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Пограничное расстройство личности и пограничная акцентуация характера: сравнение суицидальных характеристик у женщин

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АННОТАЦИЯ

Обоснование. Пограничное расстройство личности (ПРЛ) в настоящее время остается важной темой в психиатрических исследованиях из-за значительной распространенности аутоагрессивного поведения у страдающих этим расстройством лиц. Однако, до сих пор недостаточно изучены различия в суицидальном поведении между пациентами с ПРЛ и пациентами, у которых наблюдаются только отдельные пограничные личностные черты — акцентуация характера (ПАХ).

Цель. Выявить и описать различия в характеристиках суицидального поведения между пациентами с ПРЛ и ПАХ для разработки персонифицированных программ профилактики.

Методы. В наблюдательном кросс-секционном исследовании приняло участие 120 пациенток с аутоагрессивным поведением в анамнезе, проходящих стационарное лечение в Рязанской областной клинической психиатрической больнице имени Н.Н. Баженова. Для оценки использовались адаптированные специализированные клинические и психометрические шкалы.

Результаты. Пациенты с ПРЛ демонстрировали более выраженную эмоциональную дисрегуляцию (p <0,0001), когнитивные нарушения (p <0,0001), импульсивное поведение (p <0,0001) и дисфункцию в межличностных отношениях (p <0,001). Кроме того, они показали более значимые результаты по негативным аффектам (p <0,0001), отстраненности (p=0,0001), антагонизму (p=0,0009), расторможенности (p <0,0001), психотизму (p <0,0001), тревожности (p <0,0001) и депрессии (p <0,0001) среди личностных паттернов в “Personality Inventory for DSM-5 — Brief Form” (PID5BF). Пациенты с ПРЛ имели статистически значимые различия по следующим факторам риска самоубийства: эмоциональность (p <0,0001), несостоятельность (p <0,0001), пессимизм (p <0,0001), снижение временной перспективы (p <0,0001), демонстративность (p <0,0001) и уникальность (p <0,0001). Кроме того, они выражали страх быть забытыми после смерти (p=0,0112). Группа ПАХ имела статистически значимо более высокий балл по антисуицидальному индикатору (p=0,0076). Согласно результатам Мини-СМИЛ, группа ПАХ имела значительно более высокие баллы по шкале «Отрицание тревоги и гипоманиакальные тенденции» (p=0,0001). Пациенты с ПРЛ показали значительно более высокие результаты по следующим шкалам: «Соматическая тревожность» (p=0,0084), «Тревожность и депрессивные тенденции» (p=0,0009), «Подавление факторов, вызывающих тревогу» (p=0,0224), «Реализация эмоциональной ориентации в непосредственном поведении, импульсивность» (p=0,0002), «Фиксация тревоги и ограничивающее поведение» (p=0,0005) и шкала аутизации (p=0,0006).

Заключение. Результаты исследования показали, что аутоагрессивное поведение у пациенток с ПРЛ имело другие характеристики по сравнению с пациентками с ПАХ. Это важно учитывать в программах профилактики.

Ключевые слова: пограничное расстройство личности; пограничные личностные черты; саморазрушительное поведение; попытки самоубийства; несуицидальное самоповреждение.

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Borderline Personality Disorder and Borderline Character Accentuation: a Comparison of Suicidal Characteristics in Women

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ABSTRACT

BACKGROUND: Borderline personality disorder (BPD) currently remains an important topic in psychiatric research due to significant prevalence of self-injurious behavior in individuals with this disorder. However, differences in the suicidal behavior between patients with BPD and those exhibiting only specific borderline personality traits (BPT) — character accentuation are understudied.

AIM: To identify and describe differences in suicidal behavior characteristics between patients with BPD and BPT for development of personalized prevention programs.

METHODS: This observational cross-sectional study involved 120 female patients with a history of self-injurious behavior undergoing inpatient treatment in Bazhenov Ryazan Regional Clinical Psychiatric Hospital. For assessment, adapted specialized clinical and psychometric scales were used.

