REVIEW

Implications of Long-term Outcome Research for the Management of Patients with Borderline Personality Disorder

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Fifteen- and 27-year follow-up studies of patients with borderline personality disorder show that most of them no longer meet full criteria for the disorder by age 40, and that even more show improvement by age 50. The mechanisms behind remission could include maturation, social learning, and the avoidance of conflictual intimacy. Affective instability is slower to change than impulsivity. Suicide rates in patients with this disorder are close to 10%, with most completions occurring late in the course of illness; early mortality from all causes exceeds 18%. All of these findings have clinical implications. Although treatment effects must be assessed in the context of naturalistic improvement, therapy can hasten remission. (HARVARD REV PSYCHIATRY 2002;10:315–323.)

Borderline personality disorder (BPD) has long been known to be a chronic condition. The purpose of this paper is to evaluate treatment for BPD in light of its course, as shown by studies following patients for 15 years or more. If remission (i.e., reduction of symptoms over time) occurs naturally, then the effectiveness of therapy needs to be measured in this context.

The literature reviewed in this paper was located by means of Medline and PsycInfo searches for articles published in English between 1990 and 2002 and containing the keywords “borderline personality disorder.” The search identified 1803 publications, of which 938 concerned treatment, and an additional 146 concerned outcome. These publications were supplemented by selected reports published prior to 1990 but frequently referenced in recent literature. This review will specifically consider 23 papers on treatment of BPD and 26 on its outcome that shed particular light on the links between outcome and treatment.

FIFTEEN-YEAR FOLLOW-UP STUDIES OF BPD

In a memorable phrase, Schmideberg described the course of BPD as “stably unstable.” Although Schmideberg’s clinical impressions are correct in the medium term, they may not apply to the long-term outcome of patients with the disorder.

The first formal follow-up studies of patients with BPD were conducted in the 1970s. When cohorts were followed for 5 years, patients changed very little. But this period was too brief to determine the outcome of such a chronic disorder.

Four 15-year follow-up studies of borderline patients were published in the 1980s (see Table 1). The Chestnut Lodge study, conducted by McGlashan, and the Austen Riggs study, led by Plakun, followed cohorts from private, psychoanalytically oriented hospitals. The Columbia study, conducted by Stone, followed patients treated on a specialized psychotherapy ward at the New York State Psychiatric Institute. The Montreal study, led by Paris, followed a group of patients treated more briefly at an urban general hospital.

Each of these investigations had strengths and weaknesses. The Chestnut Lodge and Columbia studies located over 80% of patients, while the Austen Riggs and Montreal studies assessed less than a third of their cohorts. Clearly, the studies that located the largest percentage of the original...
patients have obvious advantages for generalizability. On the other hand, patients in the Chestnut Lodge, Columbia, and Austen Riggs samples were highly educated and affluent. Such populations do not resemble community profiles of BPD, in which most patients have low educational and socioeconomic levels. In this respect, the sample in the Montreal study, which included subjects from a wide range of socioeconomic backgrounds, was more typical. Another difference among the various samples arose from treatment histories: in the Chestnut Lodge, Columbia, and Austen Riggs studies, all patients received long-term psychotherapy, while in the Montreal study, many received only intermittent treatment.

Subjects in all four studies were followed into early middle age (about age 40). In all cohorts, the majority of subjects were female, the same proportion found in community samples. In two studies (Chestnut Lodge and Montreal), outcome was assessed through telephone interviews. In the Columbia investigation, most patients were interviewed by telephone, but some were assessed through information provided by informants. The Austen Riggs study relied on mailed questionnaires.

All studies measured global outcome at follow-up, using either the Health-Sickness Rating Scale or the Global Assessment of Functioning. The Montreal study also examined whether patients still met formal criteria for BPD, using the Diagnostic Interview for Borderlines. Despite differences in samples and methodology, all four studies of the 15-year outcome of BPD patients produced virtually identical results. Mean scores for global functioning were all in the 60s—within the broader range of normality. In all cohorts, rehospitalization was uncommon after the first few years, and by the time of follow-up, most patients were working and had a social network. The Montreal study found that only 25% of the original sample still met diagnostic criteria for BPD, with all subscales (dysphoria, impulsivity, disturbed relationships, and cognition) showing improvement over time. Since this level of improvement had not been seen in 5-year follow-up studies, it seems likely that remission requires more time, probably a decade or more after first presentation. But even with a mean time to follow-up of 15 years, each cohort showed a wide range of outcomes and of times to remission. The Chestnut Lodge study was the only one to examine separate cohorts defined by postdischarge time. In a group followed for 20 years, a significant decrease in functional level was observed, raising the question as to whether outcome has an “inverted U” pattern over time. (Data shedding light on this issue are examined below.)

