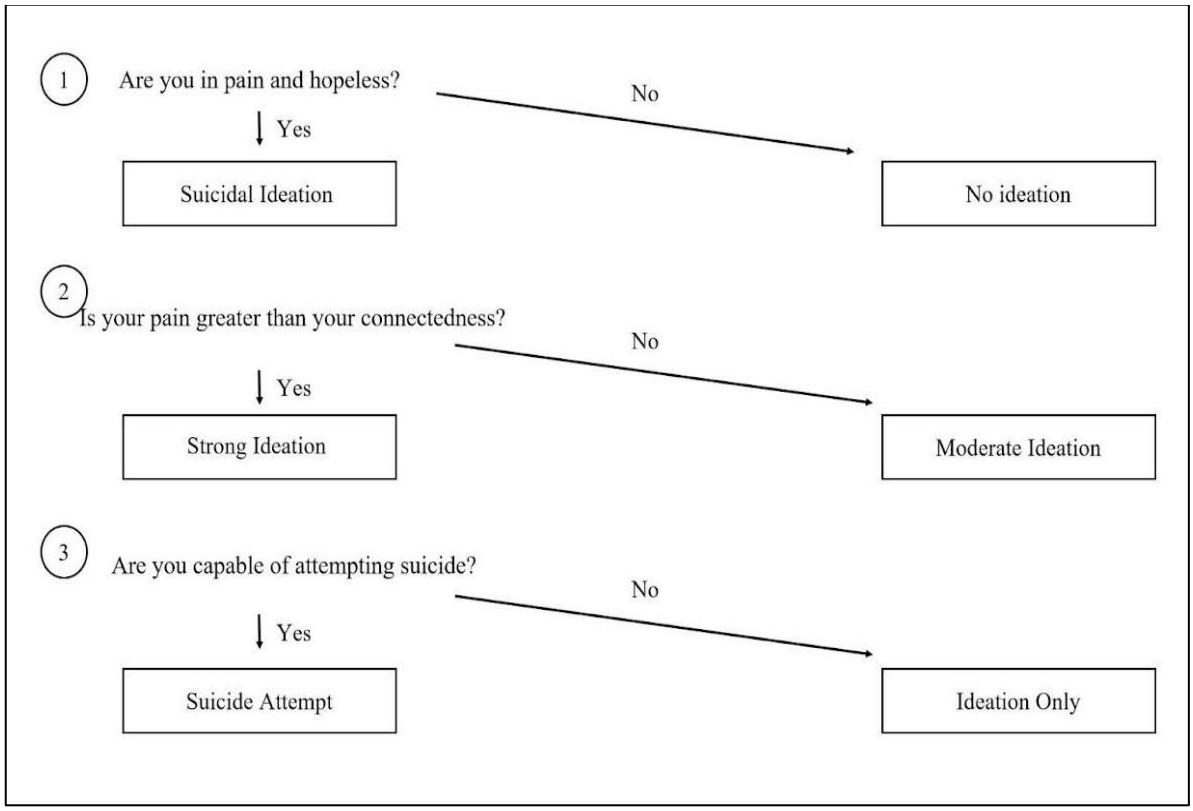

Figure 2 – Illustration of the Three-Stage Model by E.D. Klonsky

Step 2. Suicidal ideation. The second step toward potentially fatal suicidal behavior occurs when pain exceeds connectedness. The term "connectedness" is used in a broad sense and can refer to connections with other people, as well as engagement in interests, roles, projects, or any sense of purpose or meaning that keeps a person involved in life. E. D. Klonsky et al. suggest that a person experiencing pain and hopelessness who contemplates suicide may display weak suicidal ideation (e.g., “Sometimes I think I would be better off dead”) if their sense of connectedness outweighs the pain. However, suicidal intent becomes stronger (e.g., “I would kill myself if I had the chance”) when pain surpasses any feeling of connectedness.

Klonsky illustrates this with the example of a parent who, despite experiencing pain and hopelessness, remains engaged in their children's lives and feels a connection to them. If the parent's sense of connectedness is greater than their emotional pain, they are more likely to continue experiencing passive suicidal ideation, which does not escalate into an active desire for suicide. "Thwarted connectedness" aligns with concepts such as "thwarted belongingness" and "perceived burdensomeness" in T.E. Joiner's Interpersonal Theory of Suicide; however, in Joiner's theory, these constructs are seen as direct causes of suicidal ideation (Joiner T.E., 2005; Forkmann T. et al., 2020). In Klonsky's three-stage model, the primary function of connectedness is to protect against the escalation of suicidal ideation in individuals at risk due to mental pain and hopelessness.

Step 3. Transition from Ideation to Attempts. Most individuals who have suicidal thoughts do not attempt suicide. The transition to a suicide attempt requires the capacity for suicidal action. Based on T.E. Joiner's theory, E.D. Klonsky emphasizes an essential factor that contributes to this transition: the ability to overcome the natural instinct for self-preservation (Joiner T.E., 2005). Joiner's theory proposes that suicidal capacity develops through repeated exposure to painful and provocative experiences that increase one's tolerance for pain, injury, and death. Klonsky et al. expand on this by categorizing variables influencing suicidal capacity into three types: dispositional, acquired, and practical.

– Dispositional variables refer to innate traits, such as inherent pain sensitivity. For instance, some individuals have higher or lower sensitivity to pain (Young E.E. et al., 2011), with lower sensitivity correlating to a higher risk of attempting suicide.

– Acquired variables. These relate to habituation to experiences associated with pain, injuries, fear, and death. Over time, such experiences may lead to a higher risk of suicide.

– Practical variables encompass factors that facilitate the act of suicide, such as the availability of firearms, medications, or other lethal methods. Easier access to these means is associated with an increased risk of suicide.

Thus, dispositional, acquired, and practical factors contribute to the capacity for attempting suicide. Individuals with pronounced suicidal ideation will only proceed to

attempts if and when these capacities are developed. The chronicity of suicidal behavior may also occur due to the evolving "capacity for suicide attempts" – as individuals repeat suicide attempts, they become more accustomed to physical pain, and such attempts may become normalized as a perceived solution to problems.

It is important to note that Klonsky acknowledged other predictors of suicidal behavior, including mental disorders (e.g., depression), self-criticism, personality traits, temperament, predispositions, and personal experiences (e.g., interpersonal losses).

Conclusions for Chapter 1

Thus, many modern models view the chronicity of suicidal behavior not merely as a set of static factors, but as a dynamic system where suicidal thoughts initially arise, followed by intentions (ideations), and culminate in a suicide attempt. Each author emphasizes specific key components influencing the development and progression of suicidal behavior. However, most models acknowledge the significant role of biological predisposition in suicidal behavior, considering factors such as increased excitability of the nervous system, innate heightened sensitivity, and serotonergic dysfunction.

Another frequently highlighted factor in suicide models is the clinical aspect – the presence of mental disorders. While this is not deemed the sole determinant for suicide attempts, the type of mental disorder can affect the method of suicide attempts. For instance, in cases of recurrent depression, schizophrenia, and bipolar affective disorder (BAD), suicide attempts are more likely to result in a fatal outcome, thus leading to fewer repeated attempts (Shchetinina E.V. et al., 2024). In contrast, for borderline and other personality disorders, suicide attempts tend to occur more frequently and pose a higher risk of becoming chronic. The mortality risk for these disorders is lower than that seen in BAD, schizophrenia, and depression, but higher than in individuals with no history of suicide (Ramdurg S. et al., 2011).

The psychological factors highlighted by most authors (Beck A.T. et al., 1993; Joiner T., 2005; Klonsky E.D. et al., 2018; O’Connor R.C., Portzky G., 2018) include:

– Past experiences, developmental history, childhood trauma, family interactions, experiences of loneliness, and the sense of being a “burden” (Beck A.T., Freeman A.M., 1990; Linehan M., 2007).

– Personality traits such as perfectionism, narcissism, trust-building capacity, and the ability to form long-term, reliable relationships (Joiner T., 2005; Linehan M., 2007; O’Connor R. C., Portzky G., 2018).

– Cognitive factors. Many scholars discuss challenges in emotional regulation, often associated with alexithymia, difficulties in distinguishing and articulating emotions, and tendencies toward ruminative thinking and self-comparison in a negative light (Linehan M., 2007; Watkins E.R. et al., 2007; Klonsky E.D. et al., 2018).

Numerous authors have noted that repeated suicide attempts can lead to the chronicity of suicidal behavior due to the habituation and normalization of this method as a way to solve problems. Klonsky referred to these as "acquired variables" (habituation to pain, trauma, fear, and death-related experiences). O’Connor highlighted the “volitional phase,” where adolescents, influenced by examples from their close social circles, learn maladaptive coping strategies involving suicide. This marks a significant distinction between individuals who attempt suicide and those who do not. Joiner identified “capacity for suicide,” which entails elevated tolerance for pain, injury, and death (Joiner T.E., 2005; O’Connor R.C. et al., 2012; Klonsky E.D. et al., 2018).

Consequently, suicidal behavior and its potential for chronicity should be understood as a multifaceted phenomenon comprising a variety of factors. Thus, a multifactorial psychosocial model of affective spectrum disorders was developed, encompassing four blocks: macrosocial, family, personal, and interpersonal factors (Kholmogorova A.B. et al., 2010). This model synthesizes the most significant, theoretically and empirically substantiated data on the factors contributing to affective spectrum disorders and outlines a sequence of psychotherapy tasks derived from this information. It includes an approximate protocol or plan for the psychotherapist's work with these disorders, grounded in objective scientific data.

The model is based on the principle of creating individualized treatment routes, which are adjusted and specified according to the initial nature of each patient's problems and the course of therapy. Using the multifactorial psychosocial model of the affective spectrum, it is possible to systematize the various factors contributing to the chronicity of suicidal behavior described in contemporary suicide models. These include

sociodemographic (e.g., gender, age, level of education, marital status), clinical (e.g., diagnoses, severity of depression and social anxiety symptoms, level of suicidal intent), and psychological (e.g., maladaptive personality traits, dysfunctional cognitive style, and difficulties in interpersonal relationships) factors involved in the chronicity of suicidal behavior.

CHAPTER 2. MODERN EMPIRICAL STUDIES OF SUICIDAL BEHAVIOR FACTORS AND ITS CHRONICITY

2.1. Sociodemographic Characteristics of Patients with Chronic Suicidal Behavior: Overview of Current Data

Suicide and repeated suicide attempts are significant public health concerns. The influence of risk factors such as social status, gender, education, country of residence, and cultural context is crucial in population-based epidemiological studies. According to the World Health Organization (WHO), 703,000 people die by suicide annually, and many more attempt to take their own lives. Suicide affects individuals across all age groups and was the fourth leading cause of death among those aged 15–29 worldwide in 2019 (WHO, 2021). In 2019, over 77% of global suicides occurred in low- and middle-income countries (Al-Humairi A.K. et al., 2020). Globally, one in every 100 deaths is the result of suicide, and for each death, there are approximately ten times as many suicide attempts. Suicide has serious consequences for both the individuals involved and those around them (Suicidality: Results of Recent Meta-Analyses, 2023). Notably, 78% of all completed suicides globally occur in low- and middle-income countries. Compared to other causes of death, suicides account for the largest share (37%) of total loss among the "youth and young adults" age group (20–29 years), representing 27.5% of the working-age population. Therefore, suicidal behavior poses significant demographic and economic challenges (Lyubov E.B. et al., 2012; Rozanov V.A. et al., 2021).

Between 2010 and 2011, Russia was among the top five countries with the highest suicide rates. From 1955 to 2003, approximately 500,000 individuals died by suicide in Russia (Shelekhov I.L. et al., 2011). In 2020, 17,000 people died by suicide in the Russian Federation, equating to about 50 deaths daily, according to the Federal State Statistics Service. Current data show increasing indicators of suicidal behavior among young, working-age individuals (30–45 years), with a second high-risk group comprising older adults (85 years and above) (Lyubov E.B. et al., 2012; Polozhiy B.S., Lyubov E.B., 2022). In Europe, studies have found the highest suicide rates among individuals aged 24 to 34.

Similar data were reported in Egypt, where 48% of suicide deaths occurred among individuals aged 20 to 39. Another study in Egypt indicated that the majority (81.8%) of suicide attempts were in the 15–18 age group. In France, the primary age group for suicide attempts was 15–24. This trend towards younger age groups may be due to the influence of social networks and websites that promote suicidal behavior, which are frequently accessed by young people (Benson R. et al., 2022). Another hypothesis explaining the increase in suicide attempts among youth is heightened anxiety about the future, increased academic and familial pressures, and a heavy workload within this demographic (Olfson M. et al., 2005; Liu B.P. et al., 2022).

Low social income, homelessness, and unemployment are significant factors in suicidal behavior and its chronicity. The suicide rate is three times higher in rural areas than the national average and is also higher among the unemployed compared to the employed (Mashreky S.R. et al., 2013; McDaid D. et al., 2019).

India and China report the highest numbers of suicide deaths, primarily due to self-poisoning, hanging, and self-immolation (Otsuka K. et al., 2015). Research conducted in England on the suicide risk of homeless individuals found that this group primarily consisted of Caucasian men under 54 years of age with a history of self-harm and contact with psychiatric services. This group exhibited a higher risk of repeated suicide attempts and death compared to those with stable housing (Crowell S.E. et al., 2009). Similar findings were reported in Australia, where men living alone (divorced, widowed, or never married) and the unemployed were identified as high-risk groups (Sharwood L.N. et al., 2023).

A higher risk of suicide was found among individuals with lower income (e.g., general laborers, machinists, and drivers) compared to those with higher income (e.g., managers and specialists) (Hawton K. et al., 2015). Unemployment and low income are risk factors for repeated suicide attempts. Men and women with repeated suicide attempts are more likely to have only primary education and experience unemployment. American studies comparing suicide risk among individuals with varying education levels and incomes concluded that higher education can be a protective factor against suicidal behavior, partly due to associated higher income (Oexle N. et al., 2018).

Unemployment, retirement, and loneliness are risk factors for suicide in both genders. Professional challenges and increased job instability are more likely to elevate suicide risk among men (Gratz K.L., 2003; Fehling K.B., Selby E.A., 2021).

