Sustained Symptomatic Remission and Recovery and Their Loss Among Patients With Borderline Personality Disorder and Patients With Other Types of Personality Disorders:

A 24-Year Prospective Follow-Up Study

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Abstract

Objectives: The first purpose of this study was to determine time to attainment of symptomatic remissions and recoveries of 2–12 years duration for those with borderline personality disorder (BPD) and patients with other personality disorders (OPDs); the second was to determine the stability of these outcomes.

Methods: Two hundred ninety inpatients meeting both Revised Diagnostic Interview for Borderlines (DIB-R) and *DSM-III-R* criteria for BPD and 72 patients with OPDs were assessed during their index admission using a series of semistructured interviews. The same instruments were readministered at 12 contiguous 2-year time periods.

Results: Patients with BPD were significantly slower to achieve remission or recovery (which involved good social and vocational functioning as well as symptomatic remission) than patients with OPD. However, those in both study groups ultimately achieved about the same high rates of remission (BPD patients: 77%–100%; patients with OPD: 97%–100%) but not recovery (37%–60% vs 68%–89%) by the time of the 24-year follow-up. In contrast, symptomatic recurrence (11%–40% vs 5%–10%) and loss of recovery (29%–59% vs 15%–42%) occurred more rapidly and at substantially higher rates among BPD patients than patients with OPD.

Conclusions: Taken together, the results of this study suggest that sustained symptomatic remission is substantially more common than sustained recovery from BPD. They also suggest that loss of sustained recovery is more common than symptomatic recurrences for those with BPD.

J Clin Psychiatry 2024;85(4):24m15457

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Many clinicians used to believe that borderline personality disorder (BPD) was a chronic psychiatric disorder. This belief was maintained throughout the 1980s and into the early 1990s despite evidence from 4 large-scale, long-term, follow-back studies of the longitudinal course of BPD that were conducted in the 1980s.[1–4] Only 1 of these studies assessed the remission rate of patients with BPD. Paris and Zweig-Frank,[2] using an early version of the Revised Diagnostic Interview for Borderlines (DIB-R), found that 75% of patients with BPD that they studied at a mean of 27 years after their index admission no longer met the criteria for the disorder. However, all 4 studies found high rates of good overall outcome as defined by a Global Assessment of Functioning (GAF) score of 61 or higher.

NIMH decided in the early 1990s to fund 2 methodologically rigorous large-scale, prospective studies of the long-term course of BPD—the McLean Study of Adult Development (MSAD)[5] and the Collaborative Longitudinal Personality Disorders Study (CLPS).[6] Both of these studies used semistructured interviews to assess borderline psychopathology at study entrance instead of the chart reviews used in these earlier studies. They both also had patients with other

Clinical Points

- Prior to this study, there were no findings on the prospective course of long-term symptomatic remissions and overall recoveries in patients with borderline personality disorder (BPD).
- Remissions of BPD are almost ubiquitous, but it is not clear whether treatment as usual in the community plays a role in this outcome.
- Recurrences of BPD are not uncommon and may need renewed treatment for stabilization.
- Recoveries from BPD are less common and more unstable than remissions and may need an emphasis in treatment on practical aspects of living.

personality disorders (OPDs) rather than no comparison patients[2] or patients with schizotypal personality disorder or schizophrenia.[1,3,4] In addition, they used semistructured interviews to assess cooccurring disorders, psychosocial functioning, and psychiatric treatment history at baseline and at twelve 2-year follow-ups in MSAD and one 10-year-long follow-up in CLPS.

Using the data from MSAD, we have conducted 3 prior studies on the course of symptomatic remissions and recoveries which entail a concurrent remission and good psychosocial functioning in patients with BPD and patients with OPDs over 6, 10, and 16 years of follow-up.[5,7,8] In the 10-year study, we found that remissions of 2 years were substantially more common than recoveries of the same length.[5] More specifically, we found that 93% of patients with BPD achieved a 2-year remission by the end of 10-year follow-up, while only 50% attained a 2-year recovery by this time. Comparatively, CLPS found that 85% of patients with BPD achieved a remission lasting 12 months or more after 10 years of prospective follow-up, as well as 20% of patients with BPD attained a GAF score of 71 or higher for 2 months or more which is roughly akin to our definition of recovery.[6]

The current study, which is an extension of MSAD, examines even longer remissions and recoveries because it is these lengthy outcomes that signify that clinically meaningful change has occurred. More specifically, our study builds on our prior work in 2 important ways. First, we followed these 2 study groups over 8 additional years of prospective follow-up, for 24 years all told. Second, we assessed remissions and recoveries lasting 2–12 years as well as the symptomatic recurrences and loss of recoveries that followed these outcomes.

