Scientific Research Publishing

Open Journal of Social Sciences, 2026, 14(4), 875-888
https://www.scirp.org/journal/jss
ISSN Online: 2327-5960
ISSN Print: 2327-5952

# Dynamics and Outcomes of Borderline Personality Disorder in Youth: Results of a Comparative Follow-Up Study

**Aleksei Andreevich Kuleshov, Elena Sergeevna Krylova, Liubov Olegovna Volkova**

Department of Youth Psychiatry, Russian Mental Health Research Centre, Moscow, Russia
Email: kuleshovaleksei.ncpz@gmail.com

**How to cite this paper:** Kuleshov, A. A., Krylova, E. S., & Volkova, L. O. (2026). Dynamics and Outcomes of Borderline Personality Disorder in Youth: Results of a Comparative Follow-Up Study. *Open Journal of Social Sciences, 14,* 875-888.
https://doi.org/10.4236/jss.2026.144044

**Received:** March 8, 2026
**Accepted:** April 27, 2026
**Published:** April 30, 2026

## Abstract

**Objective:** The objective of the study is to determine the dynamics of borderline personality disorder (BPD) with onset in youth based on the study of two follow-up groups to assess further nosological trajectories and outcomes. **Material and Methods:** The study was conducted at the Mental Health Research Center (MHRC) in the Department of Youth Psychiatry. Clinical-psychopathological and psychometric methods were used to examine 143 patients with youth-onset BPD. Two follow-up groups were formed. Group 1 (2019-2022) consisted of 73 patients (67.1% males and 32.9% females; mean age at first presentation was 20 ± 4.2 years) who received inpatient or outpatient care at the clinical departments of the MHRC between 2019 and 2022 with a diagnosis of youth BPD. To assess further dynamics, Group 1 was re-examined in an outpatient setting between 2024 and 2026, with a follow-up duration of 4.5 ± 2.5 years. Group 2 (2006-2010) included 70 patients (61.0% males and 39.0% females; mean age at first presentation was 22 ± 5.5 years) who underwent initial examination between 2006 and 2010 and were re-evaluated between 2021 and 2022, with a follow-up duration of no less than 10 years. **Results:** BPD in youth represents a clinically heterogeneous pathological construct, within which three types are distinguished based on the dominant core psychopathological feature: "affective storm" (Type I), "addictive adrenalinomania" (Type II), and "cognitive dissociation" (Type III). In the 2019-2022 follow-up group, the stability of the BPD diagnosis was 58.9%, and for the 2006-2010 group, it was 61.43%. In the follow-up study for Type I BPD, a transformation of affective lability into distinct phases meeting the criteria for bipolar disorder (BD) was revealed in 36.4% ($p = 0.001$) of patients in the 2019-2022 group and 36.8% ($p = 0.034$) in the 2006-2010 group. The dynamics of Type I BPD were characterized by the compensation of behavioral patterns with the most favorable outcomes for social adaptation. Special attention is warranted for the nosological

trajectories in Type III BPD (with a predominance of cognitive dissociation). In a significant portion of these patients across the two follow-up groups (38.5% and 20.8%, respectively), a trajectory toward a schizotypal disorder diagnosis (F21.X) was established ($p = 0.002$). The observed dynamics indicate a nosological trajectory for Type III BPD where profound identity disturbances and progressive autization act as predictors of the schizotypal continuum. For patients with Type II BPD, the critical factor worsening the prognosis and increasing mortality risk is the addition of poly-addictive disorders. This particular subgroup demonstrates the most severe profile of outcomes, dominated by social maladaptation. A comparative analysis of the two follow-up groups (2006-2010 and 2019-2022) revealed no statistically significant differences ($p > 0.05$) in the vectors of nosological transformation. **Conclusion:** The established diagnosis of BPD in youth is confirmed in adulthood in the majority of cases. The study results demonstrate the contemporary pathomorphosis of the disease, confirmed by two independent follow-up groups, showing nosological trajectories toward affective disorders and schizotypal spectrum disorders. The identified typological variants of BPD, with their specific dynamics and outcomes, have high prognostic significance for further research and can serve as a basis for developing personalized socio-rehabilitation measures.

## Keywords

Borderline Personality Disorder, Youth, Bipolar Disorder, Schizotypal Disorder, Follow-Up Study, Social and Occupational Prognosis

## 1. Introduction

Borderline personality disorder (BPD) is a highly relevant problem given its wide prevalence during adolescence (1.5% - 14%) (Fonagy et al., 2015), with a slight decrease in occurrence in adulthood (0.7% - 6%) (Guilé et al., 2018; Wang et al., 2024). The main components of BPD—impulsivity, affective instability, and self-identity disorders—under the influence of the age factor become the basis for the formation of pathological symptom complexes accompanied by behavioral disorders with auto- and hetero-aggressive actions, which, according to several studies, reach their maximum severity during adolescence (Kaess et al., 2014; Winsper, 2021; Bohus et al., 2021; Lin et al., 2024).