Research findings indicate the importance of evaluating key risk factors and implementing intervention strategies for suicide prevention in both low- and middle-income countries and low-income populations in developed nations (Knipe D.W. et al., 2019).

There are many contradictions in the existing studies. Some researchers identify female gender and middle age as the main sociodemographic risk factors for repeated suicide attempts, while others point to male gender and advanced age in women. Some researchers argue that there are no significant gender differences (Kleiman E.M. et al., 2023), while others support these differences (Qin P. et al., 2000; Leske S. et al., 2020). This variability in findings is attributed to the reliance on data primarily from emergency and psychiatric hospitals, where patients are admitted after self-harm, leaving a significant proportion of cases unaccounted for in emergency services.

For instance, certain studies indicate that men are less likely to seek help and receive treatment, which, on the one hand, leads to the chronicity of mental disorders and suicidal behavior and, on the other hand, affects statistical data as men are less likely to come to the attention of healthcare professionals (Docherty A.R., 2020). Another issue contributing to discrepancies is the overlap of terms such as "intentional self-harm", "suicide attempt", "self-harm", and "parasuicide", which are challenging to delineate clearly. In medical practice, "intentional self-harm" is typically discussed; however, due to the indirect nature of such behaviors, activities like unprotected sexual intercourse, high-risk behavior (e.g., extreme sports or illegal racing), and substance abuse (PAS) are often excluded from this category, even though they may reflect a tendency toward self-destruction.

Several authors have noted that repeated self-harm is more frequently observed in women, while men are more likely to engage in repeated suicide attempts with lethal intent. It is well-documented that men die by suicide at higher rates than women (Fehling K.B., Selby E.A., 2021). Thus, while non-fatal repeated self-harm may be more

prevalent among women, men are more prone to repeated suicide attempts with lethal outcomes. Researchers in the Netherlands have identified male gender, low income, unemployment, low educational attainment, loneliness, lack of family, and a history of immigration as key risk factors for suicide. Protective factors include marriage, having children, no history of immigration, and higher education (Kholmogorova A.B., 2016; Phillips J.A., Hempstead K., 2017). Socioeconomic risk factors may vary between genders. A recent study found that, for men, unemployment, retirement, loneliness, and sick leave remained significant risk factors for suicide, even when psychiatric hospitalization was accounted for. In contrast, no significant socioeconomic risk factors were identified for women, except for the presence of mental illness, while having a child under two years old appeared to reduce the risk of suicide (Otsuka K. et al., 2015).

The method of suicide attempt may vary by gender and intent of the auto-aggressive act. Research shows that men tend to use more violent methods, which correlates with a higher likelihood of completed suicide (Michaud L. et al., 2021). Studies on adolescents have shown that drug use increases the risk of repeated suicide attempts (Fleischmann A. et al., 2008). Generally, women exhibit a higher risk of non-fatal self-harm, which is often a way to express emotional distress (Nock M.K. et al., 2008; Fehling K.B., Selby E.A., 2021).

Affective disorders are more common among individuals who die by suicide compared to other forms of mental illness (Harris E.C., Barraclough B., 1997; Colle L. et al., 2020). However, substance use disorders are more frequently observed in male suicides, and men with schizophrenia attempting suicide are predominant (De Hert M. et al., 2001). Eating disorders, particularly anorexia nervosa, present a high risk of suicide and repeated self-harm, primarily affecting women (Berkelmans G. et al., 2021; Ding O.J., Kennedy G.J., 2021).

Gender-specific influences on suicide risk vary across countries. For example, research on primary and repeated suicide attempts in India showed no significant gender differences but indicated that suicides and repeated self-harm occur predominantly among working-age individuals. Common reasons for suicide attempts in India include "family problems" and "illness", which often encompass issues like romantic

relationships, divorce, or difficulties related to arranged marriages (Vijayakumar L., 2010). Notably, women in India have been found to attempt suicide due to factors like extramarital pregnancy and marriage-related conflicts. These suicides can be seen as a form of protest against entrenched social norms (Saab M.M. et al., 2021). Conversely, in China, there are high rates of completed suicides among women, particularly younger women in rural areas (Chu J. et al., 2018).

Age is another significant factor. In developing countries, the risk of non-fatal and fatal repeated self-harm is twice as high in men compared to women and increases 16-fold for individuals aged 56 and older compared to those aged 10–25 (Hepple J., Quinton C., 1997; Hawton K. et al., 2015). Repeated self-poisoning attempts are more common among women under 30 (Subotich M.I., Pugovkina O.D., Kholmogorova A.B. et al., 2022; Kholmogorova A.B., Pugovkina O.D., Subotic M.I. et al., 2022). While younger individuals are more prone to suicide attempts, older adults more frequently engage in repeated attempts with lethal intent, increasing the risk of completed suicide (Soloviev A.G. et al., 2016). Middle-aged individuals are more inclined to repeated self-harm without intent to die. Studies indicate that individuals under 60 experience a cathartic effect post-attempt, which significantly reduces suicidal ideation. This effect is not observed in those over 60, who often use more severe methods (e.g., hanging or firearms) (Liu H., 2009; Kaufman J.A. et al., 2020).

Unlike younger individuals, where impulsivity may drive suicidal behavior, older adults display more rigidity and resistance to new experiences, which are critical factors (Zinchuk M.S. et al., 2019). Living alone is an essential predictor of late-life suicide, as confirmed by studies in nursing homes. Interaction with staff and cohabitation, even without family contact, can reduce suicide risk (Lyubov E.B. et al., 2017). Treatment approaches should consider sociodemographic factors and involve gender- and age-specific strategies. For instance, younger patients may be at a higher risk of non-fatal repeated attempts, while older patients may have a higher risk of completed attempts. Men typically engage in more lethal self-injury methods. Patients with lower education, low social status, and unemployment are at an increased risk of repeated attempts post-hospital discharge, potentially due to educational limitations and restricted access to psychological services.

Comprehensive psychosocial support is essential for patients post-attempt, factoring in gender, age, and social status while involving family members in the treatment process.

2.2. Modern Empirical Studies of Clinical and Psychological Factors of Suicidal Behavior and Its Chronicity

Suicidal behavior should be considered a complex phenomenon that encompasses various factors, including clinical and psychological ones. Significant predictors of chronic suicidal behavior include mental disorders, a history of suicide attempts, recent discharge from a hospital, as well as alcohol and substance abuse (Mendelevich V.D., 2005; Zhuravleva T.V., Enikolopov S.N., Chernaya M.I. et al., 2015; Shustov A.D. et al., 2019). For every completed suicide, there are between 8 and 25 suicide attempts (Polozhiy B.S., 2010). Repeated suicide attempts and self-harm contribute to the chronicity and qualitative worsening of auto-aggressive behavior, significantly increasing the likelihood of life-threatening actions (Polskaya N.A., 2014; Polskaya N.A., Vlasova N.V., 2015).

Some researchers describe patients with chronic suicidal behavior as those admitted to a medical facility following a suicide attempt soon after a recent auto-aggressive act. Chronic suicidal behavior can be defined as persistent, repetitive auto-aggressive actions used as coping mechanisms for affective distress and strong negative emotions (such as sadness, loneliness, anger, dissatisfaction with oneself, and self-abasement). These actions often stem from a deficit in stress-processing skills and emotional self-regulation, along with a lack of reliable attachment experiences within the family and inadequate social support.

According to various studies, risk factors for repeated suicide attempts can be derived from multiple disciplines, including biology, psychology, and sociology (Subotich M.I., Kholmogorova A.B., 2020; *Suicidality: Results of Recent Meta-Analyses, 2023*).

Clinical Factors of Chronic Suicidal Behavior

Mental disorders are recognized as significant factors contributing to chronic

suicidal behavior. The exacerbation of a mental disorder frequently precipitates both the primary suicide attempt and chronic suicidal behavior, especially when the patient or those around them fail to recognize the danger, and the patient refuses to seek professional help (Miller I.W. et al., 2017).

Mood disorders, neurotic disorders related to stress, somatoform disorders, as well as schizophrenia, schizotypal, and delusional disorders are primary predictors of suicide. However, the characteristics of suicide attempts (such as methods, motivations, and the likelihood of repetition) vary among these risk groups. The reasons for suicide among individuals diagnosed with psychotic disorders (including schizophrenia, schizotypal conditions, and delusional disorders) include anhedonia, anxiety, psychotic symptoms, and depression resulting from social challenges and isolation (Rychkova O.V., 2013). Additionally, when patients with schizophrenia express suicidal intent, it is often disregarded as part of their mental state. The methods of self-harm used by individuals with schizophrenia tend to be more violent, involving actions such as drowning, jumping from heights, or strangulated asphyxiation (Qin P. et al., 2000). This group also has the highest proportion of completed suicides among those with previous suicide attempts (Runeson B. et al., 2016). Consequently, these patients often exhibit suicide attempts with the intent to die, and their repeated auto-aggressive behaviors become increasingly severe. The more severe the suicide method, the greater the likelihood that a subsequent attempt will be fatal.

Depression is one of the most pervasive and dangerous forms of psychopathology due to its high association with suicide risk (Lawlor K.E. et al., 2022). Individuals suffering from mood disorders (classified as F32) are at a heightened risk for repeated suicide attempts. The method and severity of these attempts vary based on the intensity of the disorder and its comorbidity with other conditions. A pessimistic outlook on life, lack of hope for improvement, and the desire to cease experiencing feelings of hopelessness, loneliness, and despair are key experiences and motivations for suicide attempts in depression (Kholmogorova A.B., 2016). In severe cases, such as recurrent depressive disorder, schizophrenia, and bipolar disorder, repeated self-harm becomes more severe and significantly increases the risk of death. Depressive disorders notably

amplify the risk of suicide among individuals with a history of suicidal behavior (Qin P. et al., 2000).

Patients with mood disorders (F32) comorbid with personality disorders (F60) show a lower suicide risk compared to those with schizophrenia (F2) and bipolar disorder (F31). However, they still face a considerably elevated risk compared to depressive patients without personality disorders (Runeson B. et al., 2016). Methods of suicide attempts in this group tend to be less violent (e.g., self-cutting or self-poisoning) compared to individuals with bipolar disorder or schizophrenia (Zavaly L.B. et al., 2019). Nonetheless, heightened depressive symptoms (such as intensified feelings of hopelessness, social isolation, and loneliness) in individuals with personality disorders can lead to more severe self-harm with repeated suicide attempts (Kholmogorova A.B., 2016).

The most common diagnoses in individuals with repeated suicide attempts are personality and mood disorders. According to the International Classification of Diseases, 10th revision (ICD-10), one of the criteria for emotionally unstable personality disorder, including borderline personality disorder (BPD), is a tendency to engage in unstable relationships that can lead to recurring emotional crises, often accompanied by suicidal threats or acts of self-harm (Linehan M., 2007). However, individuals with other personality disorders can exhibit traits such as impulsivity and emotional instability, which may also contribute to chronic suicidal behavior (Kholmogorova A.B. et al., 2020; Saab M.M. et al., 2021). With repeated suicide attempts and the chronic nature of such behavior, symptoms of depression or anxiety may emerge or intensify, creating a vicious cycle of suicidal behavior. Patients with severe personality disorders often lack full awareness of their motives, particularly under stress. Repeated self-harm without the intent to die can escalate into genuine suicide attempts, or self-harm can unexpectedly become so severe that it results in death.

Research indicates that personality disorders have a biopsychosocial nature and can emerge from a genetic predisposition combined with adverse environmental factors, particularly attachment disorders (Runeson B. et al., 2016). A temperament characterized by rapid arousal and poor control of negative affect can be exacerbated by attachment

disorders, leading to difficulties in emotional regulation. Common risk factors for repeated self-harm include sexual abuse, maltreatment, neglect, and instability in the relationship between the child and the attachment figure (De Hert M. et al., 2001; Matsuishi K. et al., 2005).

In most cases, repeated suicide attempts in individuals with personality disorders serve various functions. Patients with BPD often engage in repeated suicide attempts as a means of emotion regulation, hindering the development of constructive problem-solving skills. These individuals may find it challenging to seek help and support, increasing their sense of helplessness, hopelessness, loneliness, and social isolation (Chernaya M.I. et al., 2016; Zinchuk M.S. et al., 2019). Some patients use chronic self-harm to alleviate difficult emotions or, conversely, to experience intense and painful emotions. For some, self-harm is a way to reconnect with reality and manage dissociation, while others may use auto-aggressive behavior to escape from an overwhelming reality, such as during interpersonal conflicts (Wedig M., Nock M.K., 2007; Urnes O., 2009). A low ability for self-regulation contributes to strong negative affect, where self-harm may provide a sense of control over internal states and exert a calming effect. Self-punishment is another motive for self-harming behavior among patients with personality disorders who frequently experience feelings of self-abasement and self-hatred. Sometimes, repeated self-harming behavior functions as an impulsive “cry for help” and is often triggered by interpersonal conflicts. It is reported that 17% to 80% of patients with BPD are prone to repeated suicide attempts without the intent to die, with common methods including self-cutting, self-poisoning, or burns (Belova M.V., Ilyashenko K.K., 2016; Temes C.M. et al., 2019; Kholmogorova A.B. et al., 2022). As noted, repeated suicide attempts and self-harm are more prevalent among adolescents and young adults and are linked to a multitude of psychosocial problems that intersect with innate vulnerability (Cheng Y. et al., 2014). The comorbidity of personality disorders with other psychiatric conditions, such as depression and anxiety disorders, heightens the risk of both primary and repeated suicide attempts (Henriksson M.M. et al., 1993; Syrokvashina K.V., Dozortseva E.G., 2020; Birchall E. et al., 2021).

