Psychiatr. Pol. 2019; 53(4): 883–899
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/89795

Neurotic personality traits and associated dysfunctional attitudes as factors predisposing patients to suicidal ideations at the end of intensive psychotherapy

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Summary

Aim. To determine the relationships between personality traits typical for neurotic disorders and dysfunctional attitudes declared by patients without suicidal ideations (SI) prior to treatment and SI at the end of an intensive psychotherapy with a predominant psychodynamic approach in the day hospital for neurotic, behavioral, or personality disorders.

Material and method. *KO "O" Symptom Checklist* for assessing SI, *Neurotic Personality Questionnaire* KON-2006 for evaluation of neurotic personality characteristics and patients' attitudes, and a *Life Questionnaire*, all completed by a group of 680 patients of a day psychotherapy ward, treated for the first time. Statistical analysis encompassed 466 non-SI patients, 4% of whom had SI at the end of treatment.

Results. A number of attitudes have been identified in patients who were significantly predisposed to SI at the end of intensive psychotherapy: physical aggression towards relatives ($p < 0.001$), grandiose fantasies ($p = 0.043$), resignation tendencies ($p = 0.022$), resignation feeling associated with the experience of loss of life opportunities ($p = 0.037$), and being guided mainly by intuition ($p = 0.035$). It was also observed that declaring certain attitudes was significantly associated with less than average chance of SI at the end of treatment.

Conclusions. In patients who declared these attitudes, there was a higher risk of SI at the end of the psychotherapy cycle than in the remaining patients (10–30% vs. 4%), which indicates the presence of specific dysfunctions of personality, in the case of which intensive psychotherapeutic work requires particular caution – it can trigger emotional stress leading to SI instances. It can be assumed that SI are the result of the reconstruction of defense mechanisms while working on insight, confrontation with the causes and consequences of the patients' own physical aggression towards the loved ones, the realization of the size of their grandiose thinking and the insight into its function, and the insight into the causes of resignation attitudes.

Key words: suicidal ideations, personality, psychotherapy

Introduction

Suicidal ideations (SI), suicidal behaviors (SB) and suicide attempts (SA) are elements of psychopathology of many psychiatric disorders, including anxiety, mood and personality disorders [1]. Meta-analysis results show that neurotic disorders and trait anxiety are independent predictors of suicidal ideations and attempts [2]. In turn, the primary and causal form of treatment for neurotic, behavioral and personality disorders is psychotherapy, which in the vast majority of cases leads to the reduction and elimination of SI in patients with these disorders [3–6].

Psychotherapy is based on the therapeutic alliance and the therapeutic relationship associated with it [7]. The basic goals of psychotherapy are to remove the symptoms and to modify the functioning of the personality that is responsible for disorders of experiencing and behavior [8, 9]. In a psychodynamic approach, psychotherapy is aimed at gaining insight, understanding of one's internal conflicts, expressed by the symptoms of unconscious content of experiences, access to which is protected by defense mechanisms. This requires recognizing the relationships between certain attitudes, behaviors, the way they are interpreted, and the associated emotional states [10, 11]. Defense mechanisms are responsible for distortions of mental and perceptual processes that allow patients to protect themselves from excessive anxiety and to preserve the integrity of their own 'self' [12]. Depending on the extent to which defense mechanisms lead to these distortions, they are categorized by distinguishing mature, neurotic and immature mechanisms [13–15]. Reconstruction of these mechanisms responsible for significant distortions of cognitive and perceptual processes and replacing them with more mature defense mechanisms are among the goals of psychotherapeutic treatment. Through analysis stimulated by interventions, immature or dysfunctional defense mechanisms are to be transformed into mechanisms that are more mature and functional.

Confrontation of patients with previously unaware experiences leads to the withdrawal of neurotic symptoms, although treatment may also be a cause of clinically significant transient mental fluctuations including affect changes, increased anxiety, frustration or anger [16]. According to psychodynamic concept, transient symptomatic worsening in a patient may be associated with regression, i.e., a return to mental functioning appropriate to the early stages of development upon which the development of the individual has been inhibited. As a consequence, in patients with regression occurs reduction of tolerance to emotional tension and stress, increased psychopathological symptoms, and new symptoms appear, including SI [17]. Behavioral psychotherapists, in turn, understand the transient worsening in psychotherapy as an increase in anxiety in response to exposure to specific stressors followed by blunting [16]. Regardless of the psychotherapeutic approach and its associated theories, the transient discomfort and emotional tension of patients initiated by psychotherapeutic interventions, and consequently – periodic symptomatic

worsening, in most cases appear to be inevitable steps towards better functioning or some kind of maturity [18].