METHODS

Study entrance began in June 1992 and continued until December 1995. The last follow-up interview was conducted in December 2018. The methodology of this study, which was reviewed and approved by the McLean Hospital Institutional Review Board, has been described in detail elsewhere.[7] Briefly, all patients were initially inpatients at McLean Hospital in Belmont, Massachusetts. Each patient was first screened to determine that they (1) were between the ages of 18–35; (2) had a known or estimated IQ of 71 or higher; and (3) had no history or current symptoms of schizophrenia, schizoaffective disorder, bipolar I disorder, or an organic condition that could cause psychiatric symptoms.

After the study procedures were explained, written informed consent was obtained. Each patient then met with a master's-level interviewer blind to the patient's clinical diagnoses for a thorough psychosocial and treatment history as well as diagnostic assessment. Four semistructured interviews were administered. These interviews were (1) the Background Information Schedule (BIS),[9] (2) the Structured Clinical Interview for *DSM-III-R* Axis I Disorders,[10] (3) the DIB-R,[11] and (4) the Diagnostic Interview for *DSM-III-R* Personality Disorders (DIPD-R).[12] The inter-rater and test-retest reliability of the BIS[13] and of the 3 diagnostic measures[14,15] have all been found to be good-excellent.

At each of 12 follow-up waves, separated by 24 months, psychosocial functioning and treatment utilization as well as symptomatic and personality psychopathology (formerly Axis I and II) were reassessed via interview methods similar to the baseline procedures by staff members blind to previously collected information. After informed consent was obtained, our diagnostic battery was readministered as well as the Revised Borderline Follow-up Interview—the follow-up analog to the BIS administered at baseline.[16] Good-excellent follow-up (within a generation of raters) and longitudinal (between generations of raters) inter-rater reliability was maintained throughout the course of the study for variables pertaining to psychosocial functioning and treatment use.[13] Good-excellent follow-up and longitudinal inter-rater reliability was also maintained for both symptomatic and personality disorders.[14,15]

Definition of Remission from BPD or Another Personality Disorder

We defined remission as no longer meeting study criteria for BPD (a score of 7 or less on DIB-R and meeting less than 5 of the *DSM* criteria for BPD) and for patients with OPD (being beneath the *DSM* cutoff for each of the personality disorders they met during their index admission) for a period of 2 years or more (or 1 follow-up period). We also studied remissions lasting 4, 6, and 8, 10, and 12 consecutive years (or 2, 3, 4, 5, or 6 consecutive follow-up periods).

Definition of Recovery from BPD or Another Personality Disorder

Our definition of recovery has 3 elements. A subject had to be in remission from their primary personality

Table 1.

Cumulative Rates of Remission for Patients With BPD and Patients With OPD Over 24 y of Prospective Follow-Up

	2 y FU	4 y FU	6 y FU	8 y FU	10 y FU	12 y FU	14 y FU	16 y FU	18 y FU	20 y FU	22 y FU	24 y FU
Remissions lasting 2 y[a]												
BPD	35	55	75	87	91	95	97	98	98	98	99	100
OPD	88	99	99	99	99	99	99	99	99	99	99	100
Remissions lasting 4 y[b]												
BPD		29	46	66	80	84	90	93	95	96	96	98
OPD		86	94	95	97	97	97	97	97	98	98	98
Remissions lasting 6 y[c]												
BPD			28	44	63	77	82	87	89	92	94	95
OPD			86	94	95	97	97	97	97	97	98	98
Remissions lasting 8 y[d]												
BPD				27	43	57	70	75	80	83	86	87
OPD				85	94	95	97	97	98	98	98	98
Remissions lasting 10 y[e]												
BPD					27	41	56	67	71	76	80	82
OPD					85	92	93	95	95	95	97	97
Remissions lasting 12 y[f]												
BPD						27	41	55	65	70	74	77
OPD						85	92	93	95	95	95	97