Psychological Factors of Chronic Suicidal Behavior

Personality Factors of Chronic Suicidal Behavior

Research on personality factors in individuals with chronic suicidal behavior indicates that this group often struggles with emotional regulation, impaired impulse control, ineffective stress coping mechanisms, and difficulties in interpersonal relationships. These characteristics are frequently associated with personality disorders, particularly emtoionally unstable (borderline) personality disorder (Brüdern J. et al., 2024). Difficulty with emotion regulation, or the ability to modulate emotional responses to achieve goal-oriented behavior (Yen S. et al., 2021), is recognized as a transdiagnostic risk factor for psychopathology, including suicidal behavior (Neacsiu A.D. et al., 2014). Studies have demonstrated that individuals with repeated suicide attempts differ from those without such a history in their inability to access effective emotion regulation strategies (Rajappa K. et al., 2012). Furthermore, it has been theoretically proposed that emotion regulation training within dialectical behavior therapy (DBT) has a positive therapeutic effect (Lynch T.R. et al., 2006). Repeated suicide attempts are often employed as a means to alleviate distressing emotions such as anger, tension, anxiety, or depression (Mccauley E. et al., 2018).

Traumatic past experiences, such as the loss of loved ones or physical or emotional abuse in childhood, can lead to the development of post-traumatic stress disorder (PTSD) and contribute to the emergence and chronicity of suicidal behavior. Re-experiencing traumatic memories, accompanied by anxiety and arousal, along with avoidance-based coping strategies, exacerbates anxiety and fosters the development of anxiety disorders (e.g., agoraphobia, obsessive-compulsive disorder, social phobia) (Auxemery Y., 2014; Solovieva S.L., 2018).

The role of narcissism in suicidal behavior has also been explored by numerous authors. Studies have found that both vulnerable and grandiose narcissism are linked to dissociation, which in turn predicts recurrent suicidal actions. The association between dissociation and suicide attempts is particularly significant among individuals with high levels of vulnerable narcissism and those with low levels of grandiose narcissism (Soloff P.H. et al., 2012).

Pathological narcissism (narcissistic grandiosity and vulnerability) is associated both with suicidal behavior and chronic suicidal tendencies. Studies have indicated that 4.7% to 23% of suicides involved individuals with narcissistic traits (Raposa E.B. et al., 2016). People with pathological narcissism often hold heightened expectations of themselves and others while being dependent on external validation, which can precipitate intense emotional reactions when they face failure, lack of recognition, or admiration. This dynamic can lead to self-criticism, shame, disappointment, and self-harming behaviors (Blasco-Fontecilla H. et al., 2010). Additionally, grandiose fantasies and exploitative behaviors have been found to correlate with impulsivity and repeated self-harm. Self-harming actions and recurrent suicide attempts may serve as methods for managing feelings of rage and shame, while simultaneously providing a sense of invulnerability and control over one's life (Subotich M.I., Rakhmanina A.A., Bykova M.S., 2020; Gabbard G.O., 2022).

Negative affect resulting from negative feedback is a significant proximate cause of aggression. Individuals high in perfectionism often focus on the discrepancy between their standards and performance, characterized by an exaggerated affective response to negative feedback. This heightened emotional response to failure may contribute to chronic self-harming behavior, as both aggression and self-harm are perceived as mechanisms for regulating negative affect. Perfectionism is linked to more aggressive behavior toward both others and oneself after receiving negative feedback and is associated with repeated self-harm (Chester D.S. et al., 2015).

Insecure attachment is also connected to perfectionistic self-presentation, where individuals mask insecurities and hide imperfections to gain social acceptance and connection. Similarly, elements of perfectionistic self-presentation are associated with social alienation and estrangement. To avoid perceived or actual social rejection, these individuals often present a "flawless facade".

Over the past decade, researchers have examined different types of perfectionism extensively. One commonly accepted classification identifies three types, as proposed by P. Hewitt and G. Flett in their perfectionism scale: self-oriented perfectionism (high personal standards that individuals set for themselves and strive to achieve in their

actions); socially prescribed perfectionism (a person's perception that others expect them to meet high standards and achieve significant results); other-oriented perfectionism (high standards imposed on others, expecting them to perform perfectly and achieve high results). A separate category is often designated as the perfectionistic cognitive style, characterized by an excessive focus on mistakes and preoccupation with personal flaws (Garanyan N.G., Kholmogorova A.B., 2002). Among these types, socially prescribed perfectionism is widely recognized as the most detrimental, strongly associated with pronounced emotional maladjustment and a heightened risk of suicide (Yasnaya V.A., Enikolopov S.N., 2007; Flett G. et al., 2018; Kholmogorova A.B. et al., 2022). Socially prescribed perfectionism involves the belief that society demands perfection from the individual. These individuals may feel compelled to act according to external standards, whether imposed by cultural norms, societal expectations, or significant people in their lives. This dimension of perfectionism is most closely linked to suicidal ideation and chronic suicidal behavior, as it involves concerns about evaluations by others and negative self-comparisons (Hewitt P. et al., 1997; Garanyan N.G. et al., 2018; Kholmogorova A.B. et al., 2020). Socially prescribed perfectionism is a vulnerability factor that heightens sensitivity to perceived failure cues, where experiences of failure/humiliation play a critical role in the onset of suicidal thoughts. Perceived humiliation refers to the negative impact felt after an event interpreted as humiliating, while fear of humiliation denotes the anxiety associated with anticipating such events, even in their absence (Linehan M.M. et al., 2000; O'Connor R.C., Kirtley O.J., 2018; O'Connor R.C., Portzky G., 2018).

Evidence suggests that socially prescribed perfectionism is particularly associated with feelings of dissatisfaction, withdrawal, and loneliness. People with socially prescribed perfectionism perceive that they have little or no control over what is expected of them. When such people fail to meet the expectations that they believe society demands of them, they are more likely to feel hopeless, isolated, and trapped (Subotich M.I., 2023).

Cognitive-Behavioral Factors of Chronic Suicidal Behavior

Recent studies have increasingly focused on cognitive, metacognitive, and

behavioral predictors that contribute to heightened anxiety and depression, which in turn initiate and sustain suicidal behavior. One significant risk factor for suicide and its chronicity is a negative cognitive style, which includes difficulties in decision-making accompanied by prolonged rumination, a reduced ability to shift between different information processing methods, impaired emotional regulation, challenges in recognizing emotions (a “detachment” of cognitive functioning from fundamental needs and emotions, leading to their suppression and loss of connection with them), and difficulties in adopting adaptive stress-coping strategies aimed at problem resolution (Sirota N.A., Yaltonsky V.M., 2003; Padun M.A., 2009).

The role of rumination and its impact on increased depressive symptoms, suicidal ideation, and the likelihood of suicide attempts is a major focus of current research. Rumination, which sustains negative thought patterns associated with a depressive mood, hinders effective problem-solving and reinforces a passive and pessimistic state (Nolen-Hoeksema S., 1991). E.R. Watkins is known for his CBT approach for depression, which specifically targets ruminative thinking. His psychotherapy method is supported by substantial evidence and is grounded in experimental studies distinguishing between constructive and unconstructive thinking styles. Constructive thinking focuses on addressing specific problems and developing solutions, while unconstructive thinking is global and evaluative, characterized by self-blame and self-criticism (Watkins E.R. et al., 2007; Klonsky E.D. et al., 2018). Maladaptive personality traits such as perfectionism (e.g., an inability to accept mistakes, setting unrealistically high standards) combined with poor problem-solving skills are key contributors to the development of ruminative thinking as a maladaptive cognitive coping style (Watkins E.R., 2009). Rumination exacerbates the sense of insurmountable problems and hopelessness, thereby increasing the likelihood of suicide as an ultimate “escape” from perceived inescapable situations (Sagalakova O.A. et al., 2022; Subotich M.I., Kholmogorova A.B., 2023). This style is also marked by avoidance of problem-solving, which leads to the accumulation of unresolved issues, heightened helplessness, and ultimately worsened depression through a vicious cycle mechanism (Pugovkina O.D. et al., 2021).

Recurring suicidal thoughts increase cognitive vulnerability to suicidal behavior by

lowering the threshold for triggering suicidal episodes. With each subsequent attempt, pain tolerance may decrease, and habituation to self-destructive behavior may develop (Beck A.T. et al., 1993; Joiner T., 2005).

Another significant risk factor for suicide is the cognitive-affective characteristic known as alexithymia. Alexithymia is defined as difficulty in understanding emotions, the inability to distinguish feelings from physical sensations that occur during emotional arousal, difficulty in communicating one's emotions to others, an underdeveloped imagination, and a cognitive style that predominantly focuses on external events (Starostina E.G. et al., 2010). A high level of alexithymia results in difficulties in expressing negative emotional states to others and, consequently, an inability to seek help when needed. This leads to a lack of emotional release and the continuous buildup of negative emotions, increasing the likelihood of sudden emotional outbursts (Akimenko A.K., 2016; Brel' E.Yu., Stoyanova I.Ya., 2017; Larionov P.M., Grechukha I.A., 2020). Recent studies have shown that disclosing suicidal thoughts, plans, or destructive behaviors to others creates opportunities for intervention and prevention of chronic suicidal behavior. Patients who more frequently shared their suicidal thoughts verbally rather than through online text messages were less likely to die by suicide than those who disclosed them online or not at all (Suicidality: Results of Recent Meta-Analyses, 2023). High levels of alexithymia are linked to poor emotional self-regulation and underdeveloped problem-solving skills, contributing to emotional buildup, an inability to understand others, and difficulties in establishing emotional connections (Moskacheva M.A. et al., 2014). This ultimately leads to feelings of hopelessness and an increased risk of suicidal behavior (Zinchuk M.S. et al., 2019).

Based on various cognitive theories, it is crucial to highlight the role of adaptive coping strategies as preventive factors in the chronicity of suicidal behavior. Lack of trust, anxiety stemming from the fear of condemnation and rejection, alexithymia, and difficulties in recognizing emotions and seeking help contribute to the formation of maladaptive stress-coping styles. The presence of avoidant coping strategies, in contrast to direct, problem-focused coping methods, is a notable characteristic of individuals who engage in repeated suicide attempts (Pollock L.R., Williams J.M., 2001; Isaeva E.R.,

2009; Luneva P.D., Ababkov V.A., 2023). Recurrent suicidal thoughts and behaviors have been conceptualized as avoidant coping mechanisms, as they often serve as a means to avoid severe negative emotions and other stressors (Chapman A.L. et al., 2006; Millner A.J. et al., 2019; Gysin-Maillart A. et al., 2020).

Interpersonal Factors of Chronic Suicidal Behavior

Interpersonal factors play a crucial role in increasing the risk of suicide, including the risk of repeated suicide attempts (Motillon-Toudic C. et al., 2022). Various theories of suicide emphasize that loneliness and lack of belonging are significant contributors to suicidal behavior (Van Orden K.A. et al., 2010). At the same time, modern studies highlight that loneliness, high levels of isolation, multiple chronic physical disorders, a family history of suicide, sexual trauma, and being female are among the most critical risk factors for chronic suicidal behavior (Rahman A. et al., 2012).

Loneliness and difficulties in forming social connections are frequently linked with suicidal and repeated suicidal behavior in individuals with personality disorders (Mann F. et al., 2022). Disrupted attachment and perceived parental rejection often lead to persistent feelings of loneliness and the perception of others as unkind. The simultaneous desire for connection and fear of it can be explained through the lens of disrupted attachments, wherein caregivers are both sources of safety and threats. This aligns with the literature illustrating the connection between loneliness, trauma, personality disorders, chronic suicidal behavior, and early traumatic life experiences (Sheridan Rains L. et al., 2021; Vasilyeva A.V. et al., 2023).

Severe loss, resulting in feelings of abandonment and loneliness, heightens the risk of suicide attempts in individuals with personality disorder traits due to the additional emotional burden and the lack of coping skills during experiences of loss (Davari F.V. et al., 2021; Bryan C.J. et al., 2018). Social isolation, feelings of being a burden to others, and the belief that others would be better off without the person are other significant predictors of suicidal ideation, repeated attempts, and completed suicidal behavior (Conwell Y. et al., 2000; Dervic K. et al., 2008; Crosby E.S. et al., 2020). Therefore, factors such as social isolation, lack of social support, living in single-parent households,

losing a spouse to death or divorce, and solitary confinement in prison are critical psychological contributors to suicide attempts with intent to die. Conversely, marriage, having children, and a larger network of friends and family are associated with a reduced risk of fatal suicidal behavior (Van Orden K.A. et al., 2012).

Interpersonal communication difficulties can be attributed to heightened personal distress in individuals with personality disorders. Studies suggest that a lack of mature empathy interferes with building stable, long-term relationships (Keysers C. et al., 2014; Salgado R.M. et al., 2020). Karyagina T.D. discusses empathic distress – experiencing others' painful emotions as one's own, resulting in "emotional contagion". Empathic distress may manifest as anger or irritation in response to others' emotional pain. However, as individuals mature and develop culturally appropriate ways of expressing empathy and offering help, they learn mechanisms that prevent emotional contagion and personal distress, enabling the separation of their emotions from others and fostering prosocial motivation and a desire to care (Karyagina T.D. et al., 2017; Karyagina T.D., Pridachuk M.A., 2017). As mentioned earlier, factors such as alexithymia, difficulties in differentiating and recognizing one's emotions, and challenges in regulating affect are significant predictors of suicidal behavior and its chronicity. Research indicates that high levels of personal distress correlate with alexithymia and difficulties in understanding one's own emotions (Karyagina T.D., Pridachuk M.A., 2017). Additionally, high levels of personal distress are associated with depression symptoms and challenges in coping with grief in individuals who have survived a suicide attempt (Toffol E. et al., 2022). Thus, individuals suffering from empathic distress are more prone to being overwhelmed by the negative emotions of others when communicating with them. They have difficulties differentiating their own emotions and understanding the cause-and-effect relationship of emotional discomfort. These challenges can lead to difficulties in regulating their emotions, avoidance of social interactions, difficulties in building trust, and feelings of loneliness, which contribute to the perpetuation of chronic suicidal behavior.

Conclusions for Chapter 2

Chronic suicidal behavior is characterized as a persistent, repetitive pattern of auto-aggressive actions that serve as a way of coping with affect and strong negative emotions

(e.g., sadness, loneliness, anger, self-dissatisfaction, self-abasement), often arising due to a lack of stress-coping skills and emotional self-regulation, as well as a lack of secure attachment experiences within the family (Lainen M., 2007; Polskaya N.A., Vlasova N.V., 2015; Runeson B. et al., 2016; Chernaya M.I. et al., 2016; Kholmogorova A.B. et al., 2020).