In the studies on the adverse effects of using various treatments for mental disorders, one of the effects is the occurrence of SI in individuals who were not burdened with them before treatment. There have been many reports of SI occurrence with the use of antidepressants [19–22]. Also SI have been reported as undesirable consequences of nonpharmacological therapy [23, 24]. It is estimated that deterioration occurs in 5–10% of patients treated with various psychotherapeutic methods [18, 25, 26]. From numerous reports, it is well known that initial high levels of psychiatric disturbances are an important factor for increasing the risk of adverse changes in psychotherapy, including the increased risk of SI. Adverse effects in this respect are attributed, among others, to deficits in interpersonal skills, tendencies to accept negative roles in the group, and resistance to 'self-disclosure' in the course of psychotherapy, as well as excessive, unrealistic expectations of psychotherapy [27].

In the study on undesirable consequences of psychotherapy in various modalities, including psychodynamic and cognitive behavioral approaches, it was demonstrated that, during psychotherapy, in patients with different diagnoses (e.g., anxiety disorders, depression, and personality disorders) SI appeared for the first in 14.9% of patients [28]. In another study, the first episode of SI in the course of outpatient treatment for depression was reported in 10.9% of patients during a 6-month follow-up. The appearance of SI in these patients correlated positively with a higher level of pre-treatment anxiety and higher depression after 6 months of treatment [29]. Nevertheless, it is assumed that the changes occurring in patients under psychotherapy are complex and unequal in different areas of functioning, and consequently, in most cases, the appearance of SI cannot be attributed to the failure of psychotherapy [27].

According to studies on patients initiating intensive psychotherapeutic treatment for neurotic, behavioral or personality disorders, the prevalence of SI may reach as much as 30% [6]. Moreover, the SI patients in this group, compared to non-SI patients, were characterized by a higher level of overall neurotic symptoms and a higher level of personality disorder [30]. A detailed analysis of this patient population has also revealed many links between the chances of reducing the initial SI presence and the presented symptoms and personality traits of patients [31]. Meanwhile, there is a lack of empirical research on patients who starting the therapy were not burdened with SI and revealed them after psychotherapeutic treatment. Literature available to the authors provides no guidance that would identify patients with high risk of SI after psychotherapy.

In response to this clinical problem and suggesting current views on SI etiology, it is assumed that an important role in the pathomechanisms responsible for SI in patients with behavioral, neurotic and personality disorders may be their personality traits and dysfunctional attitudes. It has been assumed that the analysis of the role of these factors

will expand the current knowledge of the adverse effects of psychotherapy to which SI belongs, and will facilitate the early predictions of the patients who may be prone in clinical practice. Consequently, the authors have adopted the intention to determine which personality traits or dysfunctional attitudes are important predictors of SI after psychotherapy in patients with behavioral, neurotic and personality disorders who have not previously reported SI.

Aim

The purpose of this study was to determine the relationships between personality traits typical for neurotic disorders and dysfunctional attitudes declared by patients without SI prior to treatment and SI at the end of an intensive psychotherapy session with a predominant psychodynamic approach in the day hospital due to neurotic, behavioral or personality disorders.

Material and method

Studied group

A total of 680 patients were included in the study: 473 women and 207 men treated in the Day Hospital for Treatment of Neurotic and Behavioral Disorders, Department of Psychotherapy, University Hospital, Krakow, 2005–2013. The primary source of sociodemographic data was *the Life Questionnaire* completed by patients at the qualification stage for treatment. Table 1 presents complete sociodemographic data concerning gender and age, marital status is presented in Table 2, education – in Table 3 and source of income – in Table 4. The mean age of the surveyed women was 29.9 years and men – 30.4 years. Women accounted for over 70% of the studied population.