Suicide completions were the downside of the outcome story. In the Columbia and Montreal cohorts, rates were close to 9%. Similar rates of suicide completion for patients with BPD have been confirmed in other settings: 8% in Nor-

### TABLE 1. Long-Term Studies of the Outcome of Borderline Personality Disorder

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Chestnut Lodge</th>
<th>Columbia</th>
<th>Austen Riggs</th>
<th>Montreal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of hospital</strong></td>
<td>Private</td>
<td>State</td>
<td>Private</td>
<td>General</td>
</tr>
<tr>
<td><strong>Length of follow-up (y)</strong></td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15/27</td>
</tr>
<tr>
<td><strong>% of cohort located</strong></td>
<td>86</td>
<td>91</td>
<td>27</td>
<td>32/26</td>
</tr>
<tr>
<td><strong>Number assessed</strong></td>
<td>81</td>
<td>206</td>
<td>54</td>
<td>100/64</td>
</tr>
<tr>
<td><strong>Mean age (y)</strong></td>
<td>47</td>
<td>37</td>
<td>40</td>
<td>39/51</td>
</tr>
<tr>
<td><strong>Female:male ratio</strong></td>
<td>52:46</td>
<td>70:30</td>
<td>62:38</td>
<td>84:16/83:17</td>
</tr>
<tr>
<td><strong>Socioeconomic status</strong></td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Low to high</td>
</tr>
<tr>
<td><strong>% ever married</strong></td>
<td>70</td>
<td>52; M, 29</td>
<td>?</td>
<td>67</td>
</tr>
<tr>
<td><strong>% with children</strong></td>
<td>48</td>
<td>25; M, 15</td>
<td>?</td>
<td>59</td>
</tr>
<tr>
<td><strong>Mean GAF score</strong></td>
<td>64</td>
<td>67</td>
<td>67</td>
<td>63/63</td>
</tr>
<tr>
<td><strong>% still meeting criteria for BPD</strong></td>
<td>?</td>
<td>?</td>
<td>?</td>
<td>25/8</td>
</tr>
<tr>
<td><strong>Predictors of continued dysfunction</strong></td>
<td>Low IQ, lengthy previous admissions, affective instability</td>
<td>Low IQ, childhood abuse</td>
<td>Self-harm, anger</td>
<td>Dysthymia, problems with mother</td>
</tr>
<tr>
<td><strong>% suicide</strong></td>
<td>3</td>
<td>9</td>
<td>?</td>
<td>9/10</td>
</tr>
<tr>
<td><strong>Mean age at suicide (y)</strong></td>
<td>?</td>
<td>30</td>
<td>?</td>
<td>30/37</td>
</tr>
<tr>
<td><strong>Predictors of suicide completion</strong></td>
<td>?</td>
<td>Substance abuse, major depression</td>
<td>?</td>
<td>Previous attempts, higher level of education</td>
</tr>
<tr>
<td><strong>% death other than suicide</strong></td>
<td>13</td>
<td>13</td>
<td>?</td>
<td>13/18</td>
</tr>
</tbody>
</table>

*F*, female; *GAF*, Global Assessment of Functioning; *M*, male.
way and 10% in Toronto. Although the Chestnut Lodge cohort had a much lower rate (only 3%), McGlashan (personal communication, 1991) believes that his sample was unrepresentative, given that patients were referred following treatment in general hospitals. A suicide rate around 10% would be similar to those found in schizophrenia and major mood disorders. Findings at 15-year follow-up also show that suicide generally occurs comparatively late in the course of illness—that is, after age 30.

Since outcome varies greatly in patients with BPD, it would be highly useful to identify predictive factors. McGlashan reported that the two strongest correlates of positive outcome were higher intelligence and shorter length of previous hospitalization, although neither accounted for a large percentage of the variance. McGlashan also found that high levels of affective instability were associated with a lower level of functioning, a finding supported in the Montreal study.

Because patients with BPD report having had many problems during childhood, researchers have sought to determine whether early developmental experiences are related to outcome. One study compared a group of women who still met criteria for BPD with a group of women who did not and found that childhood sexual abuse was more frequent in the women who remained symptomatic. In the Columbia cohort, “parental brutality” was linked to outcome, but this measure was not blindly assessed and accounted for only 7% of the variance. The Montreal study found a correlation between a chart review–derived measure of problems with mothers during childhood and lower outcome scores. But none of these relationships is strong or consistent enough to be clinically useful.

Research has also failed to identify clinically useful predictors for suicide. This problem is not unique to BPD: even in very large samples of psychiatric patients, it is difficult to identify suicide predictors of practical use. For example, although the number of previous attempts has some relationship to completion in individuals with BPD, most patients with multiple attempts do not complete suicide. The Columbia study found that substance abuse predicted completion, but most of the subjects who abused substances did not complete suicide. Authors of the Montreal investigation observed that patients with higher levels of education were more likely to complete suicide. This finding was not supported by a Norwegian study, which showed that BPD patients at all educational levels are at risk for completed suicide and instead suggested a correlation between separation or loss early in life and higher rates of completed suicide (a correlation also seen in a psychological autopsy study of young males with BPD who completed suicide). Again, none of these reports yielded predictors that account for enough of the variance to be useful clinical markers.