The results of studies dedicated to the further dynamics of BPD and its outcomes are contradictory (Gunderson et al., 2018). Several publications emphasize that patients with BPD have a less favorable outcome compared to other types of personality disorders (PD) (Videler et al., 2019; Wertz et al., 2020; Simonsen et al., 2025). In other studies, on the contrary, a tendency towards gradual stabilization of the personality structure of these patients was determined, with a high frequency of achieving remission, reaching 88% (Temes & Zanarini, 2018), and a gradual improvement in the level of social functioning (Arens et al., 2013; Paris & Zweig-Frank, 2001).

Borderline personality disorder in youth is associated with the addition of comorbid pathology of the affective, neurotic, and addictive spectrums (Choate et al., 2021). According to some authors, in a portion of patients, after the completion of adolescence, an increase in the influence of comorbid pathology is noted (Winsper, 2021), while the addition of drive disorders significantly complicates the dynamics of BPD and causes unfavorable outcomes (Kienast et al., 2014). In another group of patients, due to the proximity of the BPD structure, on the one hand, to bipolar affective disorder (BAD) (Durdurak et al., 2022; Feichtinger et al., 2024), and on the other hand, to the schizophrenic spectrum, a nosological trajectory towards a change in diagnosis towards these diseases is determined. This indicates the presence of pronounced diagnostic uncertainty for this category of patients and the formation of two multidirectional vectors of the course (Zandersen et al., 2019; Jørgensen et al., 2024; Jourdan et al., 2026).

Follow-up studies emphasize the influence of social and exogenous factors on the level of social functioning, where one of the important predictors of an unfavorable outcome is the high suicide rate in some patients with BPD in adulthood (Dixon-Gordon et al., 2022; Reichl & Kaess, 2021; Simonsen et al., 2025). The variability of outcomes, high suicidal risk, and the evolution of psychopharmacological approaches necessitate the study of the modern pathomorphosis of borderline personality disorder—assessing how nosological trajectories change across different generations of patients (Gunderson et al., 2018; Gartlehner et al., 2021; Liu et al., 2024).

## 2. Objective of the Study

To determine the dynamics of borderline personality disorder (BPD) with onset in youth age based on the study of two follow-up groups to assess the further nosological trajectory and outcomes.

## 3. Materials and Methods

The study was conducted at the Federal State Budgetary Scientific Institution Mental Health Research Center (FSBSI MHRC) in the Department of Youth Psychiatry. A total of 143 patients with adolescent BPD were examined using clinical-psychopathological and psychometric methods. Two follow-up groups were formed: group 1 (2019-2022) consisting of 73 patients (67.1% - 49 males and 32.9% – 24 females, mean age at first admission 20 ± 4.2 years) who were undergoing inpatient treatment or outpatient observation in the clinical departments of the FSBSI MHRC in 2019-2022 with a diagnosis of BPD in adolescence. This group was re-examined on an outpatient basis in the period 2024-2026 to assess further dynamics; the duration of the follow-up was 4.5 ± 2.5 years. The second follow-up group (2006-2010) consisted of 70 patients (61% - 43 males and 39% - 27 females, mean age at first admission 22 ± 5.5 years) who underwent initial examination in 2006-2010 and evaluation in 2021-2022, with an observation duration of at least 10 years.

To ensure the reliability of the results and preserve the initial size of the follow-up sample (n = 73 for the first group and n = 70 for the second), a comprehensive assessment of outcomes and nosological trajectories was conducted. The main part of the patients underwent a full-time outpatient examination. For patients unavailable for face-to-face contact (due to refusal to interview, change of residence, staying in closed rehabilitation centers, or penal institutions), remote assessment was applied. Remote verification of outcomes was carried out based on the analysis of current medical documentation (information about hospitalizations, visits for psychiatric and narcological care), as well as by collecting an objective anamnesis from close relatives.

*Inclusion criteria*: adolescence at the time of initial examination (16 - 25 years); diagnosis of borderline personality disorder (F60.31 – in accordance with ICD-10 criteria, emotionally unstable personality disorder (borderline type)); duration of follow-up observation of at least 2 years (Group 1) or at least 10 years (Group 2); patient's informed consent to participate in the study.

*Exclusion criteria*: presence of concomitant psychiatric, somatic, or neurological pathology that complicates the study. The main methods chosen were: clinical-psychopathological, follow-up, and psychometric methods. For BPD verification, the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD) (First et al., 2016) was used. For an integrative assessment of disorder outcomes, the SOPS psychometric scale (Miller et al., 2003) was used. Statistical processing of the obtained data was performed using the STATISTICA 10.0 software package for WINDOWS (StatSoft, USA). To determine the statistical significance of differences, Pearson's chi-squared test ($\chi^2$) and Student's t-test were used. To ensure the reliability of the results, Fisher's exact two-tailed test was additionally applied. A value of $p \leq 0.05$ was accepted as the critical level of statistical significance.