RESULTS: Patients with BPD demonstrated more pronounced emotional dysregulation ($p < 0.0001$), cognitive impairment ($p < 0.0001$), impulsive behavior ($p < 0.0001$), and dysfunction in interpersonal relationships ($p < 0.001$). In addition, they showed more significant results for negative affects ($p < 0.0001$), detachment ($p = 0.0001$), antagonism ($p = 0.0009$), disinhibition ($p < 0.0001$), psychoticism ($p < 0.0001$), anxiety ($p < 0.0001$), and depression ($p < 0.0001$) among the personality patterns in the 'Personality Inventory for DSM-5 — Brief Form' (PID5BF). Patients with BPD had statistically significant differences in the following suicide risk factors: emotionality ($p < 0.0001$), incompetence ($p < 0.0001$), pessimism ($p < 0.0001$), decreased time perspective ($p < 0.0001$), demonstrativeness ($p < 0.0001$), and uniqueness ($p < 0.0001$). In addition, they expressed fear of being forgotten after death ($p = 0.0112$). The BPT group had a statistically significantly higher score in the anti-suicide index ($p = 0.0076$). According to the Mini-SMIL results, the BPT group had significantly higher scores on the 'Denial of Anxiety and Hypomanic Tendencies' scale ($p = 0.0001$). Patients with BPD showed significantly higher results on the following scales: 'Somatic anxiety' ($p = 0.0084$), 'Anxiety and depressive tendencies' ($p = 0.0009$), 'Repression of factors causing anxiety' ($p = 0.0224$), 'Realization of emotional orientation in direct behavior, impulsiveness' ($p = 0.0002$), 'Fixation of anxiety and restrictive behavior' ($p = 0.0005$) and the autism scale ($p = 0.0006$).

CONCLUSION: The study results showed that self-harming behavior in female patients with BPD and those with BPT had different characteristics, which is important to take into account in prevention programs.

Keywords: borderline personality disorder; borderline personality traits; self-destructive behavior; suicide attempts; non-suicidal self-harm.

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Background

Borderline personality disorder (BPD) is a common psychiatric disorder affecting up to 5.9% of the population [1]. It is a complex and severe disorder that usually manifests in adolescence or early adulthood and is characterized by emotional instability, unstable self-esteem, impaired interpersonal relationships, and marked impulsivity. Currently, BPD represents a crucial focus in psychiatric research due to the high prevalence of self-destructive behavior in affected individuals. Among BPD patients, 90% engage in non-suicidal self-injury (NSSI), 75% attempt suicide, and 10% end their lives by committing suicide [2].

The International Classification of Diseases, 11th Revision (ICD-11) and Diagnostic and Statistical Manual of mental disorders, fifth edition (DSM-5) offers a new perspective on personality problems. It defined the personality disorder (6D10), marked by difficulties in self-functioning and interpersonal dysfunction. It influences aspects of the self, such as identity, self-esteem, and the development of relationships. Maladaptive cognitive, emotional, and behavioral patterns in diverse personal and social contexts manifest this disorder. Social or cultural variables do not predominantly explain these patterns, nor are they developmentally suitable. The disturbance results in considerable suffering or impairment across multiple domains of functioning, including personal, familial, social, educational, and occupational spheres. According to the ICD-11, it is also possible to identify prominent Personality Traits or patterns (6D11) by employing trait domain qualifiers to define significant personality traits that lead to personality disorders or issues. These traits are consistent with normal personality features in individuals without disorders. They do not constitute diagnostic categories but rather signify characteristics of personality structure [3].

Currently, there is a lack of data regarding the suicidological characteristics of patients with Borderline Personality Traits (BPT) compared to those with BPD. In practical terms, understanding these distinctions will facilitate the creation of prevention programs that adjust to the specific needs of the patient's rehabilitation. From a theoretical perspective, understanding the psychological factors that influence self-destructive behavior in these groups of patients will facilitate the development of programs that are intended to correct the identified differences.

The **aim** of this study to examine and describe the differences in characteristics of suicidal behavior between patients with BPD and patients with BPT to develop personalized prevention programs.

Methods

This observational cross-sectional study was conducted between September 2023 and January 2025 at the Regional Clinical Psychiatric Hospital in Ryazan. This study used a consecutive sampling to recruit participants.