Table 1. **Age of the patients**

Gender	Women	Men
Number	461	219
Mean ± standard deviation	29.9 ± 8.1 years	30.4 ± 7.4 years
Median	27,4 years	29.0 years
Minimum – maximum	18.2 – 57.1 years	18.9 – 55.6 years

Table 2. **Marital status**

Specification	Women		Men	
	Number	Percentage	Number	Percentage
Unmarried	288	62.5%	140	63.9%

table continued on the next page

Married	145	31.5%	69	31.5%
Separation	5	1.1%	2	0.9%
Divorced	20	4.3%	7	3.2%
Widow/widower	3	0.7%	1	0.5%

Table 3. **Education**

Specification	Women		Men	
	Number	Percentage	Number	Percentage
Primary education	2	0.4%	0	0.0%
Incomplete secondary education	6	1.3%	6	2.7%
Complete secondary education	112	24.3%	53	24.2%
Incomplete undergraduate or postgraduate education	23	5.0%	8	3.7%
Bachelor's or collage degree	41	8.9%	16	7.3%
Incomplete higher education	72	15.6%	33	15.1%
Completed higher education	205	44.5%	103	47.0%

Table 4. **Source of income**

Specification	Women		Men	
	Number	Percentage	Number	Percentage
Supported by a family/student	135	29.3%	50	22.8%
White collar worker	157	34.1%	72	32.9%
Service worker/craftsman	31	6.7%	17	7.8%
Laborer	3	0.7%	3	1.4%
Farmer	3	0.7%	0	0.0%
Own company, family business	18	3.9%	22	10.0%
Unemployed	60	13.0%	28	12.8%
Rent	5	1.1%	2	0.9%
Pension	1	0.2%	1	0.5%
Other	48	10.4%	24	11.0%

Research tools and qualification for treatment

The procedure of qualifying a patient for treatment in a day psychotherapeutic ward included at least two psychiatric examinations, psychological tests and suicide risk evaluation as well as exclusion of other psychiatric disorders, including affective disorders, schizophrenic psychoses, exogenous or pseudo neurotic disorders as well as

severe somatic disorders that prevent the use of psychotherapy in the ward. All patients were diagnosed according to ICD-10 within the categories F40 to F61. Outpatient consultation usually lasted 2–3 weeks. From the end of the qualification to the start of treatment in the ward, it usually took between 4 and 12 weeks

Neurotic personality traits and related dysfunctional attitudes were investigated using *the Neurotic Personality Questionnaire* KON-2006. It allows to calculate the XKON coefficient that describes the global severity of neurotic personality traits. It comprises of 24 scales reflecting the intensity of the individual characteristics of neurotic personality. Values of these scales are calculated on the basis of 243 statements, each of which can be assessed by the patient as true or false. These declarations – referring to the individual statements contained in the questionnaire – were used to evaluate dysfunctional attitudes related to neurotic personality traits [32].

The second key tool used in this study was *the Symptom Checklist "O"* (KO "O"). It covers a wide variety of symptoms of neurotic disorders and gives the opportunity to evaluate the changes in the severity of symptoms in the course of psychotherapy. Item 62. of the KO "O" – the question about the arduousness of willingness to take one's own life within the last seven days was the basis for evaluating the prevalence and intensity of SI, defined as the desire to take one's own life. The patient was able to mark a negative response (0), indicating no SI, and a positive response indicating the presence of SI. The questionnaire included three degrees of positive response that allowed to assess the severity of the symptom 'arduousness': (a) 'mild', (b) 'moderate' or (c) 'severe' [33].

All questionnaire surveys were performed twice by patients – during qualification and at the end of psychotherapy. The total time interval between measurements was on average 137.1 ± 30.3 days in women and 132.4 ± 30.5 days in men.

Types of disorders and the course of treatment

Only patients treated in the aforementioned center for the first time participated in the study, with ICD-10 F40–F61 spectrum, including patients with personality disorders accompanied by other F4 and F5 psychiatric disorders (Table 5).

Table 5.**Type of disorder according to ICD-10**

Disorders	Women (n = 461)		Men (n = 219)	
	Number	Percentage	Number	Percentage
F40 Phobic anxiety disorders	51	11.1%	31	14.2%
F41 Other anxiety disorders	145	31.5%	73	33.3%
F42 Obsessive-compulsive disorder	15	3.3%	12	5.5%
F43 Reaction to severe stress, and adjustment disorders	40	8.7%	18	8.2%
F44 Dissociative (conversion) disorders	9	2.0%	1	0.5%