## 4. Results

The study found that the first clinical manifestations of borderline personality disorder (BPD) are detected as early as childhood in the form of emotional instability, behavioral reactions, and adaptation difficulties in children's groups, which were the consequence of the presence of the main BPD personality patterns. During adolescence, pathological symptoms acquired more distinct features, and general affective tension gradually formed; in a number of patients, non-suicidal self-injury (NSSI) could be noted for the first time, which occurred against the background of conflicts and personal failures and was used to attract attention or to alleviate their condition.

During the period of clinical manifestation, the phenomena of affective instability occupied one of the central positions in conjunction with self-identity disorders, reduced impulse control, and the addition of auto-aggressive and addictive behavior, which, under the influence of the age factor, acquired a polymorphic and heterogeneous character with the formation of a single continuum of psychopathological disorders (Kaess et al., 2014; Feichtinger et al., 2024; Bohus et al.,

2021; Lin et al., 2024). Based on the results of the examination of the first follow-up group in the period 2019-2022, a typology of borderline personality disorder was developed: with phenomena of "affective storm" (type I) (Kernberg, 2003); with the dominance of drive disorders of the "addictive adrenalinomania" type (type II); with a predominance of "cognitive dissociation and self-identity disorders" (type III) (Kuleshov, 2022).

**Type I (38.4%, n = 28)**—with phenomena of "affective storm", was characterized by the dominance of affective disorders with the simultaneous coexistence of various types of affect with frequent changes in the affective component, which, in conjunction with personal reactions, caused the occurrence of outbursts of uncontrolled anger with gross behavioral disorders, including self-injurious behavior, more often of an impulsive nature. Suicide attempts (SA) in this case were a continuation of NSSI. Throughout youth, in the dynamics of this BPD type, affective instability in some patients (36.9%, n = 7) gradually transformed into full-fledged continuous bipolar affective phases with depressive, hypomanic, and affectively mixed states, which became less pronounced after the completion of youth but retained their dominant position, which corresponded to the dynamics of dysrhythmic continuous bipolar affective disorders in BPD (Kaleda & Zyablov 2020). In others (63.2%, n = 12) of this type throughout youth, the persistence of phenomena of affective instability was noted, which, in conjunction with self-identity disorders, led to the formation of overvalued ideas predominantly of an existential orientation, which were distinguished by instability and variability of the plot. During further follow-up examination of this group (22 patients were re-examined, 78.57%, in the period 2024-2026), it was found that the affective phases became more distinct and were characterized by autochthony, while the significance of the psychotraumatic factor persisted. At the same time, overvalued interests and aspirations associated with affect lost their intensity and polymorphism, integrating into the structure of the worldview with the formation of stable religious and philosophical life positions. In the structure of drive disorders, the affective component and impaired impulse control prevailed without the formation of persistent addictions. In 14 patients with type I BPD (63.64%), the further dynamics were characterized by a gradual decrease in the severity of affective instability, with the persistence of pathocharacterological reactions (**Table 1**).

**Table 1.** Nosological trajectory of BPD diagnosis in youth based on the study of follow-up group I (2019-2022).

| Diagnosis (ICD-10) | Type I (n = 22) | Type II (n = 8) | Type III (n = 26) | p-value |
|---|---|---|---|---|
| **F60.31** | 63.6% (14) | 62.5% (5) | 53.8% (14) | 0.786 |
| **F31.X** | 36.4% (8) | 0.0% (0) | 3.8% (1) | **0.001*** |
| **F20.X-25.X** | 0.0% (0) | 0.0% (0) | 3.8% (1) | 0.723 |
| **F21.X** | 0.0% (0) | 37.5% (3) | 38.5% (10) | **0.002*** |

*$p \leq 0.05$.

In 8 patients (36.36%), the dynamics were characterized by a distinct nosological shift (affective vector of transformation). In this part of the patients, affective instability transformed into distinct affective phases, gradually losing its connection with psychotraumatic triggers and meeting the criteria for bipolar affective disorder (BAD) against the background of stabilization of personality characteristics. When assessing outcomes for this group, favorable and relatively favorable outcomes were characteristic, amounting in total to 46.43%. This group included the results of a face-to-face follow-up examination of 10 patients who demonstrated a reduction in behavioral disorders and stabilization of social functioning, as well as 3 patients evaluated remotely (refusal of a face-to-face interview with confirmed psychosocial well-being and absence of visits for psychiatric care). Relatively unfavorable and unfavorable outcomes were recorded in 53.57%. Of these, 12 cases were verified during a face-to-face clinical interview (persistent maladaptation requiring periodic inpatient treatment), and 3 cases were qualified as an unfavorable outcome based on objective information (2 completed suicides, 1 imprisonment) (**Table 2**).