[a]2-year remissions: HR = 0.16, 95% CI, 0.09–0.28; $z = -6.49$, $P < .001$; BPD significantly slower time to remission.
[b]4-year remissions: HR = 0.20, 95% CI, 0.12–0.32; $z = -6.56$, $P < .001$; BPD significantly slower time to remission.
[c]6-year remissions: HR = 0.18, 95% CI, 0.11–0.30; $z = -6.89$, $P < .001$; BPD significantly slower time to remission.
[d]8-year remissions: HR = 0.16, 95% CI, 0.10–0.26; $z = -7.27$, $P < .001$; BPD significantly slower time to remission.
[e]10-year remissions: HR = 0.18, 95% CI, 0.11–0.29; $z = -7.03$, $P < .001$; BPD significantly slower time to remission.
[f]12-year remissions: HR = 0.17, 95% CI, 0.10–0.28; $z = -7.09$, $P < .001$; BPD significantly slower time to remission.
Abbreviations: BPD = borderline personality disorder, FU = follow-up, HR = hazard ratio, OPD = other personality disorders.

disorder diagnosis, have at least 1 emotionally sustaining relationship with a close friend or life partner/spouse, and be able to work or go to school consistently, competently, and on a full-time basis (which included being an unpaid carer). More specifically, an emotionally sustaining relationship was defined as one that helps a patient to function better and/or to feel better about themselves.

Statistical Analyses

The Kaplan-Meier product-limit estimator (of the survival function) was used to assess time to 2 (4, 6, 8, 10, and 12)-year remissions and time to 2 (4, 6, 8, 10, and 12)-year recoveries from BPD or another personality disorder. We defined time to attainment of these outcomes as the follow-up period at which these outcomes were first achieved.

The Kaplan-Meier product-limit estimator was also used to assess time to recurrence after remissions lasting 2–12 years and time to loss of recovery after recoveries lasting 2–12 years. We defined time to recurrence or loss of recovery as the number of years after first attaining these outcomes.

Finally, Cox proportional survival analyses were used to compare the patients with BPD and patients with OPD in terms of these time-to-event outcomes; these analyses yield a hazard ratio and 95% CI for the comparison of the 2 diagnostic groups. To adjust for multiplicity, a significance level of $P < .01$ was used for all analyses.

RESULTS

Two hundred ninety patients met both DIB-R and *DSM-III-R* criteria for BPD, and 72 met *DSM-III-R* criteria for at least 1 nonborderline personality disorder (and neither criteria set for BPD). Of these 72 patients with OPD, 4% met *DSM-III-R* criteria for an odd cluster personality disorder, 33% met *DSM-III-R* criteria for an anxious cluster personality disorder, 18% met *DSM-III-R* criteria for a nonborderline dramatic cluster personality disorder, and 53% met *DSM-III-R* criteria for personality disorder not otherwise specified (which was operationally defined in the DIPD-R as meeting all but one of the required number of criteria for at least 2 of the 13 Axis II disorders described in *DSM-III-R*).

Baseline demographic data have been presented before.[7] Briefly, 77.1% (N = 279) of the patients were female, and 87% (N = 315) were white. The average age

Table 2.

Cumulative Rates of Recurrence for Patients With BPD and Patients With OPD Over 24 y of Prospective Follow-Up