Sociodemographic factors of chronic suicidal behavior. These include working age, history of drug use, low social status and income, unemployment, and national and religious characteristics of the country, along with difficulties in accessing medical and psychosocial assistance.

The gender factor plays a varied role across different cultures. Men are more likely to die from suicide attempts (except in China and India), seek help less frequently, and often use more lethal methods of self-harm compared to women. Working-age women and young men who use drugs frequently engage in repeated suicide attempts through methods like self-cutting and self-poisoning without the intent to die, thus increasing the risk of chronic suicidal behavior. Older individuals are more likely to engage in repeated self-harm with fatal outcomes.

Feelings of loneliness, abandonment, lack of social support, and absence of family, children, or a spouse are significant predictors of chronic suicidal behavior across all patient demographics, regardless of gender, age, or religion. Social maladjustment can also serve as a risk factor for repeated suicide attempts.

Clinically, chronic suicidal behavior is often associated with diagnoses such as borderline personality disorder (BPD) and other personality disorders, which are frequently accompanied by depressive and anxiety symptoms. This group of patients typically employs less lethal means of self-harm (e.g., self-cutting, self-poisoning, or burns). However, without treatment and psychological support, these patients face an increased risk of chronic suicidal behavior, worsening depressive symptoms, and completed suicide (Pugovkina O.D. et al., 2021). The motives for self-harm in individuals with personality disorders often include destructive emotional regulation, influencing others, coping with dissociation, and stress management, usually without a desire to die. Patients diagnosed with bipolar disorder, schizophrenia, and recurrent depression tend to

engage in repeated auto-aggressive acts with lethal intent, using highly dangerous methods. These patients have a higher likelihood of completing repeated suicide attempts.

Psychological factors of chronic suicidal behavior were divided into personality, cognitive-behavioral, and interpersonal categories.

Personality factors include maladaptive traits such as mistrust, expectations of harsh treatment, lack of secure attachment experience, difficulties in forming trusting relationships, impulsivity, and heightened sensitivity. Perfectionism and narcissism are also critical predictors of chronic suicidal behavior.

Cognitive-behavioral factors encompass ruminative thinking, a focus on personal failures and challenges, and a deficit in adaptive coping strategies and problem-solving skills. The dominance of avoidant coping strategies contributes to emotional dysregulation and the accumulation of negative affect. Alexithymia is closely linked to difficulties in developing adaptive coping strategies and impaired impulse control, stemming from an inability to understand and express one's emotions.

Interpersonal factor of suicide behavior and its chronicity is feelings of loneliness, which have been highlighted as a primary predictor of suicide in both early and contemporary models. Loneliness may arise from insecure attachment experiences in childhood or as a result of maladaptive personality traits and metacognitive deficits, such as an inability to understand oneself and others. Empathic distress, closely associated with alexithymia, can lead to difficulties in emotional regulation and avoidance of close relationships. These interpersonal challenges contribute to feelings of isolation and loneliness, creating a vicious cycle of chronic suicidal behavior.

Understanding and structuring the diversity of risk factors play an important role in suicide prevention. Ensuring access to treatment for individuals with a history of a primary suicide attempt and chronic suicidal behavior is essential, as they may require regular contact and support from both relatives and specialists, as well as the formation of support groups for the relatives of those at risk (Carr M.J. et al., 2021; Borisonik E.V., 2023).

CHAPTER 3. EMPIRICAL STUDY OF CLINICAL AND PSYCHOLOGICAL FACTORS OF CHRONIC SUICIDAL BEHAVIOR

3.1. Objectives, Hypotheses, and Study Design

Objectives:

1. To analyze theoretical models of suicidal behavior and its chronicity;

2. To analyze theoretical models of suicidal behavior and its chronicity;

3. To analyze theoretical models of suicidal behavior and its chronicity;

4. Using the developed methodological complex, conduct a comparative study of two groups of patients hospitalized after primary and repeated suicide attempts;

5. To describe the factors contributing to chronic suicidal behavior and identify targets for psychological assistance for individuals with repeated suicide attempts, based on a multifactorial psychosocial model of affective spectrum disorders.

Study Object: chronic suicidal behavior.

Study Subject: sociodemographic characteristics and clinical and psychological (clinical, personality, cognitive-behavioral, interpersonal) factors of chronicity of suicidal behavior.

Main Study Hypothesis: patients with chronic suicidal behavior, compared with patients with a single attempt, more often have signs of social maladjustment, serious mental disorders and more pronounced symptoms of anxiety and depression, as well as maladaptive personality traits, avoidance of cognitive-behavioral strategies for coping with difficult life situations, and a lack of social support.

Specific Study Hypotheses:

1. Sociodemographic characteristics such as low social income, lack of higher education, and unemployment are more frequently observed in patients with chronic suicidal behavior compared to those with single attempts;

2. Patients with chronic suicidal behavior exhibit higher rates of anxiety, depression, and suicidal readiness than patients who have made a primary suicide attempt;

3. Patients with chronic suicidal behavior show more pronounced maladaptive

personality traits, including narcissism, perfectionism, and borderline personality characteristics, than those with a primary suicide attempt;

4. Patients with chronic suicidal behavior more frequently adopt unproductive cognitive-behavioral coping strategies for managing stress compared to those with a primary suicide attempt;

5. Patients with chronic suicidal behavior experience more significant difficulties in interpersonal interactions compared to patients with single attempts.

Study Design. The study was conducted from 2019 to 2023 at the State Budgetary Institution of Healthcare of the City of Moscow, "N.V. Sklifosovsky Research Institute of Emergency Medicine of the Moscow City Health Department".

Recruitment of participants (N = 119) began upon admission to the closed-type hospital in the departments of acute poisoning and somatopsychiatric disorders. The examination was conducted 2–3 days after admission and included 2–3 sessions lasting 45–60 minutes each. *During the first session*, clinical histories and patient biographies were collected from patients who provided informed consent to participate. The collection of anamnestic data by a psychiatrist, along with feedback from nursing staff and surgeons, was taken into account. Subsequently, interested patients were asked to complete a set of tests and methods. *During the second session,* patients were given feedback and provided with information about specialists and organizations they could contact after discharge. Interested patients were offered follow-up sessions upon request, using cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) methods (including crisis planning and distress tolerance training).

3.2. Characteristics of the Methodological Complex and Study Groups

To implement the empirical study, a battery of methods was compiled that aligns with the objectives and allows for testing the proposed hypotheses. To ensure the reliability of the results, both experimental and questionnaire methods were employed.

I. To assess sociodemographic characteristics or macrosocial factors (gender, age, education, social status, religiosity, availability of psychological assistance) the following were used:

1. Questionnaires (gender, age, social status, marital status);

2. Analysis of medical histories (anamnesis, diagnoses).

II. To investigate clinical and psychological factors, such as predominant diagnoses, severity of symptoms of mental disorders, dysfunctional personality traits, destructive cognitive and behavioral styles, and interpersonal relationship dysfunctions, the following methodological blocks were employed.

To assess clinical factors, particularly symptoms of depression and anxiety:

1. Retrospective analysis of case histories (diagnoses);

2. Beck Depression Inventory (Beck A.T. et al., 1961; adapted by Tarabrina N.V., 2001) – to assess the severity of depressive symptoms;

3. Beck Anxiety Inventory (Beck A.T. et al., 1988; adapted by Tarabrina N.V., 2001) – to assess the severity of anxiety symptoms.

To assess dysfunctional personality traits as factors in the chronicity of suicidal behavior:

1. Three-Factor Perfectionism Questionnaire (Garanyan N.G. et al., 2018), which includes scales for concern over evaluations from others, setting high standards for oneself, negative selectivity, and fixation on one's imperfections. The first scale measures socially prescribed perfectionism, the second self-oriented perfectionism, and the third a perfectionistic cognitive style;

2. Hypersensitive Narcissism Scale (Hendin H.M., Cheek J.M., 1997) – under validation, used for assessing covert narcissism;

3. Personality Belief Questionnaire for BPD (PBQ-BPD) (Beck A.T., Beck J.S., 1991; adapted by Konina M.A., Kholmogorova A.B., 2016) – for quick diagnostics of borderline traits and subsequent work with underlying beliefs. It includes three scales: mistrust, dependence, and protection, measuring stable personality traits linked to increased psychopathological manifestations.

To assess destructive cognitive styles and coping strategies as factors in chronic suicidal behavior:

1. The Ruminative Responses Scale (RRS) (Treynor W. et al., 2003; adapted by Pugovkina O.D. et al., 2021) – assesses ruminative thinking, with subscales such as:

1) “Anergy” – focusing on depressive symptoms; 2) “Search for global explanations” – cyclical, non-specific negative information processing; 3) “Analysis” – extended analysis of past negative experiences; 4) “Experiencing loneliness” – constant preoccupation with loneliness;

2. Toronto Alexithymia Scale (TAS-20) (Taylor G.J. et al., 1985; adapted by Starostina E.G. et al., 2010) – measures difficulties in recognizing and expressing emotions, with subscales: 1) “Difficulties in Identifying Feelings (DIF)” – issues recognizing one’s emotional state; 2) “Difficulties in Describing Feelings to Others (DDF)” – challenges in expressing emotions to others; 3) “Externally Oriented Thinking (EOT)” – focus on external stimuli over internal states;

3. COPE Inventory (Carver C.S. et al., 1989; adapted by Garanyan N.G., Ivanova P.A., 2010; Rasskazova E.I. et al., 2013) – diagnoses productive and unproductive coping strategies with 15 scales, including:

1) “Positive Reinterpretation and Growth” (perceiving stress positively and overcoming it); 2) “Mental Disengagement” (engaging in activities to distract from stress); 3) “Focus on and Venting of Emotions” (focus on experiences and expressing feelings); 4) “Use of Instrumental Social Support” (seeking additional information, advice, help; 5) “Active Coping” – taking action to manage stress; 6) “Denial” (refusal to accept the stressor’s reality; 7) “Religious Coping” (seeking solace through faith, prays); 8) “Humor” 9) “Behavioral Disengagement” (avoidance of actions); 10) “Self-Restraint” (holding back impulsive actions); 11) “Use of Emotional Social Support” (seeking comfort, empathy and understanding); 12) "Substance Use" (alcohol and drugs); 13) "Acceptance" (acceptance of the reality of a stressful situation without taking active steps to overcome it); 14) "Suppression of Competing Activities" (postponing all other activities to fully concentrate on the problem); 15) "Planning Coping" (thinking about the steps to take to solve the problem).

To assess the severity of dysfunctions in interpersonal relationships as factors in the chronicity of suicidal behavior, the following scales were used:

1. Loneliness Scale (Russell D. et al., 1980), currently under validation, used to assess the severity of subjective feelings of loneliness and social isolation;

2. Empathy Test (Davis M.H., 1983; adapted by Karyagina T.D., Kukhtova N.V., 2016) – designed to identify different types of empathy and includes four subscales:

1) Perspective-Taking (PT) – measures the tendency to consider others' viewpoints in everyday life, assessing the ability to perceive, understand, and take into account others' experiences; 2) Fantasy Scale (FS) – reflects the tendency to imaginatively transpose oneself into the feelings and actions of fictional characters in books, films, and plays; 3) Empathic Concern (EC) – assesses the tendency to feel warmth, compassion, and concern for others, indicating a "helping" attitude and sympathy for others' feelings; 4) Personal Distress (PD) – identifies feelings of discomfort and anxiety in response to others' emotions in stressful situations, such as providing assistance or observing others' distress. Unlike empathic concern, this subscale focuses on the individual's self-oriented distress. Research indicates that negative feelings such as irritation and anxiety, which arise when witnessing others' suffering, can lead to the desire to alleviate these feelings, either by ignoring others' emotions or by providing assistance, not for their well-being but for one's own peace of mind.

The statistical analysis of the data was performed using the IBM SPSS Statistics 27.0 software package. To analyze the differences between the samples with primary and repeated suicide attempts by sociodemographic indicators, Pearson's chi-square tests for 2xn tables, as well as Fisher's exact test and chi-square with continuity correction for 2x2 tables, were used. To study the differences between the samples with primary and repeated suicide attempts by psychological factors (personality, cognitive-behavioral and interpersonal), the Shapiro-Wilk test was used to study the normality of distributions, as well as the nonparametric Mann – Whitney test to study the significance of differences. In addition, measures of central tendency (medians) and quartiles for each quantitative parameter were calculated.

Exclusion criteria: Difficulty completing assessments due to significant cognitive-mnestic decline or a language barrier, age under 18, refusal to participate in assessments and testing, psychosis.

Group Description. The main group (patients who had made repeated suicide attempts) consisted of 59 individuals treated in the toxicology and somatopsychiatric

departments for surgical patients at the State Budgetary Healthcare Institution "N.V. Sklifosovsky Research Institute of Emergency Medicine of the Moscow Health Department", of whom 43 were women (73%) and 16 were men (27%). All patients had no intellectual disabilities. The majority of patients were of active working age (18 to 45 years), representing 92% of the total sample, with more than half being unemployed: 36 individuals (59%). A total of 42 patients (71%) were single or never married. 41 patients (69%) were under the influence of alcohol when they attempted suicide. Most patients (83%) did not have higher education: 17 individuals had secondary education, 25 had secondary specialized education, and 7 had incomplete higher education.

The comparison group (patients who had made a primary suicide attempt) comprised 60 individuals treated in the toxicology and somatopsychiatric departments for surgical patients at the State Budgetary Healthcare Institution “N.V. Sklifosovsky Research Institute for Emergency Medicine of Moscow Health Department", of whom 34 were women (57%) and 26 were men (43%). All patients had no intellectual disabilities. The majority of patients were of active working age (18 to 45 years), representing 91% of the total sample, with more than half being unemployed: 36 individuals (60%). A significant majority were divorced or had never been married – 46 individuals (76%) – and did not have higher education (70%): 11 individuals had secondary education, 21 had secondary specialized education, and 10 had incomplete higher education. Additionally, most patients were intoxicated at the time of their suicide attempt: 41 individuals (68%).