**Table 2.** Comprehensive assessment of follow-up outcomes in 2 observation groups.

| Outcome options | Follow-up | Type I BPD | Type II BPD | Type III BPD | p-value |
|---|---|---|---|---|---|
| **Favorable** | Group 1 2019-2022 | 7.14% (2) | 0.00% (0) | 3.45% (1) | 0.483 |
| | Group 2 2006-2010 | 10.5% (2) | 3.7% (1) | 4.2% (1) | 0.612 |
| **Relatively favorable** | Group 1 2019-2022 | **39.29% (11)** | 6.25% (1) | 10.34% (3) | **0.005*** |
| | Group 2 2006-2010 | **47.4% (9)** | 14.8% (4) | 8.3% (2) | **0.004*** |
| **Relatively unfavorable** | Group 1 2019-2022 | 39.29% (11) | 37.50% (6) | **72.41% (21)** | **0.016*** |
| | Group 2 2006-2010 | 31.6% (6) | 59.3% (16) | **79.2% (19)** | **0.003*** |
| **Unfavorable** | Group 1 2019-2022 | 14.28% (4) | **56.25% (9)** | 13.80% (4) | **0.002*** |
| | Group 2 2006-2010 | 10.5% (2) | 22.2% (6) | 8.3% (2) | 0.274 |

*$p \leq 0.05$.

**In type II BPD (21.9%, n = 16)**—with the dominance of drive disorders of the "addictive adrenalinomania" type, one of the key positions was occupied by addictions, which were accompanied by pronounced affective tension with a sense of excitement, a subjective need to relieve "tension", followed by a loss of control and insight. A high degree of severity of the condition led to social isolation and pronounced educational maladaptation of patients, with the formation of a corresponding dependent lifestyle and the emergence of addictive depressions. When assessing auto-aggressive behavior, the simultaneous existence of NSSI and SA was found, with the absence of isolated suicidal activity.

In the further follow-up study of the dynamics of this BPD type (8 patients were re-examined, 50%, in the period 2024-2026), it was found that throughout adolescence, a certain "lifestyle" was formed with the choice of extreme hobbies and a

constant need to search for new experiences, which were often accompanied by antisocial acts. The "addictive" lifestyle was destructive in nature and, during the period of pronounced clinical manifestations, became the cause of social and labor maladaptation. Patients gradually lost their previous productivity, and phenomena of negative affectivity were formed with a predominance of anhedonic and dysphoric components, which the patients tried to independently relieve by using alcohol and various psychoactive substances (PAS). After the completion of adolescence, a general tendency toward amalgamation with addictive behavioral patterns was characteristic. Affective instability retained its relationship with psychotraumatic and exogenous factors, with the addition of comorbid cyclothymic disorders in the further dynamics, the intensity of which was correlated with PAS use.

In the dynamics of follow-up observation, 5 patients (62.5%) retained clinical signs of BPD with a drive for extreme activities, inconsistency in sexual relations, and the formation of the adrenalinomania phenomenon. At the same time, a pronounced craving for PAS and alcohol persisted, where the long-term negative impact of psychoactive substances on the brain caused the development of encephalopathy and organic personality changes, which subsequently led to increased impulsivity and a deepening of self-identity disorders.

For 3 other patients (37.5%), dynamics with the complication of symptoms, the addition and intensification of neurotic disorders, and prolonged affective phases not associated with psychotraumatic situations were identified; the psychopathology of the patients at the time of re-examination corresponded to the diagnosis of schizotypal disorder (F21.X).

An integrative assessment was conducted with mandatory consideration of all outcomes (16 patients) to maintain the reliability of the sample. Eight patients underwent a face-to-face follow-up interview at the second control point. The assessment of outcomes for the remaining 8 patients was conducted based on medical documentation data and objective information from close relatives. In the case of unfavorable dynamics, patients often sought help from addiction specialists and underwent treatment in rehabilitation centers. Polyaddictive disorders contributed to the emergence of internal organ pathology, the addition of chronic infectious diseases (hepatitis C carriage), and acted as an aggravating somatic factor (fatal outcome in 1 patient, 6.25%), as well as completed suicide attempts in 3 patients (18.75%). Five individuals (31.25%) were in narcological rehabilitation centers during the follow-up examination period or are continuing treatment there at present.

**In type III BPD (39.7%, n = 29)** with a predominance of "cognitive dissociation" and self-identity disorders, the condition was characterized by a mosaic psychopathological structure based on cognitive disorders with a dichotomous type of thinking, self-identity disorders with dissociative disorders, and various depersonalization, obsessive-compulsive, and anxiety disorders with the possible occurrence of transient and attenuated psychotic symptoms at the peak of the condition.

This type was characterized by a great depth of emotional disturbances, represented, on the one hand, by the phenomena of alexithymia, and on the other hand, by emotional vulnerability, which significantly complicated the establishment of interpersonal contacts with a high risk of forming codependent and counter-dependent relationships. In this group, self-identity disorders and alexithymia phenomena within the BPD personality construct were the basis for the depersonalization type of auto-aggressive behavior. Most often, patients committed NSSI and SA to experience emotions or to interrupt a state of numbness.