	2 y after 1st remission	4 y after 1st remission	6 y after 1st remission	8 y after 1st remission	10 y after 1st remission	12 y after 1st remission	14 y after 1st remission	16 y after 1st remission	18 y after 1st remission	0 y after 1st remission	22 y after 1st remission
Recurrence after remissions lasting 2 y[a]											
BPD	16	21	29	32	33	36	37	38	40	40	40
OPD	3	3	3	5	5	7	7	7	10	10	10
Recurrence after remissions lasting 4 y[b]											
BPD	7	17	21	23	26	27	29	32	32	32	
OPD	0	0	2	2	3	3	3	7	7	7	
Recurrence after remissions lasting 6 y[c]											
BPD	11	16	19	22	23	25	28	28	28		
OPD	0	2	2	3	3	3	7	7	7		
Recurrence after remissions lasting 8 y[d]											
BPD	6	9	13	14	16	19	19	19			
OPD	2	2	3	3	3	7	7	7			
Recurrence after remissions lasting 10 y[e]											
BPD	3	7	8	10	14	14	14				
OPD	0	2	2	2	5	5	5				
Recurrence after remissions lasting 12 y[f]											
BPD	4	5	8	11	11	11					
OPD	2	2	2	5	5	5					

[a]Recurrence after 2-year remissions: HR = 5.31, 95% CI, 2.30–12.24; $z = 3.92$, $P < .001$; BPD significantly faster time to recurrence
[b]Recurrence after 4-year remissions: HR = 5.76, 95% CI, 2.09–15.89; $z = 3.38$, $P = .001$; BPD significantly faster time to recurrence.
[c]Recurrence after 6-year remissions: HR = 4.83, 95% CI, 1.74–13.44; $z = 3.02$, $P = .003$; BPD significantly faster time to recurrence.
[d]Recurrence after 8-year remissions: HR = 2.99, 95% CI, 1.05–8.52; $z = 2.05$, $P = .040$; BPD not significantly faster time to recurrence.
[e]Recurrence after 10-year remissions: HR = 2.79, 95% CI, 0.83–9.42; $z = 1.65$, $P = .098$; BPD not significantly faster time to recurrence.
[f]Recurrence after 12-year remissions: HR = 2.14, 95% CI, 0.61–7.42; $z = 1.19$, $P = .233$; BPD not significantly faster time to recurrence.
Abbreviations: BPD = borderline personality disorder, HR = hazard ratio, OPD = other personality disorders.

of the patients was 27 years (SD = 6.3), the mean socioeconomic status was 3.3 (SD = 1.5) (where 1 = highest and 5 = lowest),[17] and their mean GAF score was 39.8 (SD = 7.8) (indicating major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood).[18]

In terms of continuing participation, 83% (N = 206/249) of surviving patients with BPD (15 died by suicide and 26 died of other causes) were reinterviewed at all 12 follow-up waves. A similar rate of participation was found for patients with OPD, with 79% (N = 53/67) of surviving patients in this study group (1 died by suicide and 4 died of other causes) being reassessed at all 12 follow-up waves.

Table 1 details time to attainment of remission from BPD or another personality disorder lasting 2, 4, 6, 8, 10 or 12 years. As can be seen, rates of remission were quite high for both BPD and OPD patients. By the time of the 24-year follow-up, the cumulative rates of remission for patients with BPD ranged from 100% (for a 2-year remission) to 77% (for a 12-year remission). The corresponding rates for OPD patients ranged from 100% to 97%. Compared to their OPD counterparts, patients with BPD remitted at a significantly slower pace. For each length of remission, about 30% of patients with BPD and 85% of patients with OPD achieved a symptomatic remission at the first possible time period.

Table 2 details time to recurrence of BPD or another personality disorder after first achieving remission from that disorder. As can be seen, by 22 years after the first remission, cumulative rates of symptomatic recurrence for patients with BPD ranged from 40% after a 2-year remission to 11% after a 12-year remission. The comparable figures for patients with OPD ranged from 10% after a 2-year remission to 5% after a 12-year remission. Additionally, patients with BPD also experienced recurrences significantly more rapidly than patients with OPD experienced recurrences after remissions ranging from 2 to 6 years. However, patients with BPD did not experience a recurrence significantly faster than patients with OPD for recurrences after 8-, 10-, and 12-year remissions.

Table 3 details time to recovery from BPD or another personality disorder. By 24-year follow-up, cumulative rates of recovery for patients with BPD ranged from 60%

Table 3.