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F45 Somatoform disorders	45	9.8%	20	9.1%
F48 Other neurotic disorders	3	0.7%	8	3.7%
F50 Eating disorders	27	5.9%	0	0.0%
F60/F61 Specific personality disorders or Mixed and other personality disorders[a]	198	43.0%	94	42.9%
Other[b]	19	4.1%	13	5.9%

[a] – personality disorders were often the second diagnosis associated with F4 and F5 diagnosis

[b] – diagnosis co-occurring with diagnosis from F40–F61 spectrum

The planned duration of therapy was 12 weeks. During treatment, patients participated in intensive psychotherapy in groups with an average of 8–10 patients in the 10–15 sessions per week module, Monday to Friday, combined with one individual therapy session per week. Psychotherapy was carried out in an integrative approach with the predominance of psychodynamic approach, with elements of cognitive and behavioral therapy. In the course of psychotherapy clarifications, confrontations and interpretations were used primarily to widen patients' insights into the function of reported symptoms, the used defense mechanisms, and interpersonal processes that take place during therapy. Important elements of treatment were work with resistance and transference, empowering ego strength and patients' autonomy, correction of dysfunctional cognitive schemata, and creating circumstances that allow for corrective experiences [34–38].

A small proportion of patients benefited in parallel with psychopharmacotherapy, the extent of which, according to the assumptions adopted in the ward, was reduced depending on the patient's mental state. The aim of drug reduction was to provide optimal access to patients' experiences and symptomatic circumstances. According to separate, unpublished studies of A. Murzyn among 169 patients from 2008–2011, the proportion of subjects taking antidepressants or sedatives in the ward was 3.0%.

Methodology for searching prognostic factors of the occurrence of SI at the end of therapy

The study involved 680 patients who were treated for the first time in a day psychotherapeutic ward. Among them, 146 women and 68 men have declared SI before treatment. It was assumed that the presence of SI in patients declaring SI in qualification was conditioned by factors not related to the psychotherapy process. Consequently, this group of patients was excluded from further analysis in order to identify the factors relevant for the onset of SI in relation to the used psychotherapeutic treatment.

A further statistical analysis included the questionnaire results of 466 patients, including 327 women and 139 men. Of these populations, two subgroups were identi-

fied: a subgroup of non-SI patients initiating treatment, followed by disclosure of SI (n = 19), and a subgroup of patients without SI both at the beginning and at the end of treatment (n = 447). Both subgroups were compared among others in terms of the level of neurotic disintegration of personality, neurotic personality traits and individual attitudes reflecting dysfunctions typical for neurotic disorders. For this purpose, Pearson's χ^2 test for nominal variables and Student's t-test for independent variables with normal distribution were used.

Data obtained by means of these diagnostic tests were used with the consent of the patients, stored and processed in an anonymous form. Statistica PL – licensed statistical package was used for statistical analysis.

Results

The statistical analyzes allowed to distinguish two groups of attitudes influencing on, at the lack of SI at the onset, the risk of SI appearing at the end of treatment with intensive psychotherapy for neurotic, behavioral or personality disorders conducted in an integrative approach with the predominance of psychodynamic approach.

The first group of attitudes declared by patients was associated with a higher than average risk of SI at the end of psychotherapy, with their initial absence (Table 7). Among the statistically significant attitudes reported in *the Neurotic Personality Questionnaire* KON-2006 were: 'When I am in a difficult situation, I expect something to save me' (p = 0.007); 'I often imagine that I am somebody great' (p = 0.043); 'I am primarily driven by instinct, intuition' (p = 0.035); 'I happen to beat a family member or a friend' (p < 0.001); 'Even when everything goes well, I often give up' (p = 0.022); 'I often miss my life chances because I withdraw needlessly' (p = 0.037); and close the significance level: 'I am often cruel to my loved ones' (p = 0.057).

Table 7. **Attitudes reported by patients, associated with a higher than average risk of SI at the end of therapy at their initial absence (n = 466)**

Attitudes	p	Pearson's χ^2	OR	95% CI
I happen to beat a family member or a friend.	< 0.001	14.59	7.68	2.27–25.94
I am often cruel to my loved ones.	0.057	3.64	2.40	0.95–6.04
I am primarily driven by instinct, intuition.	0.035	4.45	2.78	1.04–7.43
When I am in a difficult situation, I expect something to save me.	0.007	7.23	6.00	1.37–26.29
I often imagine that I am somebody great.	0.043	4.08	2.51	1.00–6.33
Even when everything goes well, I often give up.	0.022	5.22	2.83	1.12–7.13
I often miss life chances because I withdraw needlessly.	0.037	4.33	4.25	0.97–18.64