The ***inclusion criteria*** comprised female patients aged 18 to 60 presenting various forms of self-destructive behavior, including suicide attempts (SAs), NSSI, and impulsive, life-threatening behaviors such as addiction and engagement in harmful sexual activities.

The ***exclusion criteria*** included an acute psychotic episode or serious somatic diseases that prevented patients from properly answering the questionnaire.

In this study, we used a clinical anamnestic questionnaire and psychometric scales adapted for the Russian-language. The main one was the Revised Diagnostic Interview for Borderlines (DIB-R). It is a semi-structured interview designed to assess BPD by evaluating four major aspects: affect, cognition, impulse action patterns, and interpersonal relationships. Developed by Zanarini M.C. et al. (1989), it is widely used in clinical research for diagnosing and studying BPD [4]. The DIB-R makes it possible to distinguish BPD from other psychiatric disorders and to show which areas are more affected. Korolenko C.P. and

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Zagorujko E.N. translated and adapted this interview into the Russian language in 1997. The Russian version is very effective and is still used today in psychiatric clinics to diagnose BPD among Russian patients [5].

The Personality Inventory for DSM-5 Brief Form (PID5BF) is a self-report scale for adults aged 18 and over that assesses five personality trait domains: negative affect, detachment, antagonism, disinhibition, and psychoticism. It provides information on the severity of dysfunctional personality traits in a patient, crucial for diagnosing personality disorders [6]. In 2019, the Russian version was adapted by Lozovanu S. et al. [7] it showed satisfactory internal consistency and maintained the five-factor model of pathological personality domains presented in the DSM-5 and ICD-11 [7].

To evaluate the sum of positive and negative affects we used the Positive and Negative Affect Schedule (PANAS) in its Russian adaptation [8, 9]. It consists of two subscales: one for positive affect and another for negative affect, each with 10 items. Also, we utilized the Russian versions of the Zung Self-Rating Depression Scale (ZDS) and the Zung Self-Rating Anxiety Scale (ZAS), both developed by Dr. William W.K. Zung [10, 11]. These scales are useful for determining the existence and intensity of depression and anxiety symptoms.

We also used the Death Attitude Profile Revised (DAP-R) and the Fear of Personal Death Scale (FPDS) in their Russian adaptation [12]. The DAP-R evaluates the beliefs of individuals regarding death, such as their acceptance of it as a means of escape from daily obstacles, their belief in heaven and God's union after death, and their fear of it [12, 13]. The FPDS is a multidimensional tool for studying personal, interpersonal, and transpersonal fears of death. It shows which parts of life are more important, and the person is afraid to lose them [12, 14].

For diagnosing and identifying the severity of suicidal risk, we used the Suicide Risk Questionnaire modified by Razuvaeva T.N. This Russian questionnaire, most effective and frequently used in clinical psychiatry, consists of a series of questions designed to determine the level of suicidal risk and the formation of suicidal intentions [15].

Lastly, we used Sobchik's Mini-SMIL questionnaire, which is the Russian version of the Minnesota Multiphasic Personality Inventory (MMPI). It was made to fit Russian culture and clinical settings. The Mini-SMIL is designed primarily for clinical practice and focuses on the subjective assessment of a patient's condition [16]. We tested the truthfulness of responses based on the Lie (L) scale and included only those participants who scored less than 3 points on it.

Statistical analysis was performed using MedCalc software (MedCalc Software Ltd, USA). The Kolmogorov-Smirnov test was used to assess the normality of the distributions. Normal distributions were described as ‘Mean (Standard Deviation)’, other than normal distributions as ‘Mean [95% confidence interval for the Mean]’. Normal distributions were compared using the Student's T-test, other than normal distributions were compared using the χ^2 method with the Bonferroni correction. Statistical significance of differences was considered at $p < 0.05$.