Cumulative Rates of Recovery for Patients With BPD and Patients With OPD Over 24 y of Prospective Follow-Up

	2 y FU	4 y FU	6 y FU	8 y FU	10 y FU	12 y FU	14 y FU	16 y FU	18 y FU	20 y FU	22 y FU	24 y FU
Recoveries lasting 2 y[a]												
BPD	14	26	36	42	47	50	56	58	59	59	59	60
OPD	51	67	70	75	84	85	85	85	85	89	89	89
Recoveries lasting 4 y[b]												
BPD		12	23	33	40	44	46	50	53	54	54	54
OPD		47	63	66	68	76	82	82	82	82	84	84
Recoveries lasting 6 y[c]												
BPD			12	22	30	37	41	42	46	50	51	52
OPD			43	59	62	66	74	78	78	78	78	81
Recoveries lasting 8 y[d]												
BPD				11	21	28	34	38	39	43	46	47
OPD				42	57	59	62	71	74	74	74	74
Recoveries lasting 10 y[e]												
BPD					11	19	27	33	37	37	40	42
OPD					40	56	57	61	68	71	71	71
Recoveries lasting 12 y[f]												
BPD						10	19	26	32	34	34	37
OPD						36	52	54	57	62	66	68

[a]2-year recoveries: HR = 0.31, 95% CI, 0.22–0.44; $z = -6.42$, $P < .001$; BPD significantly slower time to recovery
[b]4-year recoveries: HR = 0.33, 95% CI, 0.23–0.48; $z = -5.92$, $P < .001$; BPD significantly slower time to recovery.
[c]6-year recoveries: HR = 0.35, 95% CI, 0.24–0.51; $z = -5.57$, $P < .001$; BPD significantly slower time to recovery.
[d]8-year recoveries: HR = 0.37, 95% CI, 0.25–0.54; $z = -5.05$, $P < .001$; BPD significantly slower time to recovery.
[e]10-year recoveries: HR = 0.35, 95% CI, 0.24–0.53; $z = -5.11$, $P < .001$; BPD significantly slower time to recovery.
[f]12-year recoveries: HR = 0.35, 95% CI, 0.23–0.53; $z = -4.99$, $P < .001$; BPD significantly slower time to recovery.
Abbreviations: BPD = borderline personality disorder, FU = follow-up, HR = hazard ratio, OPD = other personality disorders.

for recoveries lasting 2 years to 37% for recoveries lasting 12 years. In terms of patients with OPD, cumulative rates of recovery ranged from 89% for recoveries lasting 2 years to 68% for recoveries lasting 12 years. Achievement of recoveries of all lengths occurred significantly more slowly for patients with BPD than for patients with OPD. For each length of recovery, about 10% of patients with BPD achieved recovery at the first possible time period, while the rate of recovery for patients with OPD was about 4 times as high.

Table 4 details time to loss of recovery for patients with BPD and OPD. For patients with BPD, rates of losses of recoveries ranged from 59% (after a recovery lasting 2 years) to 29% (for a recovery lasting 12 years). Comparatively, these losses ranged from 42% (after a recovery lasting 2 years) to 15% (for a recovery lasting 12 years) for OPD patients. These between-group differences, while substantial, were not statistically significant.

DISCUSSION

This study has 5 main findings. The first finding is that symptomatic remissions are very common for those in both study groups. In fact, cumulative rates of remission at 24-year follow-up for patients with BPD ranged from 100% for a 2-year remission to 77% for a 12-year remission. However, the results of the current study also found that remissions of all lengths occurred significantly more rapidly for patients with OPD than for patients with BPD.

The second main finding is that recurrences following symptomatic remissions from BPD were relatively rare, ranging from 40% after a 2-year remission to 11% after a 12-year remission, while patients with OPD reported even lower rates of recurrences (10%–5%, respectively). However, the results of the current study found that recurrences occurred significantly more slowly for patients with OPD than for patients with BPD for recurrences following 2-year through 6-year remissions. No significant differences in time to recurrence were found for recurrences following 8-, 10- or 12-year remissions.

The third main finding is that recovery from BPD occurred at a lower rate and more slowly than recovery from another personality disorder. While only 60% of patients with BPD attained a 2-year recovery by the end of the 24-year follow-up period, 89% of patients with OPD

Table 4.