The second group concerned attitudes related to significantly lower than average risk of SI at the end of the intensive psychotherapy cycle, with the initial absence of SI, (Table 8). Such attitudes, declared in *the Neurotic Personality Questionnaire* KON-2006, included: 'I know what is good and what is wrong' ($p = 0.002$); 'I like sexual arousal' ($p = 0.017$); 'Usually, before I make a decision, I thoroughly analyze all the facts and details' (0.043); 'I want to act in such a way to satisfy everyone' (0.048); 'I happen to be so overworked, that I have no time for entertainment' ($p = 0.044$); 'Even when I try very hard, I do not work as fast as others' ($p = 0.049$); 'I get annoyed by all kinds of weirdness, strangeness, unnaturalness' ($p = 0.026$).

Table 8. **Attitudes reported by patients, associated with a lower than average risk of SI at the end of therapy at their initial absence (n = 466)**

Attitudes	p	Pearson's χ^2	OR	95% CI
I know what is good and what is wrong.	0.002	9.38	0.25	0.10–0.65
Usually, before I make a decision, I thoroughly analyze all the facts and details.	0.043	4.08	0.40	0.16–1.00
I get annoyed by all the weirdness, strangeness, unnaturalness.	0.026	4.98	0.22	0.05–0.94
I happen to be so overworked, that I have no time for entertainment.	0.044	4.07	0.30	0.09–1.03
Even when I try very hard, I do not work as fast as others.	0.049	3.86	0.31	0.09–1.06
I want to act in such a way to satisfy everyone.	0.048	3.91	0.39	0.15–1.02
I like sexual arousal.	0.017	5.74	0.31	0.11–0.85

While applying the Student's *t*-test for independent samples, none of the 25 scales of *the Neuropsychiatric Personality Questionnaire* KON-2006 (24 scales and the XKON coefficient) was associated with SI at the end of the intensive psychotherapy cycle, with their absence at the beginning of the intensive therapy. The predictive value near the level of statistical significance was found only in the case of one scale: the average level of sense of threat was higher in patients with SI at the end of therapy compared to the others ($p = 0.058$).

Discussion

Results of other studies on patients treated with intensive psychotherapy due to neurotic, behavioral or personality disorders have shown that the overall severity of neurotic personality disorders (measured by the KON-2006 using *the global neurotic personality disintegration scale* XKON) correlates positively with the presence of SI at the beginning of treatment [6]. However, this study, devoted exclusively to patients who did not initially display SI, contrary to expectations showed that the global severity of neurotic personality disorders (measured by the XKON coefficient

of the KON 2006) did not predict the risk of SI at the end of psychotherapeutic treatment. While assessing the predictive value of individual neurotic personality traits using the KON-2006, only a single trend close to the statistical significance level ($p = 0.058$) was found, which suggests that relatively high sense of threat at baseline indicates some predisposition to SI at the end of therapy. These results may indicate significant heterogeneity of SI-related personality factors in the studied subjects and a high complexity of the changes that occur in this area under the influence of psychotherapy. These observations confirm the appropriateness of more detailed analysis of variables such as those used to evaluate neurotic personality traits and individual attitudes.

Such an orientation of the analyses allowed for the identification of a number of dysfunctional attitudes in the area of neurotic personality traits that significantly predispose to SI disclosure due to the intensive psychotherapeutic treatment. Such attitudes were: 'When I am in a difficult situation, I expect something to save me' ($p = 0.007$) and 'I often imagine that I am somebody great' ($p = 0.043$). These attitudes illustrate the use of fantasizing by patients as a defensive mechanism, especially grandiose fantasy which creates of a sense of security and self-esteem [39]. Tendencies of this kind are considered typical for narcissistic personality. In its feature there is the need to maintain a false image of oneself, subjective conviction of one's own uniqueness and importance, and a strong expectation of gratification, admiration and appreciation, as well as focus on oneself and little interest in other people's affairs. Suicidal ideations and suicide attempts may occur in such situations when confrontation with reality makes it impossible to maintain the magnitude of self-image. This leads to an overwhelming sense of disappointment with one's own insufficient value and imperfection, and it gives rise to strong feelings of regret towards oneself, shame and anger.