3.3. Sociodemographic Characteristics and Specificity of Suicide Attempts in Patients with Chronic Suicidal Behavior

Based on the results of a clinical interview, questionnaires, and analysis of case histories of 119 patients with suicide attempts, it was established that the majority of those examined were women (55% with primary suicide attempts, 71% with repeated attempts), men accounted for 45% with primary suicide attempts, 29% with repeated attempts.

Most patients in both groups did not have higher education; higher education was attained by only 30% of patients with primary suicide attempts and 16% of those with

repeated attempts. Patients were often unmarried or divorced, constituting 70% of those with primary suicide attempts and 80% of those with repeated attempts. Additionally, just over half of the patients in both groups were unemployed (60% of patients with primary suicide attempts and 59% with repeated attempts).

Therefore, it can be said that such socio-psychological characteristics as low level of education, difficulty in building trusting relationships and living alone are prevalent in this population and may contribute to an increased risk of suicidal behavior.

As shown in Table 1, a comparison of the ratio of men and women with primary and repeated suicide attempts using the chi-square test with Yates' correction revealed differences at the trend level between the groups of patients with primary and repeated suicide attempts based on gender (chi-square = 3.412; p = 0.065).

Table 1 – Age, gender, and social characteristics of individuals with repeated suicide attempts and with a primary suicide attempt

		Primary suicide attempt, *N* = 60 (100%)	Repeated suicide attempts, *N* = 59 (100%)	Test; p
Gender (f/m)	Female	33 (55 %)	42 (71%)	chi-square = 3.412; p = 0.065
	Male	27 (45%)	17 (29%)	
Age	15-25 years	23 (38%)	22 (37%)	chi-square = 3.890; p = 0.274
	26-35 years old	26 (44%)	24 (41%)	
	36–45 years old	6 (10%)	9 (15%)	
	46 years and above	5 (8%)	4 (7%)	
Education	Higher	18 (30%)	10 (16%)	chi-square = 2.137; p = 0.1 44
	Incomplete higher education	10 (17%)	7 (12%)	
	Secondary	11 (18%)	18 (31%)	
	Secondary special	21 (35%)	24 (41%)	
Employment	Employed	24 (40%)	24 (41%)	chi-square = 0.006; p = 0.939
	Not employed	36 (60%)	35 (59%)	
Marital status	Single/divorced	42 (70%)	47 (80%)	chi-square = 0.803; p = 0.370
	Married/married/ in a relationship	18 (30%)	12 (20%)	

Patients with a first suicide attempt were more likely to have higher education compared to patients with repeated suicide attempts (30% versus 16%). However, no statistically significant differences were identified between the groups in terms of education level (chi-square = 2.137; p = 0.144). In both groups, the proportion of single and divorced individuals (70% and 80%) exceeded that of married individuals (30% and 20%), though no significant differences were observed between the two samples (chi-square = 0.803; p = 0.370) (see Table 1). There were no significant differences between the samples with primary and repeated suicide attempts by age when compared using *Pearson chi-square test* (chi-square=3.890; p = 0.274). No statistically significant differences were found between the groups with primary and repeated suicide attempts in terms of employment level (chi-square = 0.006; p = 0.939).

Table 2 presents the reasons for suicide attempts based on clinical interviews with patients and their relatives, questionnaires and analysis of records in medical histories.

Table 2 – Reasons for suicide attempts in individuals with repeated suicide attempts and with a primary suicide attempt

Reasons	Primary suicide attempt, *N* = 60 (100%)	Repeated suicide attempts, *N* = 59 (100%)	Test; p
Conflict with a significant loved one (conflict with parents, partner, sibling, friends)	38 (6 4 %)	30 (51%)	chi-square = 0.941; p = 0.332
Depressed mood (depressive symptoms, “I just felt sad”)	12 (21%)	19 (32%)	chi-square = 1.581; p = 0.209
Overwhelmed by feelings of loneliness and anxiety	5 (9%)	7 (12%)	chi-square = 0.333; p = 0.564

As shown in Table 2, the most significant reason cited by patients in both groups was “conflict with a significant loved one” (64% and 51%), which includes conflicts with parents, partners, siblings, and friends. Patients who had repeated suicide attempts more frequently reported reasons such as “low mood” (“just felt sad”) compared to those with a first suicide attempt (32% versus 21%). However, as illustrated in Table 2, no

statistically significant differences were found between the groups regarding the reasons for suicidal behavior.

Conclusions for Section 3.3

1. Repeated suicide attempts are more prevalent among women compared to men; a trend towards statistical significance has been identified for this indicator.

2. Patients with primary and repeated suicide attempts more often have secondary or secondary specialized education.

3. Patients with primary and repeated suicide attempts are more often unmarried or divorced. These indicators may reflect communication difficulties and, consequently, feelings of loneliness and isolation.

4. Patients with primary and repeated suicide attempts most often noted such reasons for suicide as “conflict with significant loved ones” (conflicts with parents, partners, siblings, and friends), suggesting difficulties in maintaining long-term trusting relationships in this group.

3.4. Clinical and Psychological Factors of Chronic Suicidal Behavior

3.4.1. Clinical Factors of Chronic Suicidal Behavior

Based on the type of physical injury, the following groups were identified:

1. Stab wounds of the extremities (X78);
2. Stab wounds of the head, neck, chest and abdomen (X78);
3. Strangulation asphyxia (X70);
4. Self-poisoning (X61–X69);
5. Jumping under a moving object (X81);
6. Gunshot wounds (X72–X74);
7. Ingestion of vinegar (X83);
8. Self-harm by flame (X76);
9. Jumping from a height (X80).

Table 3 presents data on the distribution of various methods of deliberate self-harm among patients with single versus repeated suicide attempts.

Table 3 – Types of physical trauma (methods of intentional self-harm) in individuals with repeated suicide attempts and with a primary suicide attempt

Types of physical trauma	Primary suicide attempt, *N* = 60	Repeated suicide attempts, *N* =59	Test; p
Stab wounds of extremities (X78)	29 (48%)	38 (64%)	chi-square = 1.209; p = 0.272
Stab wounds to the head, neck, chest and abdomen (X78)	5 (8%)	7 (12%)	chi-square = 0.333; p = 0.564
Self-poisoning (X61–X69)	17 (28%)	14 (24%)	chi- square = 0.290; p = 0.590
Other types of physical trauma (jumping from a height, gunshot wounds, self-harm with flame, asphyxia, etc.)	9 (16 %)	0 (0 %)	the use of the statistical criterion is inappropriate

As seen in Table 3, patients experiencing a primary suicide attempt demonstrate a wider range of methods for inflicting injury, from stab wounds to the forearms to jumping from a height. Conversely, patients with repeated suicide attempts tend to use fewer types of self-harm, primarily involving stab wounds to the extremities, wounds to the head, chest, neck, and abdomen, as well as self-poisoning. Notably, patients with repeated suicide attempts are more likely to inflict stab wounds to the extremities (forearms) (64%) and to the neck, chest, and abdomen (12%) than those with a primary suicide attempt (48% and 8%, respectively). However, no statistically significant differences were observed between the groups regarding the prevalence of specific methods of suicide (see Table 3). This may be attributed to the limited representation of rarer types of suicide attempts.

Classification by primary psychopathological disorder resulted in the following categories:

1. Affective disorders: depressive episode (F32);

2. Adjustment disorder, reaction to severe stress and adjustment disorders (F43);

3. Personality disorders: emotionally unstable type, dissocial, personality, and behavior disorder related to alcohol and psychoactive substance use (F60, F19.7);

4. Schizophrenia and other acute psychoses, schizotypal disorder (F20–F25);

5. Organic disorders of the central nervous system (F06).

Table 4 presents data on the correlation between various clinical diagnoses in individuals with primary versus repeated suicide attempts.

The group with repeated suicide attempts is diagnosed with “Adjustment Disorder” at a rate more than twice lower than that of the primary attempt group (17% and 6%, respectively). The diagnosis of “Personality Disorder” is approximately 10% more prevalent in the repeated attempt group (56% versus 46%).

However, as shown in Table 4, no statistically significant differences were identified in the prevalence of specific diagnoses between the groups with primary and repeated suicide attempts.

Table 4 – Psychopathological disorders in individuals with repeated suicide attempts and with a primary suicide attempt

Psychiatric diagnosis	Primary suicide attempt, *N* = 60	Repeated suicide attempts, *N* =59	Test; p
Affective disorders: F32	16 (27%)	18 (31%)	chi-square = 0.118; p = 0.732
Adjustment disorder: F43	10 (17%)	4 (6%)	chi-square = 2.571; p = 0.109
Schizophrenia and other acute psychoses: F20, F21	5 (8%)	4 (6%)	chi-square = 0.111; p = 0.739
Personality disorders: F60, F60.2, F19.7	28 (46%)	33 (56%)	chi-square = 0.410; p = 0.522
Organic diseases of the central nervous system: F06	1 (2%)	0 (0%)	the use of the statistical criterion is inappropriate

As can be seen from Table 5, when comparing the severity of symptoms of anxiety and depression in groups of patients with one and repeated suicide attempts according to

the Mann – Whitney criterion, there are statistically significant differences according to the Beck Depression Inventory (p = 0.044).

Table 5 – Severity of anxiety and depression symptoms in primary suicide attempt and repeated suicide attempts (Beck Depression Inventory; Beck Anxiety Inventory, Mann – Whitney criterion)

Scales	Mdn [Q1; Q2]		U Mann – Whitney	Level of significance
	Suicide in the past			
	No (*N* = 60)	Yes (*N* = 59)		
Beck Depression Inventory	9 [5; 17.5]	13.0 [5; 26]	1281.5	0.044 *
Beck Anxiety Inventory	11 [3; 20]	11.5 [3.75;27]	1452.0	0.127

Note – *significant at p < 0.05.

Table 6 provides more detailed data from the Beck Depression Inventory on the severity of depressive symptoms in the two compared groups.

Table 6 – Severity of depressive symptoms in primary suicide attempt and repeated suicide attempts (Beck Depression Inventory)

Distribution of patients according to the number of suicide attempts and depressive symptoms	Absence of depressive symptoms	Symptoms of mild depression	Symptoms of moderate depression	Symptoms of severe depression	Test; p
Primary suicide attempt (*N* = 60)	42 (70%)	5 (8.3%)	8 (13.4%)	5 (8.3%)	chi-square – 9.507; p = 0.020*
Repeated suicide attempts (*N* = 59)	28 (47.5%)	5 (8.5%)	9 (15%)	17 (29%)	

Note – *significant at p < 0.05.

The group of patients who had made repeated suicide attempts reported symptoms of severe depression nearly four times more often than patients with a primary suicide attempt (29% versus 8.3%). As shown in Table 6, patients with a primary suicide attempt more frequently reported an absence of depressive symptoms (70% versus 47.5%).

When comparing indicators using *Pearson's chi-square test*, statistically

significant differences were identified between the groups of patients who had made a primary suicide attempt and those who had made repeated attempts (chi-square = 9.507; p = 0.020).

Table 7 presents data from the Beck Anxiety Inventory regarding the severity of anxiety symptoms in two comparison groups.

As shown in Table 7, patients who have made more than one suicide attempt report a high level of anxiety slightly more often than patients with a primary suicide attempt (12% versus 3%). However, statistically significant differences in the degree of anxiety severity were not found (chi-square = 3.283; p = 0.178).

Table 7 – Severity of anxiety symptoms in primary suicide attempts and repeated suicide attempts (Beck Anxiety Inventory)

Distribution of patients according to the number of suicide attempts and anxiety symptoms	Mild level of anxiety	Moderate anxiety level	High level of anxiety	Test; p
Primary suicide attempt (*N* = 60)	46 (77%)	12 (20%)	2 (3%)	chi-square = 3.283; p = 0.178
Repeated suicide attempts (*N* = 59)	39 (66%)	13 (22%)	7 (12%)	

In both groups, a mild level of anxiety is most often identified. These indicators on the Beck Depression and Anxiety Inventories indicate an increase in psychopathological symptoms as repeated suicide attempts are made. The emergence of anxiety and depression symptoms may be a consequence of maladaptive personality traits and the absence of adaptive coping strategies, instead of which patients commit repeated suicidal acts.

Table 8 presents data on the subjective assessment of varying degrees of readiness for repeated suicide in the two groups under consideration.

As shown in Table 8, some degree of suicidal readiness (thoughts, intentions, or willingness when the opportunity arises) is almost twice as common in patients with repeated suicide attempts – 46% compared to 25% in those with a single attempt.

When comparing the indicators using *Pearson's chi-square test*, a trend-level

statistical significance was found between the groups of patients who made a primary suicide attempt and those with repeated suicide attempts regarding the severity of suicidal readiness (chi-square = 6.920; p = 0.074).

Table 8 – Presence of suicidal thoughts and intentions after the primary suicide attempt and after repeated suicide attempts (Beck Depression Inventory)

Distribution of patients depending on the number of suicide attempts and the severity of suicidal thoughts and intentions	"I have no thoughts about committing suicide"	"I have thoughts about committing suicide, but I don't do it"	"I would like to commit suicide"	"I would commit suicide if the opportunity presented itself"	Test; p
Primary suicide attempt (*N* = 60)	45 (75%)	10 (16.7%)	3 (5%)	2 (3.3%)	chi-square = 6.920; p = 0.074
Repeated suicide attempts (*N* = 59)	32 (54.2%)	13 (22.1%)	10 (16.9%)	4 (6.8%)	

Thus, suicide attempts were more often made by patients with established diagnoses of "Personality disorder" and "Affective disorders". The main types of injuries in suicide attempts were stab wounds to the extremities and self-poisoning attempts. Patients with repeated suicide attempts more often noted symptoms of depression and suicidal tendencies than patients with a primary suicide attempt, which confirms studies that the first suicide attempt is a crucial factor increasing the risk of further suicide attempts.

3.4.2. Personality Factors of Chronic Suicidal Behavior

The expression rates of maladaptive personality traits in the form of perfectionism, narcissism and dysfunctional beliefs in BPD were compared in individuals with a primary suicide attempt and repeated suicide attempts.

Table 9 shows that statistically significant differences were found in the results of the BPD dysfunctional beliefs questionnaire for the total score and for all three subscales according to the Mann – Whitney criterion.