Cumulative Rates of Loss of Recovery for Patients With BPD and Patients With OPD Over 24 y of Prospective Follow-Up

	2 y after 1st recovery	4 y after 1st recovery	6 y after 1st recovery	8 y after 1st recovery	10 y after 1st recovery	12 y after 1st recovery	14 y after 1st recovery	16 y after 1st recovery	18 y after 1st recovery	20 y after 1st recovery	22 y after 1st recovery
Loss of recoveries lasting 2 y[a]											
BPD	18	25	33	38	44	45	50	52	54	57	59
OPD	11	18	22	26	32	32	36	38	40	42	42
Loss of recoveries lasting 4 y[b]											
BPD	7	17	25	30	33	40	44	46	47	50	
OPD	8	12	16	22	22	26	29	31	33	33	
Loss of recoveries lasting 6 y[c]											
BPD	11	18	25	28	35	39	42	43	47		
OPD	4	9	15	15	20	22	25	27	27		
Loss of recoveries lasting 8 y[d]											
BPD	9	18	21	29	33	36	38	41			
OPD	4	11	11	16	19	21	24	24			
Loss of recoveries lasting 10 y[e]											
BPD	9	13	21	27	30	32	36				
OPD	7	7	12	15	18	21	21				
Loss of recoveries lasting 12 y[f]											
BPD	4	13	19	22	25	29					
OPD	0	5	8	11	15	15					

[a]Loss of 2-year recoveries: HR = 1.61, 95% CI, 0.99–2.64; $z = 1.37$, $P = .057$; BPD not significantly faster time to recurrence
[b]Loss of 4-year recoveries: HR = 1.65, 95% CI, 0.94–2.93; $z = 1.73$, $P = .084$; BPD not significantly faster time to recurrence.
[c]Loss of 6-year recoveries: HR = 1.96, 95% CI, 1.03–3.76; $z = 2.04$, $P = .042$; BPD not significantly faster time to recurrence.
[d]Loss of 8-year recoveries: HR = 1.90, 95% CI, 0.93–3.89; $z = 1.75$, $P = .079$; BPD not significantly faster time to recurrence.
[e]Loss of 10-year recoveries: HR = 1.82, 95% CI, 0.81–4.10; $z = 1.46$, $P = .145$; BPD not significantly faster time to recurrence.
[f]Loss of 12-year recoveries: HR = 2.12, 95% CI, 0.77–5.81; $z = 1.45$, $P = .146$; BPD not significantly faster time to recurrence.
Abbreviations: BPD = borderline personality disorder, HR = hazard ratio, OPD = other personality disorders.

attained the same outcome. In terms of recoveries lasting 12 years, these rates declined to 37% and 68%, respectively.

The fourth main finding is that the loss of recovery was substantially but not significantly more common for patients with BPD than for patients with OPD at all time periods. Rates of loss of recovery after a 2-year recovery were 59% for patients with BPD and 42% for patients with OPD. Rates of loss of recovery after a 12-year recovery were 29% for BPD patients and 15% for OPD patients.

The fifth main finding is that recoveries occurred at lower levels than remissions for both study groups. Only 60% of patients with BPD achieved a recovery lasting 2 years as opposed to 100% of patients with BPD achieving a 2-year remission. This discrepancy was smaller for patients with OPD, as 100% had a 2-year remission during the course of 24 years of prospective follow-up and 89% attained a 2-year recovery. In terms of remissions and recoveries lasting 12 years, comparable figures for those with BPD were 77% remitted vs 37% recovered. In the comparison group, these figures were 97% remitted and 68% recovered.

Taken together, the results of this study suggest that patients with BPD as well as patients with OPD continue to make progress in terms of remission and recovery during the 8 additional years of follow-up covered in this study.[8] Future research would do well to assess the factors that allow patients with BPD to attain remissions and recoveries later on in the course of their illness.

Taken together, the high rates of remission, and relatively low rates of symptomatic recurrence, are good news for patients with BPD, their families, and the clinicians treating them. Given these findings, it seems fair to suggest that BPD in inpatients has a better symptomatic outcome than in patients with other major psychiatric illnesses, such as major depression and bipolar I disorder.[19–22] This is so because inpatients with these mood disorders frequently display psychotic features, which are difficult to treat and frequently recur over time.