Results

Sample characteristics

Our study included 120 female patients with the antecedents of multiple forms of self-destructive behaviors. The main diagnoses of the recruited patients are borderline personality disorder, mixed personality disorder, bipolar affective disorder, depressive disorder, anxiety disorder, schizoaffective disorder. Based on the primary results of the DIB-R, we divided the patients into two groups. A group of patients having main diagnosis of BPD with a DIB-R score ≥8 (BPD; *n*=60; mean age=25.267 [23.357÷27.177] years old, and a group having only individual bipolar traits (BPT) with a DIB-R score <8 (BPT; *n*=60; mean age=28.417 [25.699÷31.134] years old). When comparing the anamnestic characteristics of the two groups, the BPD group had only one significant difference a higher number of suicide attempts (BPD:

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1.85 [1.064÷2.636]; BPT: 0.517 [0.296÷0.737]; *p*=0.0303).

Based on the DIB-R's results, BPD patients showed more elevated scores in all four main sections. The affective section measures depression, anger, anxiety, and other dysphoric affects such as chronic feelings of loneliness, boredom, or emptiness (BPD: 1.85 [1.746÷1.954]; BPT: 1.183 [1.045÷1.322]; *p* <0.0001). The cognitive section evaluates thought disorders, sensation disorders, delusional disorders, and psychotic experiences (BPD: 1.75 [1.619÷1.881]; BPT: 0.8 [0.611÷0.989]; *p* <0.0001). The impulsive section examines serious substance abuse, forms of sexual disorder, SAs, NSSIs, and other impulsive behaviors. The results showed a highly significant difference in the BPD patients (BPD: 2.633 [2.499÷2.768]; BPT: 0.633 [0.364÷0.902]; *p* <0.0001). As well as the interpersonal relationships section that evaluates patterns of interaction with others, including intolerance of loneliness, abandonment concerns, counter-dependency, unstable close relationships, recurrent problems in close relationships, and troubled psychiatric relationships (BPD: 2.85 [2.757÷2.943]; BPT: 1.45 [1.137÷1.763]; *p* <0.0001).

Clinical characteristics

Personality Inventory for DSM-5 — Brief Form (PID5BF)

Comparing the two groups, the BPD group showed a higher total score (*p* <0.0001), along with elevated scores in all five domains. The domain of negative affectivity involves emotional instability and distress (*p* <0.0001); the domain of detachment represents the avoidance of social interactions and limited affect (*p*=0.0001); the domain of psychoticism characterizes eccentricity and unusual beliefs (*p* <0.0001); the domain of antagonism is characterized by manipulative, deceitful, and grandiose behaviors (*p*=0.0009); and the domain of disinhibition features impulsivity and irresponsibility (*p* <0.0001) (Table 1). The elevated BPD scores were anticipated and confirmed the validity of our classification of patients in the BPD group and the BPT group based on ICD-11 and DSM-5 perspectives.

Table 1. Comparative results of the Personality Inventory for DSM-5 — Brief Form

Domains	Borderline personality traits	Borderline personality disorder	*p*
n	60	60	
Negative affectivity	6.367 (SD=3.8881)	10.033 [9.167÷10.900]	<0.0001*
Detachment	4.350 [3.531÷5.169]	6.467 (SD=2.6774)	0.0001*
Antagonism	3.950 [3.149÷4.751]	6.333 [5.305÷7.362]	0.0009*
Disinhibition	4.733 (SD=3.0302)	8.350 (SD=3.1827)	<0.0001*
Psychotism	3.083 [2.384÷3.783]	7.533 [6.572÷8.495]	<0.0001*
Total	22.067 (SD=10.7544)	38.933 [36.204÷41.663]	<0.0001*

Note: * statistically significant differences

Positive and Negative Affects, Anxiety and Depression

Patients with comorbid BPD presented more negative affects compared to the patients with BPT (BPD: 34.467 [32.219÷36.714]; BPT: 23.633 (SD=8.3746); *p*=0.0001). There was no significant difference concerning positive affects (BPD: 26.267 [24.058÷28.475]; BPT: 26.483 [24.138÷28.829]; *p*=0.6839). BPD patients also showed elevated levels of anxiety in ZAS (BPD: 50.917 [47.850÷53.984]; BPT: 41.1 (SD=11.4473); *p* <0.0001) and depression in ZDS (BPD: 51.4 [48.818÷53.982]; BPT: 41.467 (SD=11.0813); *p* <0.0001) compared with BPT patients.