Table 9 – Severity of maladaptive personality traits in primary suicide attempt and repeated suicide attempts (BPD Dysfunctional Beliefs Questionnaire)

Scales	Mdn [Q1; Q2]		U Mann – Whitney	Level of significance
	Suicide in the past			
	no (*N* = 60)	yes (*N* = 59)		
PBQ-BPD Total Score	17 [11.75; 24]	23 [14.75; 33.5]	1165.5	0.004 *
PBQ-BPD: "Distrust"	8 [4; 11]	10.5 [7; 14]	1181.5	0.006 *
PBQ-BPD: "Dependency"	4 [2; 5.25]	6 [2.75; 9]	1225	0.011 *
PBQ-BPD: "Protection"	4.5 [3; 8]	7 [4; 10]	1244.5	0.015 *

Note – *significant at $p < 0.05$.

Statistically significant differences between the groups of patients with primary and repeated suicide attempts were found on the scales: "Distrust", reflecting the expectation of exploitation, dishonesty, betrayal on the part of other people ($p = 0.006$); "Dependency", reflecting the idea of helplessness without constant support from other people ($p = 0.011$); "Protection", reflecting the need for preventive actions to prevent possible exploitation or rejection; also reflects the opinion of oneself as unworthy of love ($p = 0.015$). Difficulties in affect regulation, a tendency to be involved in intense relationships, experiencing perceived or real threats to relationships, expectations of betrayal or rejection, dishonesty from close people, and a tendency for impulsive termination of relationships as a preemptive measure are more pronounced in patients with repeated suicide attempts.

As can be seen from Table 10, statistically significant differences between patients with primary and repeated suicide attempts were found in the perfectionism questionnaire.

Statistically significant differences were found for both the “Total Perfectionism Score” ($p = 0.034$) and two subscales – “Concern with Evaluations” ($p = 0.001$) and “Negative Selection, Life in Comparison Mode” ($p = 0.017$). “Concern with Evaluations” in the modern typology of perfectionism corresponds to the most destructive type – socially prescribed perfectionism. Socially prescribed perfectionism includes external motivation for perfection, that is, the conviction that other people expect perfection from

an individual and the need to meet their expectations. Only the fulfillment of these impossible demands, in the individual's opinion, can guarantee acceptance, love, a sense of belonging to a group, and prevent rejection and abandonment. In the event of failure to meet these expectations, such as making mistakes, encountering difficulties, or experiencing setbacks, feelings of hopelessness and helplessness are triggered.

Table 10 – Severity of various aspects of perfectionism in primary suicide attempt and repeated suicide attempts (Three-factor perfectionism questionnaire)

Scales	Mdn [Q1; Q2]		U Mann – Whitney	Level of significance
	Suicide in the past			
	no (*N* = 60)	yes (*N* = 59)		
"Total Perfectionism Score"	36 [29; 43]	41 [30; 51]	1323	0.034 *
"Concern with Evaluations"	11 [7; 16]	15 [11; 20.25]	1097.5	0.001 *
"High Standards"	15 [12; 16]	13 [10; 16]	1373	0.064
"Negative selectivity, life in comparison mode"	10 [7; 14]	14 [7; 17.25]	1274.5	0.017 *

Note – *significant at $p < 0.05$.

The “Negative Selectivity and Life in Comparison Mode” scale reflects a fixation on one's own mistakes and a tendency to make unfavorable comparisons with the achievements of others. Patients with repeated suicide attempts are more likely to focus on their failures and imperfections. Statistically significant differences were not found in the “High Standards” subscale (self-oriented perfectionism), which aligns with other studies that question the destructiveness of this type of perfectionism (Kholmogorova A.B., Garanyan N.G., Tsatsulin T.O., 2019; Stoeber J., Madigan D.J. et al., 2020).

Thus, a recent study has proven that the indicators on the scale of high performance standards (self-oriented perfectionism) are directly and significantly related to the overall self-efficacy score, that is, high demands on oneself can be based on faith in one’s ability to cope with complex tasks and on an active, conscious position in educational activities (Tsatsulin T.O., Kholmogorova A.B., 2024).

Thus, concern about evaluations from others with unfavorable comparisons with them (socially prescribed perfectionism) and a tendency to focus on failures are personal factors in committing repeated suicide attempts. These two types of perfectionism are associated with symptoms of anxiety and depression. The High Standards scale, which describes self-oriented perfectionism, on the contrary, is associated with self-confidence and self-efficacy but has the opposite direction in individuals with repeated suicide attempts. When comparing the indicators of hypersensitive narcissism in patients with primary and repeated suicide attempts according to the Mann – Whitney criterion, statistically significant differences were revealed. The level of hypersensitive narcissism is higher in patients who have committed repeated suicide attempts compared to those who have committed a suicide attempt for the first time ($p = 0.011$) (see Table 11).

Table 11 – Severity of narcissism in primary suicide attempt and repeated suicide attempts (Hypersensitivity Narcissism Scale)

Scales	Mdn [Q1; Q2]		U Mann – Whitney	Level of significance
	Suicide in the past			
	no ($N = 60$)	yes ($N = 59$)		
Narcissism	27 [24; 32.75]	32 [26; 37]	1173.5	0.011 *

Note – *significant at $p < 0.05$.

Individuals with hypersensitive narcissism, unlike the grandiose type, tend to experience feelings of guilt and anxiety, lack of self-confidence, which interferes with the satisfaction of the need for self-realization and provokes auto-aggressive behavior. These patients more often use the strategy of suppressing emotions and more often suffer from difficulties in emotional regulation, which may be associated with a feeling of mistrust and the expectation that other people "can take advantage of the patient's emotional manifestations and weaknesses". The combination of mistrust with a feeling of self-doubt and anxiety can provoke patients to hide their emotions, not share them with others, and thus hinder their ability to ask for support.

3.4.3. Behavioral and Cognitive Factors of Chronic Suicidal Behavior

The study compared the severity of maladaptive cognitive-behavioral style in the form of rumination, alexithymia, and coping strategies in patients with primary and repeated suicide attempts using the Mann – Whitney criterion.

Statistically significant differences between the two groups were found both for the total score (p = 0.008) and for the subscales of the ruminative thinking questionnaire: “Anergy” (p = 0.002) and “Experience of loneliness” (p = 0.003) (see Table 12).

These scales reflect such phenomena as fixation of attention on one's depressive symptoms and constant thinking and experiencing of one's isolation from others. The data obtained correlate well with the concept E. Watkins, proving the destructive nature of ruminative thinking as a factor in the chronicity of depression, as well as with the concept of O'Connor R. C. on ruminative thinking as a risk factor for suicide (Miranda R., Nolen-Hoeksema S., 2007; Watkins E.R., 2009; Akimenko A.K., 2016; O'Connor R.C., Portzky G., 2018).

Table 12 – Severity of ruminations in patients after the primary suicide attempt and repeated suicide attempts (Rumination scale)

Scales	Mdn [Q1; Q2]		U Mann – Whitney	Level of significance
	Suicide in the past			
	no (*N* = 60)	yes (*N* = 59)		
Total Rumination Score	40 [32; 50.25]	51 [36; 63]	1087.000	0.008 *
Ruminations: "Anergy"	12 [9.75; 15.25]	15 [11; 21]	1026.000	0.002 *
Ruminations: "Search for global explanations"	9 [7; 12.25]	11 [8; 15.5]	1232.000	0.069
Ruminations: "Analysis"	6 [5; 7]	7 [5; 9]	1267.000	0.105
Ruminations:"Experiencing loneliness"	7 [4.5; 9]	6 [4; 7]	1033.500	0.003 *

Note – *significant at p < 0.05.

The data from the alexithymia measures, which measure the severity of the maladaptive cognitive style that contributes to emotional regulation disorders, are presented in Table 13.

Table 13 – Severity of alexithymia indicators in primary suicide attempt and repeated suicide attempts (Alexithymia Scale)

Scales	Mdn [Q1; Q2]		U Mann – Whitney	Level of significance
	Suicide in the past			
	no (*N* = 60)	yes (*N* = 59)		
Alexithymia: "DIF"	15.5 [10; 20.25]	19 [12.5; 25]	1245.000	0.022*
Alexithymia: "DDF"	11 [9; 16.25]	16 [11; 18]	1196.000	0.010*
Alexithymia: "EOT"	18.5 [14; 22]	18 [15; 21]	1631.500	0.904
Total Alexithymia Score	45.5 [36.75; 55.25]	53 [41; 63]	1260.500	0.0 28 *

Note – *significant at $p < 0.05$.

As can be seen from the above table, statistically significant differences were found between patients with primary and repeated suicide attempts according to the Mann – Whitney criterion both for the total score of the Alexithymia scale ($p = 0.028$) and for two subscales – Difficulty identifying feelings ($p = 0.002$) and Difficulty describing feelings to others ($p = 0.010$). Differences in the tendency to focus attention on external stimuli and situations rather than on internal states are not noted. Difficulties in identifying emotions and describing them to others prevail in individuals with repeated suicide attempts. They lead to the accumulation of negative emotions, disruption of emotional self-regulation and impulse control, which, in turn, increases the risk of repeated suicidal acts.

Table 14 presents the differences in the choice of behavioral coping strategies for stress in patients with single suicide attempts and chronic suicidal behavior.

As shown in the table, statistically significant differences between the groups are noted in such stress coping strategies as “Behavioral disengagement” ($p = 0.004$) and “Mental disengagement ($p = 0.006$), “Substance use” ($p = 0.033$) and “Humor” ($p = 0.030$).

These styles of coping with stress are related to the avoidance style of behavior – a strategy of denying the problem, behavioral avoidance of its solution and a strategy of focusing on negative emotions (venting emotions), which is similar to rumination.

The Humor subscale score has a significant difference between the groups, which may indicate an avoidant style of coping with stress – distancing in the form of humor, often black, instead of looking for ways to solve the problems that have arisen.

An avoidant coping style prevents the solution of problems, leads to their accumulation, a feeling of helplessness and hopelessness, which can increase the risk of repeated suicide attempts.

Table 14 – Severity of various coping strategies in patients who have made a primary suicide attempt and repeated suicide attempts (COPE Questionnaire)

Scales	Mdn [Q1; Q2]		U Mann – Whitney	Level of significance
	Suicide in the past			
	no (*N* = 60)	yes (*N* = 59)		
"Positive reinterpretation and growth"	10.5 [9; 12]	11 [9; 13]	1495.500	0.464
"Mental disengagement"	8 [10; 12]	10 [8; 11]	1147.000	0.006 *
"Focusing on and venting of emotions"	9 [6; 10.75]	10 [7.75; 11]	1334.500	0.099
"Use of instrumental social support"	10 [8; 12]	11.5 [8; 13]	1419.500	0.244
"Active coping" (active actions to overcome a stressful situation)	11 [10; 12.75]	11 [9; 12.25]	1513.500	0.528
"Denial"	7 [5; 8.75]	8 [6; [9.25]	1285.000	0.052
"Religious coping"	4 [4; 8]	4.5 [4; 8]	1594.000	0.854
"Humor"	7 [5; 9]	8 [6.75; 11]	1245.000	0.030*
"Behavioral disengagement"	6 [4; 8]	7.5 [6; 10]	1121.500	0.004 *
"Restraint"	10 [8; 11]	10 [9; 11]	1512.000	0.520
"Use of emotional social support"	11 [9; 12]	11 [9; 13]	1591.500	0.853
"Substance use"	5.5 [4; 8]	7 [4; 10]	1258.500	0.033*
"Acceptance"	10 [9; 12]	11 [9; 13]	1405.000	0.211
"Suppression of competing activities"	9 [8; 11]	9 [8; 11]	1558.500	0.707
"Planning coping"	11 [9; 12]	11 [9; 12.25]	1608.500	0.927

Note – *significant at $p < 0.05$.

3.4.4. Interpersonal Factors of Chronic Suicidal Behavior

The study compared the severity of loneliness and empathy in individuals with a primary suicide attempt and repeated suicide attempts using the Mann – Whitney criterion.

As can be seen from Table 15, statistically significant differences between the groups are noted in the Loneliness scale (p = 0.025). The level of patients' experience of loneliness and social isolation is higher in patients with repeated suicide attempts, which is confirmed by T.E. Joiner's theory of suicide, where the feeling of loneliness and thwarted belongingness are among the leading factors of suicide attempts. The feeling of loneliness, in turn, is strongly associated with social isolation and depressive symptoms. Thus, many authors describe the feeling of loneliness as a lack of social contacts or as an imaginary or real absence of close ties with significant others. With an increase in the number of suicide attempts, psychopathological symptoms may increase in the form of difficulties in building long-term relationships, the inability to ask for help and talk about one's emotions, which leads to social isolation.

Table 15 – Severity of loneliness in primary suicide attempt and repeated suicide attempts (Loneliness scale, Mann – Whitney criterion)

Scales	Mdn [Q1; Q2]		U Mann – Whitney	Level of significance
	Suicide in the past			
	no (*N* = 60)	yes (*N* = 59)		
"Loneliness"	36 [30; 45.75]	40 [33; 55]	1206.5	0.025 *

Note – *significant at p < 0.05.

As can be seen from Table 16, there were no significant differences in the Empathy scale. However, there is a tendency for significant differences in the Empathy PD scale (p = 0.072), which reflects the level of empathic distress. Patients with repeated suicide attempts have a harder time coping with the negative emotions of those around them.

This observation highlights the emotional responses elicited when perceiving another individual's feelings. These responses can either mirror the emotions of the other

person (direct empathy, experiencing the same emotions) or take the form of parallel emotions. For example, the negative emotions of others (such as pain or grief) may evoke irritation, anxiety, and a desire to withdraw from interaction, as opposed to eliciting sympathy and a desire to provide comfort or assistance. Consequently, the inability to distinguish one's emotions from those of others and to differentiate emotions is more prevalent among patients with repeated suicide attempts.