However, our results pertaining to recovery are more concerning. While 60% of patients with BPD attained a 2-year recovery after 24 years of prospective follow-up, 89% of patients with OPD attained this outcome by this time period. Even more concerning is the fact that only 37% of patients with BPD but 68% of patients with OPD attained a recovery that lasted 12 years.

The lower rates and slower times to remission (and higher rates and more rapid times to recurrence) may well be due to the severity of borderline psychopathology compared to that of OPDs. It may also be due to their higher rates of co-occurring symptomatic disorders over time.[23] The lower rates of recovery and more rapid times to loss of recovery may also be due, to a certain extent, to the greater severity of borderline psychopathology and frequency of co-occurring symptomatic disorders in those with BPD.

However, the difficulty achieving and maintaining recovery may also be due to the difficulty some patients with BPD have working or going to school consistently and competently over time[24,25] and/or the 20%–25% of patients with BPD who report being socially isolated (ie, having no emotionally sustaining relationships).[26] The reasons for the vocational dysfunction may differ from patient to patient. Some of this difficulty may be due to a variety of factors, including residual symptoms of BPD or symptoms of concurrent symptomatic disorders as mentioned above, as well as the persistent personal or familial, and perhaps clinical, viewpoint that they are too fragile to work or go to school. In terms of social isolation, it may be that some patients with BPD are so impaired from adversity that they deliberately avoid social contact. Or, temperamentally, they may suffer from high levels of experiential avoidance.[27]

Clinical Perspective

Overall, the goals of many psychotherapies for those with BPD may be too narrow. More specifically, the primary focus in many therapies is on lessening the severity of borderline psychopathology, such as suicide attempts, self-harm episodes, and turbulent relationships. However, we suggest focusing on each patient's goals for flourishing after their symptoms have diminished in severity; in other words, what level of social or vocational adjustment they hope to achieve.

This type of approach would require psychiatrists, psychologists, and social workers in training to acquire new skills that are very practical in nature. It would also suggest this type of training for mental health professionals already in practice. Thus, this type of approach would require not just the acquisition of new skills but also a new attitude toward treating those with BPD. It should not be viewed as a step down to focus on vocational and/or social adjustment, but rather a crucial aspect of treatment after symptoms have reached a milder level. Without this focus on practical aspects of daily living, patients without many built-in supports or uncommon levels of resilience might remain on the sidelines vocationally or in a socially isolated emotional cul-de-sac that they do not know how to leave.

This study has a number of limitations. The first is that all patients were initially inpatients. It may well be that patients with BPD who have never been hospitalized are less severely ill symptomatically and less impaired psychosocially and, thus, more likely to remit more rapidly and attain a good global outcome over time. The second is that the majority of those in both study groups were in nonintensive, typically intermittent, psychotherapy as usual in the community.[28] In addition, many patients were also taking psychotropic medications, often involving aggressive polypharmacy, which not infrequently involved concurrent use of an antipsychotic, an antidepressant, and a mood stabilizer.[29] Thus, the results of this study may not generalize to untreated patients. We also recognize that our sample primarily consists of white women, and thus, our results may not generalize to samples of people of color or men.

Taken together, the results of this study suggest that sustained symptomatic remission is substantially more common than sustained recovery from BPD. They also suggest that sustained remissions and recoveries are substantially more difficult for patients with BPD to attain and maintain than those with other forms of personality disorder.

Article Information

Published Online: October 23, 2024. https://doi.org/10.4088/JCP.24m15457

Submitted: June 3, 2024; accepted August 8, 2024.

To Cite: Zanarini MC, Frankenburg FR, Hein KE, et al. Sustained symptomatic remission and recovery and their loss among patients with borderline personality disorder and patients with other types of personality disorders: a 24-year prospective follow-up study. *J Clin Psychiatry.* 2024;85(4):24m15457.

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Relevant Financial Relationships: The authors do not have any conflicts of interest or financial relationships to disclose.

Funding/Support: This research was supported by 2 National Institute for Mental Health (NIMH) grants, MH47588 and MH62169 (Bethesda, Maryland), awarded to Dr Zanarini.

Role of the Sponsor: NIMH had no role in analyzing these data or writing this paper.

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