Part of the suicidogenic theories similarly describes the formation of SI. An example of this could be *the Escape Theory of Suicide* by Roy F. Baumeister [40, 41], which points to a great disappointment, possible to be related to unrealistic, too rigorous expectations for themselves, as the start of a six-step decision tree leading first to SI, and then to suicide. It can therefore be presumed that in some cases the onset of SI at the end of psychotherapy may be the result of confronting patients with painful discrepancies between their expectations for themselves and the reality and difficulty in resigning from these exaggerated expectations. Overly high self-esteem and self-centeredness may also result in little openness to therapeutic interventions. In cases of narcissistic defense mechanisms of low maturity, interventions can be paradoxically perceived as manifestations of hostility, and thus building therapeutic bonds can be particularly difficult.

As a consequence of these phenomenon, the deconstruction of narcissistic defense mechanisms in psychotherapy, especially those characterized by significant immaturity,

may lead to the accumulation of emotional tension and the occurrence of symptoms from the spectrum of autoaggression, including SI. The detrimental impact of the grandiose attitude seems to be all the more likely as attitudes somewhat opposing it correlated with a lower risk of SI at the end of psychotherapy. These attitudes included: an attitude suggesting not accepting standing out of or mismatching the group ('I get annoyed by all kinds of weirdness, strangeness, unnaturalness'; $p = 0.026$) and attitudes that may in some sense express that a person values interpersonal relationships ('I want to act in such a way to satisfy everyone'; $p = 0.048$ and 'I like sexual arousal'; $p = 0.017$). These results are consistent with Thomas Joiner's interpersonal theory of suicide [42], where thwarted belongingness is one of the two key factors leading to the occurrence of SI.

In turn, attitudes predisposing to the emergence of SI at the end of psychotherapy – such as: 'I often miss my life chances because I withdraw needlessly' ($p = 0.037$) and 'Even when everything goes well, I often give up' ($p = 0.022$) – show an image of a person prone to unwarranted pessimism and premature resignation from their aspirations. Literature provides many empirical evidence for the link between resignation tendencies and SI [42]. Exaggerated tendencies for resignation can be expressed by resignation thoughts, which are considered precursors or components of SI. The authors of psychodynamic theories suggest that resignation may be the result of an intrapsychic compromise between various unacceptable feelings such as anger, regret or excitement, and anxiety, shame or guilt activated by those feelings [42–44]. The occurrence of SI in psychotherapy conditions directed at insight can in such cases result from a collision with these difficult to bear feelings. Among others, Erik Erikson draws attention to the prosuicidal aspect of this kind of mental states, which he, within the frames of his psychosocial development theory, attributes to the cumulative and consolidation of unfavorable solutions to a number of developmental crises [45]. In addition, these results resemble Aaron T. Beck's statements that withdrawal and resignation may be the result of dysfunctional cognitive patterns that lead to unwarranted pessimism, expecting excessively negative events, and creating discouraging imagery of the future. The overwhelming sense of helplessness and lack of hope resulting from these cognitive distortions may, according to Beck, lead to SI and suicide [42]. Becoming aware of the extent of missed life opportunities, related to the correction of cognitive patterns in the course of psychotherapy, may be another source of SI.

The dysfunctionality of cognitive patterns id also suggested by the attitude 'I am primarily driven by instinct, intuition' ($p = 0.035$), which also proved to predispose to SI at the end of psychotherapy. From the point of view of cognitive approach, this irrationality of applied cognitive patterns in the psychodynamic perspective may correspond to the general immaturity of defense mechanisms and the tendency to wishful thinking. Often such a way of functioning is due to poor ability to cope with

frustration and inability to defer gratification. These are dysfunctions whose therapy is time consuming and inevitably associated with frustration. Experiencing frustration in relatively safe treatment conditions gives patients the opportunity to develop more mature mechanisms to cope with specific sources of frustration. In this context, the occurrence of SI is not surprising, and consequently patients with such difficulties are most often referred to continue psychotherapeutic treatment [46].