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The Death Attitude Profile Revised

The results showed no significant differences between the two groups in any of the five components (Table 2).

Fear of Personal Death Scale

The two groups showed no significant differences except for the domain of fear of being forgotten, where patients with comorbid BPD presented a higher significant score (*p*=0.0112) (Table 3).

Table 2. Comparative results of the Death Attitude Profile Revised

Components	Borderline personality traits	Borderline personality disorder	*p*
n	60	60	
Death Avoidance	16.500 (SD=6.7811)	15.000 [13.293÷16.707]	0.3104
Neutral Acceptance	17.083 [15.917÷18.250]	16.817 [15.588÷18.045]	0.6793
Approach Acceptance	10.950 [9.275÷12.625]	11.683 [10.014÷13.353]	0.6639
Escape Acceptance	9.730 (SD=4.7901)	10.567 [9.180÷11.954]	0.3621
Fear of Death	17.383 [15.314÷19.453]	16.120 (SD=6.9284)	0.4269

Table 3. Comparative results of the Fear of Personal Death Scale

Components	Borderline personality traits	Borderline personality disorder	*p*
n	60	60	
Consequences to family and friends	18.983 (SD=6.4269)	17.617 [15.633÷19.600]	0.4149
Consequences for Personality	31.533 [28.427÷34.640]	31.567 (SD=11.0812)	0.8192
Consequences for body	9.283 [7.572÷10.994]	9.983 [8.164÷11.803]	0.7743
Fear of Being Forgotten	7.450 [6.318÷8.582]	10.133 (SD=5.6312)	0.0112*
Transcendental Consequences	17.333 [15.071÷19.595]	17.583 [15.285÷19.881]	0.8488

Note: * statistically significant differences

The Suicide Risk Questionnaire by T.N. Razuvaeva

The BPD group demonstrated significant differences in several indicators of suicidal risk: «Affectivity» (BPD: 5.078 [4.747÷5.410]; BPT: 3.245 [2.806÷3.684]; *p* <0.0001), «Temporal perspective» (BPD: 3.648 [3.129÷4.168]; BPT: 2.035 [1.595÷2.475]; *p* <0.0001), «Demonstrativeness» (BPD: 3.422 [3.010÷3.833]; BPT: 1.92 [1.554÷2.286]; *p* <0.0001), «Insolvency» (BPD: 5.375 [4.812÷5.938]; BPT: 3.15 [2.521÷3.779]; *p* <0.0001), «Social pessimism» (BPD: 4.067 [3.741÷4.392]; BPT: 2.967 [2.583÷3.350]; *p* <0.0001) and «Uniqueness» (BPD: 3.5 [3.072÷3.928]; BPT: 1.86 [1.488÷2.232]; *p* <0.0001). However, the BPT group had a significant higher score in the «Antisuicidal indicator»: (BPD: 4.053 [3.600÷4.507]; BPT: 4.907 [4.438÷5.375]; *p*=0.0076).

The Mini-SMIL

According to the results, the group of participants with individual BPD traits had significantly higher scores on the scale of «Denial of anxiety and hypomanic tendencies» (*p*=0.0001). Patients with BPD showed significantly higher scores on the following scales: «Somatic anxiety scale» (*p*=0.0084), «Anxiety and depressive tendencies» (*p*=0.0009), the scale of «Repression of factors causing anxiety» (*p*=0.0224), the scale of «Realization of emotional orientation in direct behavior, impulsiveness» (*p*=0.0002), the scale of «Fixation of anxiety and restrictive behavior» (*p*=0.0005) and the scale of «Autisation» (p=0.0006) (Figure 1).