Throughout the adolescent period, cognitive distortions caused the emotional splitting characteristic of BPD, combining, on the one hand, phenomena of morbid insensitivity and alexithymia, and on the other hand, emotional hypersensitivity. Cognitive distortions and anxiety-depressive affect intensified the phenomena of neurotic fixation, which actualized concomitant obsessive-phobic and obsessive-compulsive disorders. These negatively affected cognitive abilities, triggering a mechanism of obsessive ruminative introspection with existential reflections and representations of a polythematic structure. Patients more often refused informal communication, experienced difficulties in communication, and at times completely broke off social contacts. It should be noted that during the period of pronounced clinical manifestations, this type was the most difficult to distinguish from patients with schizotypal personality disorder (STPD).

After the completion of adolescence, a significant portion of the patients, 14 individuals (53.8%) with this BPD variety, retained their clinical polymorphism. This was caused by the presence of all psychopathological components: impulsivity and affective instability, but above all, the dominance of self-identity disorders and dissociative symptoms, while remaining within the nosological criteria of BPD. In the structure of affective disorders, prolonged depressive states prevailed with an intensification of the formation of negative affectivity and hypochondriacal fixation within the BPD structure. At the same time, unlike patients with a trajectory towards schizotypal disorder, insight into their own behavior and condition was preserved, along with a sufficiently high level of social functioning (albeit at a somewhat lower level), which became a reason for committing SA in adulthood and determined various options for BPD outcomes.

The proportion of patients who experienced a transformation of the diagnosis towards schizotypal disorder was 38.5% ($p = 0.001$). These patients were characterized by a complication of symptoms with an increase in self-identity disorders, growing negative changes in the personality sphere, a loss of the volitional component and motivation for any activity, along with increasing autism, suspiciousness, and social isolation characteristic of the schizotypal spectrum of disorders.

An integrative assessment recorded the most severe profile of outcomes. Favorable and relatively favorable outcomes accounted for only 13.79% (4 out of 29 patients), which corresponded to cases of partial clinical and social compensation confirmed during a face-to-face examination. Relatively unfavorable and unfavorable outcomes dominated, accounting for 86.21% (25 out of 29 patients). This

group included both patients examined during a face-to-face follow-up interview (persistent pronounced social maladaptation, inability to engage in regular labor activity against the background of increasing negative or subpsychotic symptoms), and patients whose outcomes were verified remotely based on medical documentation and information from relatives.

To determine the features of the dynamics and outcomes of BPD in the long-term follow-up group (2006-2010) after the completion of adolescence, a study of the characteristics of social and labor adaptation was conducted. During the period of pronounced clinical manifestations of BPD in youth, all observed patients exhibited impairments in social and labor adaptation, the main cause of which were behavioral disorders and concomitant clinical signs of BPD. However, in adulthood, the formation of adaptive mechanisms was noted as the severity of psychopathological disorders decreased. All examined BPD patients were able to obtain a general secondary or specialized secondary education. At the same time, throughout adolescence, educational and labor adaptation remained unstable. The severity of clinical symptoms of BPD caused the inability of patients to engage in purposeful and systematic activity, which reflected a rather high percentage of those who did not complete a university degree program (37.1%, n = 26). Patients frequently discontinued their studies, took academic leaves for medical and family reasons, and changed their field of study and specialty. However, according to follow-up data, a significant number of patients obtained a specialized secondary (14.3%, n = 10) and higher education (44.3%, n = 31), which indicates a stabilization of the condition of BPD patients after the completion of adolescence and confirms that educational maladaptation was episodic in nature with maximum severity during the youth period.

In the follow-up study, BPD patients were characterized by an uneven distribution of employment characteristics. In some patients, professional growth (15.7%, n = 11) and stabilization of work activity (31.4%, n = 21) were noted. However, a decrease in working capacity was recorded in 44.3% (n = 31) of patients, who were characterized by frequent changes in employment, with an average employment duration of up to six months and long periods without permanent employment. The main reasons for dismissals and changing jobs were interpersonal conflicts and difficulties in maintaining discipline and planning their work activity. Due to persistent impairments in labor adaptation, phenomena of social drift were noted in a number of cases, involving a transition to jobs that did not correspond to their level of education.

The obtained data indicate, on the one hand, the persistence of the impact of the psychopathic structure on the decrease in the overall quality of life, which correlates with previous studies (Bohus et al., 2021; Lin et al., 2024). On the other hand, it is impossible to exclude the influence of comorbid disorders of the affective spectrum, especially BAD with a dysrhythmic type of course (Kaleda & Zyablov, 2020), disorders of the neurotic spectrum, and especially pronounced addictive disorders, which contribute to a decrease in the quality of life of patients.

An assessment of family status at the time of the follow-up study revealed that some patients were married; however, a rather high percentage of divorces was noted. At the same time, some patients had never been in long-term, stable relationships at the time of the study, while more than half of the examined patients had children at the time of the follow-up examination. Furthermore, 21 patients (31.4%) characterized their marital relationships as conflictual, and 5 individuals (9.8%) admitted to using violence against their family members. Thus, personality anomalies exert a negative impact on family status.