Table 16 – Expression of empathy in primary suicide attempt and repeated suicide attempts (Empathy test, Mann – Whitney criterion)

Scales	Mdn [Q1; Q2]		U Mann – Whitney	Level of significance
	Suicide in the past			
	no (*N* = 60)	yes (*N* = 59)		
"Total Empathy Score"	60 [52.75; 71]	62 [56; 73]	1505.5	0. 330
"Empathy PT"	16 [12.75; 18]	16 [12.75; 20.25]	1601.5	0.655
"Empathy FS"	15 [12; 19]	16.5 [13; 21]	1490.5	0.178
"Empathy EC"	17 [14; 21]	17.5 [14; 20]	1509	0.338
"Empathy PD"	12 [8; 15]	13 [10; 18]	1356.5	0.072

Conclusions for Section 3.4

1. Patients with primary suicide attempts exhibit a wider variety of self-harm methods. In contrast, patients with repeated suicide attempts more frequently inflict stab wounds to the extremities (forearms), as well as to the neck, chest, and abdomen. In this group, self-harm may be a persistent method of emotion regulation or coping with stress.

2. Diagnoses such as personality and affective disorders are more commonly observed in patients with both primary suicide attempts and repeated suicidal behaviors.

3. Patients who have made repeated suicide attempts report more severe depressive symptoms compared to those with a primary suicide attempt.

4. The degree of suicidal readiness (thoughts, intentions, willingness to commit suicide when an opportunity arises) is more prevalent in patients with repeated suicide attempts than in those with a primary suicide attempt. This suggests an increase in the severity of psychopathological symptoms as suicidal behavior becomes chronic.

5. Patients with chronic suicidal behavior exhibit significantly more pronounced dysfunctional personality traits, such as hypersensitive narcissism, socially prescribed perfectionism, negative selectivity, and fixation on their own imperfections. They also frequently demonstrate dysfunctional beliefs (e.g., involvement in tense relationships, experiencing perceived or actual relationship threats, impulsive termination of relationships as a preemptive measure, and feelings of helplessness without continuous support).

6. A predominantly maladaptive cognitive style and maladaptive problem-solving strategies are characteristic of patients with chronic suicidal behavior. These include rumination (a tendency to repeatedly analyze past mistakes and failures), alexithymia (difficulty in understanding, describing, and differentiating one's emotions), and avoidant coping strategies.

7. Patients with chronic suicidal behavior often experience significant dysfunctions in interpersonal relationships. These patients are more likely to feel isolated from others, and their level of empathic distress when witnessing negative emotions in others is higher compared to individuals with a primary suicide attempt.

3.5. Targets for Prevention of Repeated Suicide Attempts

Preventing chronic suicidal behavior is one of the most challenging areas of medical, psychological, and social assistance (Semke V.Ya., 1988; Polozhiy B.S., 2010). The timely identification, thorough understanding, and systematization of numerous factors contributing to suicidal behavior are essential for developing adequate and targeted prevention strategies, as well as preventing repeated suicide attempts and the chronicity of such behavior. Based on the bio-psycho-social model of affective spectrum disorders, the following targets for medical, social, and psychological assistance for patients after repeated suicide attempts can be identified: sociodemographic, clinical, and psychological targets (Kholmogorova A.B., 2002).

Currently, most patients hospitalized in emergency settings following an initial suicide attempt do not have access to comprehensive medical, social, and psychological care. After discharge, these patients often remain without proper attention or follow-up,

either due to a lack of knowledge, unwillingness, or fear of seeking help from state psychiatric institutions. As a result, these individuals frequently go without assistance, increasing the risk of repeated suicidal behavior and chronicity (Zubareva O.V., Chernaya M.I., Leonova P.V., 2014).

Findings indicate that special attention should be given to patients with secondary and vocational education, the unemployed, individuals in difficult living situations, those with addictions, and both men and women of working age. The objectives of working with these patients may include increasing psychoeducation, reducing the stigma associated with suicidal behavior, and normalizing help-seeking behavior for psychological and psychiatric support. For instance, "health festivals" and open days in clinics, where psychologists and psychiatrists provide information on treatment options and mental health prevention, are becoming more common.

The clinical target for preventing the chronicity of suicidal behavior involves creating multidisciplinary teams in psychiatric, addiction, and surgical departments to manage patients with diagnoses such as personality disorders (particularly BPD), affective disorders (particularly bipolar disorder), and comorbid conditions (Korobaynikov I.A., Babkina N.V., 2017; Fesenko Yu.A., Kholmogorova A.B., 2017; Subotic M.I., Rakhmanina A.A., Roy A.P. et al., 2018; Prokhorov A.S., Krivoklyakina A.V., Subotic M.I. et al., 2019). Particular attention should be given to patients after a suicide attempt or those with a history of suicide attempts and self-harm (regardless of the time elapsed since the incident). It is vital for such teams to include a surgeon, psychiatrist, and psychologist. For suicide risk screening, tools such as A.T. Beck's Depression and Anxiety Inventories and the PBQ-BPD scale (for identifying BPD symptoms) should be used. A comprehensive treatment approach helps patients better understand and adapt to their condition and plan rehabilitation paths after hospital discharge. Psychoeducation that explains the causes of suicidal behavior, the patient's history of mental disorders (if applicable), and potential ways for future support can significantly reduce the risk of chronic suicidal behavior and rehospitalization.

The psychological target for preventing the chronicity of suicidal behavior emphasizes careful attention to patients with a history of suicide attempts or self-harm,

interpersonal communication difficulties (e.g., conflicts within family or partnerships), and traumatic past experiences (e.g., abusive relationships). Maladaptive personality traits, such as perfectionism, narcissism, impulsivity, and difficulties establishing trust, often serve as significant predictors of chronic suicidal behavior. Psychotherapy aimed at preventing repeated attempts should address the severity of ruminative thinking, alexithymia, maladaptive coping strategies (such as avoidance), experiences of loneliness, and social maladjustment.

Cognitive-behavioral therapy (CBT) is currently employed to prevent suicide, developed to reduce the risk and prevent relapse, and theoretically based on CBT and dialectical behavior therapy (DBT) principles.

The identified areas for psychological assistance can be implemented in the following formats

1. Individual psychological work with patients after primary and repeated suicide attempts (or self-harm episodes), considering all the identified risk factors for repeated attempts.

2. Group psychological work with patients post-primary and repeated suicide attempts (or self-harm episodes). This work should incorporate M. Linehan’s skills training, which focuses on emotional regulation, adaptive problem-solving, distress tolerance, and enhancing interpersonal skills.

3. Engagement with the immediate environment of patients post-primary and repeated suicide attempts (or self-harm episodes). This includes respectful interaction among medical professionals (e.g., surgeons, psychiatrists) and patients' relatives, as well as organizing individual and group sessions for relatives of patients who have attempted suicide. The DBT-based "Family Connections" model, which involves psychoeducation and the development of validation and interpersonal communication skills, can be utilized as a reference.

Thus, the integration of individual psychological consultations, psychoeducation, and DBT and CBT skills training in emergency and psychiatric hospitals, along with support groups for the relatives of suicide victims, are critical preventive measures for mitigating the chronicity of suicidal behavior.

DISCUSSION

Through the analysis of existing theoretical and empirical data, chronic suicidal behavior can be defined as persistent, recurring self-injurious actions that function as coping mechanisms for affect and intense negative emotions (such as sadness, loneliness, anger, dissatisfaction with oneself, self-abasement). These behaviors arise due to deficits in stress processing skills and emotional self-regulation, as well as a lack of experience with secure attachment within the family and social support. The study of factors contributing to the chronicity of suicidal behavior was based on a multifactorial psychosocial model of affective spectrum disorders. This model includes macrosocial, personality, family, and interpersonal factors (Kholmogorova A.B., Garanyan N.G., 1998; Kholmogorova A.B. et al., 2010; Kholmogorova A.B., 2011).

In this work, sociodemographic and macrosocial factors included gender, age, education, place of residence, social status, religiosity, and accessibility to psychological help.

Clinical factors included the presence of psychiatric diagnoses, levels of anxiety and depression, and suicidal readiness (the presence of suicidal thoughts and intentions).

Psychological factors encompassed maladaptive personality traits such as borderline personality characteristics, narcissism, and perfectionism, as well as a maladaptive cognitive style marked by alexithymia and ruminative thinking, maladaptive coping strategies, and interpersonal difficulties such as experiencing loneliness and empathic distress.

Two groups of patients were studied to investigate these factors: 1) those with a primary suicide attempt; 2) those with repeated suicide attempts.

The study yielded the following results regarding the factors of chronic suicidal behavior.

1. Sociodemographic characteristics and specifics of suicide attempts in patients with chronic suicidal behavior

Based on clinical interviews, questionnaires, and analysis of the medical histories of 119 patients with suicide attempts, it was found that the majority of those examined

were women (55% with primary suicide attempts, 71% with repeated attempts), while men accounted for 45% with primary suicide attempts and 29% with repeated attempts. When comparing the gender ratio of men and women with primary and repeated suicide attempts using the Pearson chi-square test, differences at the trend level were identified between the groups of patients who had made a primary and repeated suicide attempt (chi-square = 3.412; p = 0.065). There are differing opinions regarding the gender distribution of individuals with suicide attempts; some authors report no significant differences between men and women in the frequency of suicide attempts (Qin P. et al., 2000; Leske S. et al., 2020). Other researchers consider female gender a risk factor for suicide attempts (Michaud L. et al., 2021). It should be noted that these discrepancies may arise due to men seeking help less frequently (Leske S. et al., 2020). For the same reason, men are less likely to receive treatment, which can lead to the chronicity of mental disorders and suicidal behavior (Docherty A.R. et al., 2020). It is also important to note that men are more likely to carry out completed suicide attempts using more violent methods (Fehling K.B., Selby E.A., 2021). However, women and young men are more prone to repeated and non-lethal suicide attempts (Michaud L. et al., 2021). This may be attributed to women’s higher tendency to inflict non-lethal injuries.

No significant age differences were found between the samples with primary and repeated suicide attempts when comparing using Fisher's exact chi-square test (chi-square = 3.890; p = 0.274). However, numerous studies indicate that working-age individuals more frequently engage in repeated suicide attempts (McDaid D. et al., 2019; Subotich M.I., Kholmogorova A.B., 2023). Single and completed suicide attempts are predominantly committed by older individuals (Hawton K. et al., 2015; Soloviev A.G. et al., 2016). The data obtained highlight the necessity of considering not only the psychological and demographic aspects of this issue but also analyzing it as a factor that results in significant economic damage due to early mortality and the loss of productive years of life (Lyubov E.B. et al., 2012).

Patients with a first suicide attempt are more likely to have higher education compared to those with repeated suicide attempts (30% versus 16%). However, no statistically significant differences were found between the groups of patients who had a

primary or repeated suicide attempts in terms of education level (chi-square = 2.137; p = 0.144). The unemployment rate is almost identical for patients who made primary and repeated suicide attempts, constituting 61% of the total sample. No statistically significant differences were found between the groups regarding employment level (chi-square = 0.006; p = 0.939). These findings align with numerous studies demonstrating that low income and unemployment are risk factors for repeated suicide attempts (Crowell S.E. et al., 2009; Chernaya M.I. et al., 2016). Higher education may serve as a protective factor against suicidal behavior, partly due to its association with increased income (Oexle N. et al., 2018). Thus, the necessity of paying special attention to individuals living in adverse conditions, with low income, and limited access to education in order to prevent the chronicity of suicidal behavior is reaffirmed (Mashreky S.R. et al., 2013; McDaid D. et al., 2019; Subotich M.I., 2023).

In both patient groups, the number of individuals who are single or divorced (70% and 80%) exceeds the number of those who are married (30% and 20%), although no significant differences were found between the two samples (chi-square = 0.803; p = 0.370). These findings are supported by authors such as O'Connor, E.D. Klonsky, and T.E. Joiner, who emphasize the significance of thwarted interpersonal needs: feelings of abandonment and perceiving oneself as a burden, as well as acquired capability for suicide or fearlessness about death (Joiner T.E., 2005; Klonsky E.D. et al., 2018; O'Connor R.C., Kirtley O.J., 2018; O'Connor R.C., Portzky G., 2018; Bannikov G.S. et al., 2020).

Therefore, individuals with chronic suicidal behavior are more likely to have low income and lack higher education. They are often women who engage in suicide attempts using less violent methods compared to men (e.g., self-inflicted cuts on the forearms or self-poisoning).

2. Study of clinical and psychological factors of chronic suicidal behavior

Clinical Factors of Chronic Suicidal Behavior

In the groups of patients with primary and repeated suicide attempts, the diagnosis of affective disorders (F32, 27% and 31%) was observed with similar frequency. Patients

with a primary suicide attempt more frequently reported the absence of depressive symptoms compared to patients with repeated suicide attempts (70% versus 47.5%). Statistically significant differences were found between the groups of patients who had made a primary suicide attempt and those with repeated attempts (chi-square = 9.507; p = 0.020). Various degrees of suicidal readiness (thoughts, intentions, willingness when an opportunity arises) were almost twice as common in patients with repeated suicide attempts—22% versus 13% in cases of a single attempt. At the trend level, statistically significant differences were noted between the groups of patients who had made primary and repeated suicide attempts in terms of the severity of suicidal readiness (chi-square = 6.920; p = 0.074).

These findings align with numerous studies indicating that individuals with mood disorders are at the highest risk of suicide attempts, including repeated attempts (Qin P. et al., 2000; Kholmogorova A.B., 2016). However, the method of suicide also varies depending on the severity of the mental disorder and its comorbidity with other conditions.

The diagnosis of "Personality Disorder" (46% and 56%) was more frequently noted in the group with primary and repeated suicide attempts. Personality disorder is also an important predictor of suicidal behavior and, unlike depression, is particularly associated with repeated suicide attempts. These findings are consistent with studies showing that patients with affective disorders (F32) comorbid with personality disorders (F60) had a lower risk of completed suicides compared to patients with schizophrenia (F20–F29) and bipolar disorder (F31). However, their risk of suicide was still significantly higher than that of patients with depression without personality disorders (Runeson B. et al., 2016).

The results of this study suggest that a lack of stress-coping skills, combined with personality traits of individuals attempting suicide (such as difficulties in building trusting relationships, distrust, perfectionism, and an avoidant problem-solving style), can lead to the chronicity of suicidal behavior and contribute to an increase in depressive and anxiety symptoms (Chernaya M.I. et al., 2016).