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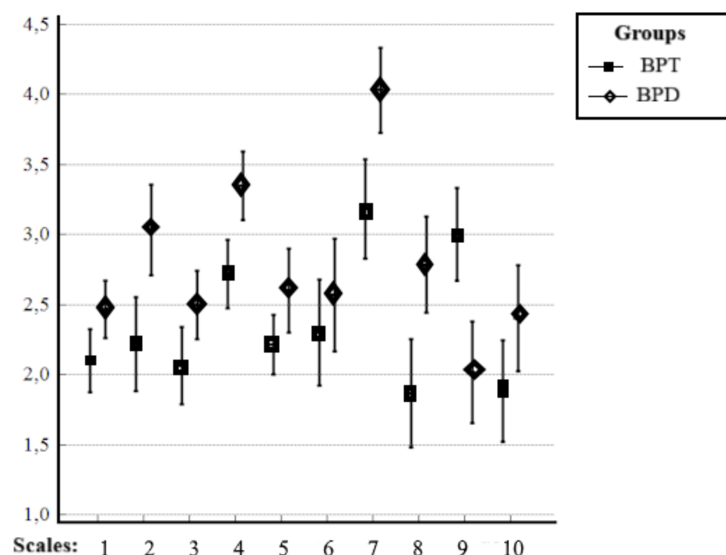

Fig. 1. Comparative results of the Mini-SMIL: 1 — Somatic anxiety scale, 2 — Anxiety and depressive tendencies, 3 — Scale of "Repression of factors causing anxiety", 4 — Realization of emotional orientation in direct behavior, impulsiveness, 5 — Expression of male and female character traits, 6 — Rigidity of affect, 7— Scale of "Fixation of anxiety and restrictive behavior", 8 — Autisation (individualism), 9 — Scale of "Denial of Anxiety and Hypomanic Tendencies", 10 — Social contacts (introversion).

Discussion

Based on various studies, self-destruction (SD) in the context of BPD has a variety of characteristics and aspects. Depending on the age, adolescents are more susceptible to engaging in NSSIs, but adults are more likely to commit SAs. In most cases, NSSIs take the form of skin cuts, self-scratching, head-beating, and self-flagellation. Suicide attempts included overdose (41.67%), hanging (16.67%), and jumping from a height (8.33%). Depending on the clinical dynamics, SD in BPD can be impulsive, addictive, demonstrative or occur in the context of depersonalization. Self-harming behavior is also associated with specific symptoms of BPD, such as feelings of chronic emptiness, avoidance of abandonment, emotional instability, and identity disturbance [17]. The pathogenesis of self-destructive behavior in BPD is characterized by a complex combination of neurobiological and psychosocial factors [18]. All these characteristics support the importance of studying self-destructive behaviors in the context of borderline personality disorder.

According to our results, patients with comorbid BPD presented an increased alteration in all four primary sections of the DIP-R compared to the BPT patients. The affect section indicated that individuals with BPD suffer from increased emotional dysregulation characterized by anxiety, irritability, anger, and dysphoria. Studies have demonstrated that the hyperactivity of the hypothalamic-pituitary-adrenal axis and the atrophy of the frontal-temporal-limbic regions, which are implicated in the pathogenesis of self-destructive behavior in borderline personality disorder, result in reduced cognitive functions. This impairment prevents individuals with this disorder from effectively managing negative emotions, leading to emotional dysregulation and increased impulsivity, which increases the risk of developing self-destructive behavior [20, 21]. The cognition section indicated that individuals with BPD may exhibit various cognitive impairments, including mental distortions, paranoid ideation, and transitory psychotic episodes. Under these circumstances, individuals with BPD resort to NSSI as a means of coping with transient

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paranoia and dissociative episodes [22, 23]. The alteration of impulse action patterns and the interpersonal relationships sections were strongly manifested in BPD patients. The increased impulsivity was explained by the fact that individuals with BPD who had traumatic experiences in their childhood are more likely to have glutamate dysfunction in the hippocampus, leading to neurocognitive decline, which causes increased impulsivity and the manifestation of autoaggression [20]. Research indicate that disruption of the mu-opioid system might lead to disturbances in relationships, consequently resulting in symptoms of “mental pain” and a “feeling of emptiness”. Individuals with borderline personality disorder attempt to manage these symptoms through non-suicidal self-injury [24–27]. Patients with BPD should receive more intensive and prolonged interventions for the prevention of self-destructive behaviors.