Among the analyzed attitudes, the strongest predisposition to reveal SI at the end of psychotherapy was found in the case of the declaration ʻI happen to beat a family member or a friend' ($p < 0.001$), which shows a clear tendency to aggression and impulsiveness (Similar, close to the level of statistical significance, was also the attitude: ʻI am often cruel to my loved ones'; $p = 0.057$, predisposing to SI) This leads to the assumption that psychotherapeutic work on the causes or consequences of one's own physical aggression towards the loved ones triggers emotional tension leading to reveal SI. The role of impulsivity and problems in interpersonal relations in suicidogenesis is included in a number of theoretical models of suicide. An example of this may be the motivational-volitional model by Rory C. O'Connor [42], integrating many previous concepts. Literature also provides empirical evidence for the existence of positive correlations between aggression, impulsivity and suicidal tendencies, including SI. The most common are research on patients with mental disorders in which impulsivity plays an important role, for example, emotionally unstable personality disorders, dissocial personality disorders, histrionic personality disorders, and affective disorders [47]. Especially in young people, frequent coexistence of impulsivity, irritability and aggression with autoaggressive symptoms such as SI, SA or non-suicidal self-injury is observed [48]. At the same time, some researchers [49, 50] assume that impulsivity is a manifestation of low conscientiousness and treats these two variables as opposites. This view coincides with the results of attitudes that show conscientiousness: (ʻUsually, before I make a decision, I thoroughly analyze all the facts and details'; $p = 0.043$ and ʻI happen to be so overworked, that I have no time for entertainment'; $p = 0.044$), which is linked with significantly lower than average risk of SI. Overall, the results confirm the need for extreme caution in the psychotherapy of patients with impulsivity and aggression problems even when SI are initially excluded .

As in the case of the two aforementioned attitudes, a clear ʻprotective' effect from SI was found in the attitude ʻI know what is good and what is wrong' ($p = 0.002$). This attitude seems to reflect a strong sense of inner-direction and having clear moral principles (also observed in the ʻprotective' attitude ʻEven when I try very hard, I do not work as fast as others'; $p = 0.049$). These results coincide with the conclusions of a classic of suicidology, Émile Durkheim [51], according to which the loosening or unclearness of norms and social rules can lead to SI and suicide (so-called anomic suicide). Likewise, a suicideologist Benjamin Wolman emphasized in his studies, among

others, the pro-suicidal influence of the 20th-century culture promoting the degradation of family bonds, alienation, depersonalization of interpersonal relationships, and the loss of values and identity [42].

The apparent limitation of the study was the fact that the item of the KO "O" regarding 'willingness to take one's own life' refers to the past seven days, therefore it was possible not to detect SI during therapy and to omit SI that might have been present before treatment. The conditions of the conducted therapy also did not allow to verify the durability of the obtained results. In addition, as in all survey studies, it cannot be excluded that the patients were inaccurate in the completion of the questionnaire. It should also be noted that despite the unambiguous content of the item regarding SI, clinical experience shows that the SI declared by patients cannot be identified in all cases with SI identified in a clinical examination. Clinical conditions also did not allow comparison of the obtained observations with the observations in the control group.

The course of psychodynamic therapy did not assume a strictly defined plan of psychotherapeutic interventions. Therapeutic interventions were formulated on an ongoing basis with regard to specific individuals forming psychotherapeutic groups. Consequently, the observed changes for each patient may have been the result of slightly different psychotherapeutic interventions being a part of integrative therapy approach with the predominance of psychodynamic approach. The inevitable limitation that results from the conditions of day treatment is not including patients at high risk of suicide. It should also be added that SI are a symptom of highly complex etiopathogenesis, and this study focused only on a part of a broad spectrum of factors that could affect their occurrence.

Conclusions

The multitude of contexts of the appearance of SI in patients undergoing psychotherapy is a significant difficulty for the therapeutic team. From the point of view of patients' safety and better adjustment of therapeutic interventions, the knowledge of neurotic personality traits and dysfunctional attitudes predisposing to SI during psychotherapy in people with anxiety, behavioral and personality disorders is essential to plan treatment in the day ward. In patients without SI at baseline who reported the aforementioned attitudes at a higher level than others, the risk of SI occurrence at the end of psychotherapy (10–30% vs. 4%) indicates dysfunctions in specific areas of personality, in the case of which intensive psychotherapeutic work requires particular caution – it can trigger emotional stress leading to SI instances.. The obtained results suggest that SI may be the result of the reconstruction of defense mechanisms while working on insight, confrontation of the causes and consequences of the patient's own physical aggression towards

the loved ones, revising their grandiose thinking and insight into its function, and into the causes of resignation attitudes.

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