Psychological factors of chronic suicidal behavior

For the study, psychological factors were divided into three blocks: personality,

cognitive-behavioral, and interpersonal.

In examining *personality factors*, the focus was on maladaptive personality traits, specifically perfectionism, narcissism, and dysfunctional beliefs. These indicators were compared between patients with primary suicide attempts and those with repeated attempts using the Mann – Whitney test.

Individuals with repeated suicide attempts displayed more pronounced maladaptive personality traits and beliefs. Statistically significant differences were found in the Personality Belief Questionnaire for BPD across subscales: "Mistrust", reflecting expectations of exploitation, dishonesty, and betrayal by others ($p = 0.006$); "Dependence", reflecting the perception of helplessness without continuous support from others and difficulty in controlling emotions ($p = 0.011$); "Protection", involving the belief in the necessity of precautionary actions to prevent potential exploitation or rejection, and viewing oneself as unworthy of love ($p = 0.015$). Individuals with repeated suicide attempts often face interpersonal communication challenges due to a fear of betrayal, on the one hand, and a sense of dependence and inability to manage their emotional experiences and difficulties on the other. These patients are more likely to impulsively end relationships when experiencing perceived or real threats of partner betrayal. Such traits align with those seen in personality disorders, as corroborated by M. Linehan’s research, which indicates that repeated suicide attempts are characteristic of individuals with BPD (Linehan M.M. et al., 2000; Colle L. et al., 2020).

The level of perfectionism is also higher among individuals with repeated suicide attempts.

Patients exhibiting socially prescribed perfectionism believe that others impose standards that must be met to receive love (Garanyan N.G. et al., 2001; Kholmogorova A.B., 2011; O’Connor R.C., Portzky G., 2018). The findings align with M. Linehan’s theory of an invalidating environment in which patients with personality disorders grow up (Linehan M.M., 1993). A key characteristic of such an environment is an excessive focus on personal achievements within the family, combined with suppression of one's emotions and an inability to make demands on those around them. The study found that individuals with repeated suicide attempts demonstrated a more

pronounced perfectionistic cognitive style. The Mann – Whitney test revealed statistically significant differences in the Perfectionism Questionnaire, both in the "Total Perfectionism Score" ($p = 0.034$) and in the subscales "Concern with Evaluations" ($p = 0.001$) and "Negative Selectivity, Life in Comparison Mode" ($p = 0.017$). These patients tend to focus on their own mistakes and perceived imperfections more frequently. This fixation on one's imperfections and unfavorable comparisons may serve as personality factors that contribute to rumination, which, in turn, hinder adaptive problem-solving methods and increase the risk of depression (Watkins E.R. et al., 2007; Kholmogorova A.B., 2011; Pugovkina O.D. et al., 2021).

Individuals with repeated suicide attempts exhibit more pronounced traits of hypersensitive narcissism. A comparison between patients with primary and repeated suicide attempts in terms of narcissism levels revealed statistically significant differences ($p = 0.011$). Unlike the grandiose type, individuals with hypersensitive narcissism tend to experience guilt, anxiety, and self-doubt, which hinder their ability to achieve self-fulfillment and provoke self-aggressive behavior. Hypersensitive narcissism also involves suppressing emotions, distrust of others, and feelings of insecurity. Thus, suicide attempts in individuals with traits of hypersensitive narcissism may not necessarily be associated with depression (Links P.S., 2013). Intense feelings of shame, a sense of not meeting perceived or actual standards, and feelings of inadequacy are primary causes of suicide attempts (Gabbard G.O., 2022).

In examining the cognitive factors contributing to the chronicity of suicide attempts, particular attention was given to patients' tendency toward a ruminative thinking style, alexithymia, and maladaptive stress coping strategies. These indicators were compared between patients with primary and repeated suicide attempts using the Mann – Whitney criterion.

Statistically significant differences were found between the two groups in terms of both the overall score ($p = 0.008$) and the subscales of the Ruminative Thinking Questionnaire: "Anergy" ($p = 0.002$) and "Experiencing Loneliness" ($p = 0.003$). Patients with repeated suicide attempts showed a greater propensity for ruminative thinking, a factor reflected in contemporary theories of suicide (Watkins E.R. et al., 2007;

Klonsky E.D. et al., 2018). O'Connor, in his theory, identifies rumination as a catalyst for suicidal behavior during the second, motivational phase, where it leads to a fixation on negative events or circumstances from the initial pre-motivational phase, such as failure or negative emotions (O'Connor R.C., Kirtley O.J., 2018). A.T. Beck also emphasized ruminative thinking, which triggers feelings of hopelessness and the perception of an inescapable situation, ultimately resulting in a suicide attempt (Beck A.T. et al., 1993). Ruminative thinking is often seen as a behavior that hinders adaptive stress coping and problem-solving.

Maladaptive stress coping strategies were also more pronounced in patients with repeated suicide attempts. These patients exhibited strategies such as denial, behavioral disengagement, and focusing on negative emotions (emotional venting), similar to rumination. Statistically significant differences between the groups were noted in strategies such as "Behavioral Disengagement" ($p = 0.004$), "Mental Disengagement" ($p = 0.006$), "Substance Use" ($p = 0.033$), and "Use of Humor" ($p = 0.030$). The use of distancing through humor, often dark, instead of seeking solutions to problems, was also characteristic of individuals with repeated suicide attempts. A disengagement coping style impedes problem resolution, leads to the accumulation of problems, and fosters feelings of helplessness and hopelessness, thereby increasing suicide risk (Sirota N.A., Yaltonsky V.M., 2003; Luneva P.D., Ababkov V.A., 2023).

Alexithymia, characterized by difficulties in recognizing one's emotions and understanding oneself, is an important factor in emotional dysregulation. Statistically significant differences were found both in the overall score on the "Alexithymia" scale ($p = 0.028$) and in two subscales: "Difficulty Identifying Feelings" ($p = 0.002$) and "Difficulty Describing Feelings to Others" ($p = 0.010$). Patients with repeated suicide attempts showed higher levels of alexithymia. These patients tend to suppress or repress emotions, which increases the risk of emotional outbursts and the release of negative feelings. It is often at the peak of emotional distress that repeated suicide attempts are made as a means to alleviate accumulated psychological pain and achieve emotional regulation (Linehan M.M., 1993; Moskacheva M.A. et al., 2014).

In the study of interpersonal factors, feelings of loneliness and levels of empathy

were examined. These indicators were compared between patients with primary and repeated suicide attempts using the Mann – Whitney test.

The experience of loneliness and social isolation was found to be higher among patients with repeated suicide attempts ($p = 0.025$). These findings support T.E. Joiner's suicide theory, in which feelings of loneliness and "thwarted belongingness" are identified as significant factors contributing to suicide attempts (Joiner T.E., 2005; Syrokvashina K.V., 2017). The feeling of loneliness is closely linked to social isolation and depressive symptoms. Causes of loneliness may include maladaptive personality traits, such as distrust, expectations of mistreatment or cruelty from others, and dependency. These traits often hinder self-disclosure, seeking support, and forming strong, reliable relationships.

A trend towards significant differences was found on the "Empathy PD" scale ($p = 0.072$), which reflects the level of empathic distress. Empathic distress is closely related to alexithymia and difficulties in recognizing one's emotions, self-reflection, and understanding the emotions of both the patient and their interlocutor. These results align with a study by Chinese researchers, which noted that low empathy levels and weak social skills are significant predictors of suicidal ideation in male adolescents (Kwok S.L., Shek D.T., 2010). Thus, constant stress experienced during social interactions and the inability to provide support to others may lead to avoidance of relationship-building and contribute to the development of loneliness.

CONCLUSION

The study aimed to examine the factors of suicidal behavior and its chronicity based on a multifactorial psychosocial model of affective spectrum disorders, incorporating sociodemographic, clinical, and psychological factors. These factors were compared between patients with a primary suicide attempt and those with repeated suicide attempts. Clinical factors considered included the presence of psychiatric diagnoses, clinically significant levels of anxiety and depression, and suicidal readiness (thoughts and intentions). Psychological factors analyzed included maladaptive personality traits such as borderline characteristics, narcissism, and perfectionism; a maladaptive cognitive style characterized by pronounced alexithymia and ruminative thinking; maladaptive coping strategies; and interpersonal difficulties such as experiences of loneliness and empathic distress.

The study's findings support the main hypothesis that serious mental disorders (personality disorders and affective spectrum disorders), greater severity of maladaptive personality traits, avoidance-based behavioral coping strategies, alexithymia, ruminative thinking, significant anxiety and depression symptoms, signs of social maladaptation, and a lack of social support are more prevalent in patients with chronic suicidal behavior compared to those with a single suicide attempt.

The results indicate the necessity of implementing an initial stage of rehabilitation for individuals who have attempted suicide during their stay in emergency hospitals, following primary or repeated suicide attempts. It is crucial to integrate psychologists and psychiatrists into emergency hospital departments where such patients are treated. Early-stage interventions should include group and individual therapy based on CBT and DBT methods (such as crisis plan development, emotional regulation skills training, and active coping strategies). Additionally, motivating patients and planning further referral pathways for continued medical, psychological, and social support are essential.

SUMMARY

Suicidal behavior and the risk of its chronicity are multifactorial constructs; however, there is a lack of comprehensive studies on the factors contributing to the chronicity of suicidal behavior. Various studies and models highlight the importance of biological predisposition to suicidal behavior, as well as sociodemographic factors (gender, age, employment, marital status), clinical factors (diagnosis, severity of psychopathological symptoms), and psychological factors (maladaptive personality traits, dysfunctional cognitive style, and difficulties in interpersonal relationships) in the chronicity of suicidal behavior.

A comprehensive study of the factors contributing to the chronicity of suicidal behavior, based on a multifactorial psychosocial model of affective spectrum disorders, identified gender differences between patients with single and repeated suicide attempts, with women being more frequently represented. The majority of patients with both primary and repeated suicide attempts were socially maladjusted: unemployed, unmarried, or divorced.

The comprehensive study of factors contributing to the chronicity of suicidal behavior, based on a multifactorial psychosocial model of affective spectrum disorders, identified differences in several clinical factors between patients with single and repeated suicide attempts. It was shown that patients with repeated suicide attempts more frequently reported symptoms of depression and were almost twice as likely to indicate some degree of suicidal readiness (thoughts, intentions, readiness to commit suicide when given the opportunity) compared to patients with single suicide attempts. It was also found that most patients with both primary and repeated suicide attempts suffer from personality and affective disorders and engage in repeated self-harm, such as self-inflicted cuts and poisonings. A small number of patients with a primary suicide attempt had other types of physical trauma (jumping from a height, gunshot wounds, self-harm by flame, asphyxia, etc.).

The comprehensive study of factors contributing to the chronicity of suicidal behavior, based on a multifactorial psychosocial model of affective spectrum disorders,

identified differences in several psychological factors between patients with single and repeated suicide attempts. It was shown that patients with repeated suicide attempts more frequently exhibit:

– maladaptive personality traits (hypersensitive narcissism and socially prescribed perfectionism), the presence of dysfunctional beliefs, and traits characteristic of borderline personality disorder (dependency, hostility, impulsivity).

– maladaptive cognitive and behavioral coping strategies (perfectionistic cognitive style, ruminations characterized by a tendency to constantly revisit past mistakes and failures, alexithymia leading to difficulties in emotional self-regulation, and destructive disengagement strategies such as avoidance of problem-solving and venting of emotions).

– disruptions in interpersonal connections in the form of feelings of isolation and loneliness, combined with a tendency to experience heightened empathic distress when confronted with others' negative emotions, which can lead to avoidance of social interactions.

RECOMMENDATIONS

The obtained results allow for developing recommendations for providing comprehensive psychological assistance to patients following primary and repeated suicide attempts within emergency hospital settings, aimed at initial patient rehabilitation and prevention of repeated suicide attempts:

– psychoeducation aimed at improving the understanding of one’s illness and psychological characteristics, with particular attention given to patients with lower levels of education, the unemployed, those in difficult living conditions, and individuals suffering from alcohol and substance dependence, to prevent the chronicity of suicidal behavior.

– individual counseling focused on developing a crisis plan (CBT, DBT), which includes information, psychoeducation ("a list of organizations and specialists for assistance"), the development of emotional self-regulation skills, and constructive stress-coping strategies (Linehan M.M. et al., 2000).

– individual work using Novel Brief Therapy for patients who have attempted suicide. This type of therapy incorporates elements of narrative psychotherapy, where initial sessions involve the client recounting their suicide attempt story, completing homework assignments, reviewing video recordings during the next session, and discussing reasons for living. The final session is dedicated to developing a crisis plan and stress-coping strategies. Importantly, patients receive supportive letters from the therapist following the completion of the three sessions (Gysin-Maillart A. et al., 2016; Teismann T., Gysin-Maillart A., 2022).

– group training sessions based on DBT programs, aimed at developing emotional self-regulation and interpersonal effectiveness.

– group work with the relatives of patients after primary and repeated suicide attempts, using the "Family Connection" program, focused on psychoeducation and support for relatives.

– regular case reviews of suicides, including chronic forms, conducted by a multidisciplinary team involving a psychologist, toxicologists, surgeons, and psychiatrists, to develop a unified strategy for managing patients during their initial rehabilitation stage in emergency hospital settings.

LIST OF ABBREVIATIONS AND SYMBOLS

BAR	– Bipolar Affective Disorder
WHO	– World Health Organization
DBT	– Dialectical Behavior Therapy
CBT	– Cognitive Behavioral Therapy
ICD-10	– International Classification of Diseases, 10th Revision
PAS	– Psychoactive Substances
BPD	– Borderline Personality Disorder
DIF	– Difficulty Identifying Feelings
DDF	– Difficulty Describing Feelings to Others
CNS	– Central Nervous System
COPE	– Coping Orientation to Problems Experienced Inventory
EC	– Empathic Concern
FS	– Fantasy
PBQ-BPD	– Personality Belief Questionnaire – Borderline Personality Disorder
PD	– Personal Distress
PT	– Perspective Taking
TAS-20	– Toronto Alexithymia Scale

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ILLUSTRATIONS