An integrative assessment of outcomes revealed that type I is characterized by the most favorable socio-labor prognosis indicators: a "favorable" outcome and a relatively favorable outcome (10.5% and 47.4% of cases, respectively). Type II and III BPD were characterized by relatively unfavorable (59.3% and 79.2%) and unfavorable outcomes (22.2% and 8.3%- 8 patients), which is due to the clinical specificity of these varieties with a predominance of drive disorders and self-identity disorders in their structure.

Based on the results of the nosological assessment, the following diagnostic trajectories were identified. In some patients, the dynamics of affective disorders at the time of the follow-up study showed signs of a "bipolar experience" of an endogenous nature (Lobban et al., 2012; Feichtinger et al., 2024). At the time of the follow-up, diagnostic criteria were retained by 61.43% of patients with BPD in youth: 63.16% of type I patients, 62.96% of type II patients, and 58.33% of type III patients. In the dynamics of the BPD variety with phenomena of "affective storm" (type I), comorbidity with bipolar affective disorders was characteristic, with a tendency toward two options for the further trajectory: with a gradual reduction of affective disorders and the dominance of personality reactions in 63.2%, and with the formation of BAD and stabilization of pathological personality manifestations in 36.8% (7 observations).

Varieties II and III of BPD were distinguished by a significant expansion of diagnostic categories, with the addition of BAD (type II - 7.4% of patients, type III - 16.67% of patients) and the presence of nosological trajectories toward diagnoses of the endogenous-processual spectrum: schizophrenia (type II - 11.11% of patients, type III - 4.2% of patients) and schizotypal disorder (type II - 18.5% of patients, type III - 20.8% of patients) (**Table 3**).

**Table 3.** Nosological trajectory of BPD diagnosis in youth based on the study of follow-up group II (2006-2010).

| Diagnosis (ICD-10) | Type I (n = 19) | Type II (n = 27) | Type III (n = 24) | p-value |
|---|---|---|---|---|
| **F60.31** | 63.16% (12) | 62.96% (17) | 58.33% (14) | 0.936 |
| **F31.X** | 36.84% (7) | 7.41% (2) | 16.67% (4) | **0.034*** |
| **F20.X-25.X** | 0.00% (0) | 11.11% (3) | 4.17% (1) | 0.190 |
| **F21.X** | 0.00% (0) | 18.52% (5) | 20.83% (5) | 0.119 |

*$p \leq 0.05$.

## 5. Discussion

The conducted comparative study of two follow-up groups of patients (2006-2010 and 2019-2022) allows us to draw an important conclusion about the high stability of pathodynamic processes in borderline personality disorder in youth. When comparing the two follow-up groups with each other, an absence of statistically significant differences ($p > 0.05$) in nosological trajectories between the two follow-up groups was found. This indicates the regularity of the dynamics of borderline personality disorder, as well as the stability of the identified nosological trajectories and further prognostic assessment.

The BPD typology identified on the basis of clinical-psychopathological analysis (with phenomena of "affective storm", "addictive adrenalinomania", and "cognitive dissociation") demonstrated high prognostic validity.

The dynamics of type I (with phenomena of "affective storm") confirm the concept of a close genetic and pathogenetic connection of this form of BPD with bipolar spectrum disorders. The transformation of affective instability into distinct phases meeting the criteria for BAD (in 36.4%, $p = 0.001$ of patients in the first follow-up group and 36.8%, $p = 0.034$ in the second follow-up group), which is confirmed by statistical significance, was accompanied by a stabilization of behavioral patterns and led to the most favorable outcomes of social adaptation.

Nosological trajectories in type III BPD (with a predominance of cognitive dissociation) deserve special attention. In a significant portion of these patients in the two follow-up groups (38.5% and 20.8%), a trajectory towards the diagnosis of schizotypal disorder (F21.X) was recorded ($p = 0.002$). The observed dynamics reflect not a diagnostic error, but a true nosological trajectory, in which deep self-identity disorders and increasing autism act as predictors of the schizotypal continuum. It is this subgroup that demonstrates the most severe profile of outcomes with the dominance of social maladaptation.

The analysis of socio-labor adaptation revealed the phenomenon of "social drift". Despite the preserved intellectual potential and the ability of the majority of patients to obtain higher or specialized secondary education, their long-term professional realization remains highly unstable. Frequent changes of jobs and interpersonal conflicts (in 44.3% of patients), as well as a high level of divorces and domestic violence, emphasize that clinical stabilization of affective symptoms does not always correspond to the restoration of social functioning. For type II patients, a critical factor that worsens the prognosis and increases the risk of mortality is the addition of polyaddictive disorders.

## 6. Conclusion

Thus, borderline personality disorder (BPD) in youth represents a clinically heterogeneous pathology, in the structure of which, based on the dominant psychopathological radical, three types are distinguished: with phenomena of "affective storm" (type I), "addictive adrenalinomania" (type II), and "cognitive dissociation" (type III). The further dynamics of BPD after the completion of adolescence

are characterized by pronounced diagnostic uncertainty with the formation of multidirectional nosological trajectories. Type I demonstrates high comorbidity with bipolar affective disorder (BAD) and has the most favorable social prognosis. Types II and III are associated with an expansion of diagnostic categories towards schizotypal disorder and schizophrenia, which causes the predominance of unfavorable outcomes. A comparative analysis of the two groups with different follow-up durations (2006-2010 and 2019-2022) did not reveal statistically significant differences ($p > 0.05$) in the vectors of nosological transformation. This proves the independence of the identified pathodynamic patterns of BPD from the time factor and generational change. The high risk of forming chemical and non-chemical addictions, auto-aggressive behavior, and a persistent decrease in the level of socio-labor adaptation ("social drift") necessitates the development of differentiated therapeutic and rehabilitation intervention programs as early as the initial stages of treatment for patients with borderline personality disorder in youth.

## Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

## References

Arens, E. A., Stopsack, M., Spitzer, C., Appel, K., Dudeck, M., Völzke, H. et al. (2013). Borderline Personality Disorder in Four Different Age Groups: A Cross-Sectional Study of Community Residents in Germany. *Journal of Personality Disorders, 27,* 196-207. https://doi.org/10.1521/pedi.2013.27.2.196

Bohus, M., Stoffers-Winterling, J., Sharp, C., Krause-Utz, A., Schmahl, C., & Lieb, K. (2021). Borderline Personality Disorder. *The Lancet, 398,* 1528-1540. https://doi.org/10.1016/s0140-6736(21)00476-1

Choate, A. M., Fatimah, H., & Bornovalova, M. A. (2021). Comorbidity in Borderline Personality: Understanding Dynamics in Development. *Current Opinion in Psychology, 37,* 104-108. https://doi.org/10.1016/j.copsyc.2020.09.015

Dixon-Gordon, K. L., Waite, E. E., Ammerman, B. A., Haliczer, L. A., Boudreaux, E. D., Rathlev, N. et al. (2022). Learning from Gain and Loss: Links to Suicide Risk. *Journal of Psychiatric Research, 147,* 126-134. https://doi.org/10.1016/j.jpsychires.2021.12.016

Durdurak, F., Mallikarjun, P., & Marwaha, S. (2022). Understanding the Development of Bipolar Disorder and Borderline Personality Disorder in Young People: A Meta-Review of Systematic Reviews. *Neuroscience & Biobehavioral Reviews, 142,* Article ID: 104886.

Feichtinger, K., Laczkovics, C., Alexopoulos, J., Gruber, M., Klauser, M., Parth, K. et al. (2024). Personality Functioning in Bipolar 1 Disorder and Borderline Personality Disorder. *BMC Psychiatry, 24,* Article No. 846. https://doi.org/10.1186/s12888-024-06297-8

First, M. B., Williams, J. B. W., Benjamin, L. S., & Spitzer, R. L. (2016). *Structured Clinical Interview for DSM-5® Personality Disorders (SCID-5-PD).* American Psychiatric Association.

Fonagy, P., Speranza, M., Luyten, P., Kaess, M., Hessels, C., & Bohus, M. (2015). ESCAP Expert Article: Borderline Personality Disorder in Adolescence: An Expert Research Review with Implications for Clinical Practice. *European Child & Adolescent Psychiatry, 24,* 1307-1320. https://doi.org/10.1007/s00787-015-0751-z

Gartlehner, G., Crotty, K., Kennedy, S., Edlund, M. J., Ali, R., Siddiqui, M. et al. (2021).

Pharmacological Treatments for Borderline Personality Disorder: A Systematic Review and Meta-Analysis. *CNS Drugs, 35,* 1053-1067. https://doi.org/10.1007/s40263-021-00855-4

Guilé, J. M., Boissel, L., Alaux-Cantin, S., & Garny de La Rivière, S. (2018). Borderline Personality Disorder in Adolescents: Prevalence, Diagnosis, and Treatment Strategies. *Adolescent Health, Medicine and Therapeutics, 9,* 199-210. https://doi.org/10.2147/ahmt.s156565

Gunderson, J. G., Herpertz, S. C., Skodol, A. E., Torgersen, S., & Zanarini, M. C. (2018). Borderline Personality Disorder. *Nature Reviews Disease Primers, 4,* Article No. 18029. https://doi.org/10.1038/nrdp.2018.29

Jørgensen, M. S., Møller, L., Bo, S., Kongerslev, M., Hastrup, L. H., Chanen, A. et al. (2024). The Course of Borderline Personality Disorder from Adolescence to Early Adulthood: A 5-Year Follow-Up Study. *Comprehensive Psychiatry, 132,* Article ID: 152478. https://doi.org/10.1016/j.comppsych.2024.152478

Jourdan, J., Estric, C., O'Donoghue, B., Chanen, A., & Schandrin, A. (2026). Co-Occurrence of Psychotic Disorders and Borderline Personality Disorder: A Systematic Review and Meta-Analysis. *Psychological Medicine, 56,* e43. https://doi.org/10.1017/s0033291726103432

Kaess, M., Brunner, R., & Chanen, A. (2014). Borderline Personality Disorder in Adolescence. *Pediatrics, 134,* 782-793. https://doi.org/10.1542/peds.2013-3677