Our research found that patients with comorbid borderline personality disorder showed more negative affect, as seen by the PANAS and PID5BF results. The negative affect signifies a state of distress and emotional instability, elevating the risk of self-destructive behaviors [20, 21]. Additionally, the PID5BF revealed that individuals with BPD exhibit more pronounced global personality dysfunction. Along with negative affect, patients with BPD revealed a higher level of psychoticism, which is marked by oddities and irrational thoughts or beliefs, such as perceptual dysregulation and having strange experiences. They also indicated more elevated scores in areas of antagonism, detachment and disinhibition, clarifying the increased impulsivity, risk-taking, manipulative, and grandiose behaviors. Our findings indicated that BPD patients had significant levels of anxiety as well as depression. Studies indicated that self-destructive behaviors in the context of BPD are frequently associated with comorbid depression and anxiety. In fact, the frequency and intensity of non-suicidal self-injury and suicidal attempts increase with the severity of comorbid depression and anxiety symptoms [28, 29].

Psychotherapy can be the first suggestion for negative affect’s correction. Research demonstrated that dialectical behavior therapy [30], mentalization-based therapy [31], and schema therapy [32] are the most effective in reducing the severity of negative affects and self-destructive behaviors associated with BPD. Dialectical behavior therapy is beneficial for treating comorbid depression and anxiety [33]. Pharmacotherapy is recommended for significant comorbidities, including major depressive episodes or severe anxiety. For treating symptoms of comorbid depression, selective serotonin reuptake antidepressants may be prescribed [34]. Aripiprazole has demonstrated efficacy in reducing depression, anxiety, and other negative emotions, including anger and hostility [35]. There were no significant differences in the various components of death attitudes between the two groups of patients. However, patients with comorbid BPD demonstrated a higher fear of being forgotten. These findings may help in developing preventative approaches designed to correct the perceptions of death among BPD patients. Individuals with BPD presented elevated scores across multiple indicators of suicide risk. Firstly, there existed the affectivity indicator, which signifies emotional instability. Secondly, there was the insolvency indicator, defined by the inability to face and resolve challenges. The disparity in the time perspective indicator shows that individuals with BPD possess pessimistic views about life. The demonstrativeness explains that patients with BPD can engage in self-destructive behaviors that reflect their emotional state. Social pessimism proves that patients with BPD have a negative attitude toward society and social interactions. The uniqueness indicator associates suicidal risk with the sensation of being distinct and isolated from others. The indicators of suicide risk should be considered as targets in psychotherapy for individuals with BPD to

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reduce the risk of committing intentional suicide attempts. The BPT group had higher score in the antisuicidal indicator. These results confirm that patients with BPD have higher suicidal risk. We also found that patients with BPT had more hypomanic tendencies. The patients with BPD also had hypochondriac, pessimistic, emotionally labile, impulsive and anxious deviations and individualism, which confirms the alteration of interpersonal relationships, emotional instability and the frequent self-harming behaviors in BPD.

Based on our results, we are recommending the comprehensive, intensive and multimodal prevention tactic for the BPD patients. It's consisting of psychotherapy in the first line and use the medications under psychiatric supervision to stabilize severe symptom. Also can be useful the affect regulation training, suicide-specific preventive interventions, impulse control protocols and cognitive restructuring with elements from CBT and MBT to improve cognitive coherence and reality testing.

For the BPT Group, we are recommending the focused, skills-based and resilience-oriented prevention tactic. The primary focus cam be on the psycho-education and skills training in the groups. Also, it's important to use the motivational interviewing and strengths-based approaches to actively bolster their existing internal «antisuicidal» factors.

Limitations of research: only women in our study, studying the differences for men is a perspective for further research. The examination of self-destructive behaviors in individuals with addictive disorders and BPD continues to be a separate concern.

Conclusion

Preventive and psychotherapeutic programs for borderline personality disorder patients should target factors associated with increasing the risk of self-destructive behavior. Such factors include higher levels of depression and anxiety, negative affect, cognitive impairment, impulsivity, unstable interpersonal relationships, antagonism, detachment, disinhibition, increased fear of being forgotten, and a tendency toward hypochondria, pessimism, emotional lability and individualism.

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