Kaleda, V. G., & Zyablov, V. A. (2020). Continuous Cycling Bipolar Affective Disorders in Youth. *Zhurnal nevrologii i psikhiatrii im. S.S. Korsakova, 120,* Article No. 14. https://doi.org/10.17116/jnevro202012004114

Kernberg, O. F. (2003). The Management of Affect Storms in the Psychoanalytic Psychotherapy of Borderline Patients. *Journal of the American Psychoanalytic Association, 51,* 517-545. https://doi.org/10.1177/00030651030510021101

Kienast, T., Stoffers, J., Bermpohl, F., & Lieb, K. (2014). Border-line-persönlichkeitsstörung und komorbide abhängigkeitserkrankungen: Epidemiologie und therapie. *Deutsches Arzteblatt International, 111,* 280-286.

Kuleshov, A. A. (2022). Clinical and Psychopathological Features of Borderline Personality Disorder in Adolescence. *Psikhiatriya, 20,* 32-41. https://doi.org/10.30629/2618-6667-2022-20-2-32-41

Lin, Y., Guo, Z., Zhou, Y., Wei, Y., Xu, L., Tang, X. et al. (2024). Distribution of Self-Reported Borderline Personality Disorder Traits Symptoms in a Large-Scale Clinical Population. *Frontiers in Psychiatry, 15,* Article ID: 1424966. https://doi.org/10.3389/fpsyt.2024.1424966

Liu, Y., Chen, C., Zhou, Y., Zhang, N., & Liu, S. (2024). Twenty Years of Research on Borderline Personality Disorder: A Scientometric Analysis of Hotspots, Bursts, and Research Trends. *Frontiers in Psychiatry, 15,* Article ID: 1361535. https://doi.org/10.3389/fpsyt.2024.1361535

Lobban, F., Taylor, K., Murray, C., & Jones, S. (2012). Bipolar Disorder Is a Two-Edged Sword: A Qualitative Study to Understand the Positive Edge. *Journal of Affective Disorders, 141,* 204-212. https://doi.org/10.1016/j.jad.2012.03.001

Miller, T. J., McGlashan, T. H., Rosen, J. L., Cadenhead, K., Ventura, J., McFarlane, W. et al. (2003). Prodromal Assessment with the Structured Interview for Prodromal Syndromes and the Scale of Prodromal Symptoms: Predictive Validity, Interrater Reliability, and Training to Reliability. *Schizophrenia Bulletin, 29,* 703-715. https://doi.org/10.1093/oxfordjournals.schbul.a007040

Paris, J., & Zweig-Frank, H. (2001). A 27-Year Follow-Up of Patients with Borderline

Personality Disorder. *Comprehensive Psychiatry, 42,* 482-487. https://doi.org/10.1053/comp.2001.26271

Reichl, C., & Kaess, M. (2021). Self-Harm in the Context of Borderline Personality Disorder. *Current Opinion in Psychology, 37,* 139-144. https://doi.org/10.1016/j.copsyc.2020.12.007

Simonsen, E., Vestergaard, M., Møller, L., Bo, S., Kongerslev, M., Hastrup, L. H. et al. (2025). Prediction of Non-Remission in a 5-Year Follow-Up of Borderline Personality Disorder in Adolescence. *Personality and Mental Health, 19,* e70041. https://doi.org/10.1002/pmh.70041

Temes, C. M., & Zanarini, M. C. (2018). The Longitudinal Course of Borderline Personality Disorder. *Psychiatric Clinics of North America, 41,* 685-694. https://doi.org/10.1016/j.psc.2018.07.002

Videler, A. C., Hutsebaut, J., Schulkens, J. E. M., Sobczak, S., & van Alphen, S. P. J. (2019). A Life Span Perspective on Borderline Personality Disorder. *Current Psychiatry Reports, 21,* Article No. 51. https://doi.org/10.1007/s11920-019-1040-1

Wang, Q., Li, Z., & Zhong, J. (2024). Network Analysis of Borderline Personality Features in Adolescence Using a Screening Tool in a Chinese Community Sample. *Psychopathology, 57,* 182-191. https://doi.org/10.1159/000535586

Wertz, J., Caspi, A., Ambler, A., Arseneault, L., Belsky, D. W., Danese, A. et al. (2020). Borderline Symptoms at Age 12 Signal Risk for Poor Outcomes during the Transition to Adulthood: Findings from a Genetically Sensitive Longitudinal Cohort Study. *Journal of the American Academy of Child & Adolescent Psychiatry, 59,* 1165-1177.e2. https://doi.org/10.1016/j.jaac.2019.07.005

Winsper, C. (2021). Borderline Personality Disorder: Course and Outcomes across the Lifespan. *Current Opinion in Psychology, 37,* 94-97. https://doi.org/10.1016/j.copsyc.2020.09.010

Zandersen, M., Henriksen, M. G., & Parnas, J. (2019). A Recurrent Question: What Is Borderline? *Journal of Personality Disorders, 33,* 341-369. https://doi.org/10.1521/pedi_2018_32_348