**PROSPECTIVE STUDIES OF BPD OUTCOME**

The 15-year follow-up studies of BPD all used a “follow-back” method. Prospective designs yield more-reliable baseline data, allowing outcome predictors to be identified more accurately. The main limitation of prospective methods is that patients with BPD who agree to be followed over time may have unusual characteristics, such as higher compliance, that make them different from populations clinicians see. Moreover, to reduce attrition, prospective studies of BPD have focused on patients in long-term treatment, in whom distinguishing between treatment effects and naturalistic remission is difficult.

A major prospective study of patients with BPD was conducted at McMaster University in Hamilton, Ontario. The researchers followed a cohort of 130 former inpatients, of whom 88 had a diagnosis of BPD and 42 had “borderline traits.” At 7-year follow-up, approximately two thirds of the cohort remained. Two patients had died of natural causes, and six (5%) had committed suicide. Forty-seven percent of the remaining cohort still met criteria for BPD, while 53% showed symptomatic remission. That this level of improvement was only about two thirds of the level observed at 15-year follow-up in the Montreal cohort supports the concept that BPD patients often require 10 years or more to attain relatively normal levels of functioning. The McMaster study found that severity of initial pathology was the best predictor of outcome, accounting for 17% of the variance. Patients with serious comorbid substance abuse (about a quarter of the sample) had a much poorer outcome. The main limitation of this otherwise informative study was that 7 years is not long enough to observe remission or establish a definitive suicide rate.

Zanarini’s group at McLean Hospital, in Belmont, Massachusetts, has been conducting a prospective study of a previously admitted cohort, following 290 patients with BPD and 72 patients with other Axis II diagnoses. At 4-year follow-up, 75% of the patients with BPD were still in outpatient therapy, but only 36% had been rehospitalized. Although these findings are preliminary, the study will eventually provide data on long-term outcome.

The largest-scale current investigation of BPD outcome is the National Institute of Mental Health–funded Collaborative Longitudinal Personality Disorders Study, now being conducted in Boston, New Haven, New York, and Providence. The researchers have been tracking a group of patients with BPD and other Axis II disorders for over 5 years. The most striking finding thus far is that BPD has a waxing and waning course: when assessed every few months, patients may or may not meet criteria, depending on what is occurring in their lives. This study is still in its early stages but will in time provide data on the long-term outcome of BPD.
A 27-YEAR OUTCOME STUDY OF BPD

The Montreal group has recently completed a 27-year follow-up of patients with BPD. Data were obtained on 81 of the 100 individuals studied after 15 years. In the intervening period, five had died from natural causes, and three had committed suicide. Nine patients known to be alive refused to be evaluated. Thus, 64 subjects (12 men and 52 women) who had then reached a mean age of 51 were interviewed.

Although mean global functioning scores were unchanged, the overall rate of suicide completion increased to 10.3%. The mean age at suicide was 37.3 ± 10.3 years. Thus, completions occurred late in the course of illness, with few among patients in their early 20s, when attempts were very common.

The cohort had an unusually high rate of early death, a finding also observed in the Columbia study. At 27-year follow-up, a total of 18.2% of the original sample had died, either from natural causes or from suicide, a much higher rate than would be expected for a population of this age. The high level of mortality associated with BPD is one of the most important findings of research on long-term outcome.

The most striking change between 15 and 27 years involved the number of subjects who still met criteria for BPD. Only 8% of the total still had a borderline diagnosis at 27 years, as opposed to 25% at the 15-year point. (In the later study, the Revised Diagnostic Interview for Borderlines, a less inclusive measure than the original Diagnostic Interview for Borderlines, was used for diagnosis, but the results would probably have been similar even if the original instrument had been employed.) The subscale showing the most significant improvement between the two follow-up points involved quality of relationships.

As for Axis I, only 5% of the remaining cohort had active substance abuse or met criteria for major depression at 27 years. Social adjustment was also close to normative values. The main indicator of continued problems was that 22% met criteria for dysthymia. This diagnosis indicates low-level chronic depression but can also be seen as a marker for affective instability. Early-onset dysthymia is found quite often in individuals with BPD and is one of the most common Axis I comorbidities in the disorder. The continued presence of these symptoms suggests that affective lability changes more slowly over time than does impulsivity. The strongest predictors of 27-year outcome were levels of functioning at 15-year follow-up. Childhood experiences, as measured by self-report scales, had no relationship to outcome.

The findings of the Montreal study show that remission in BPD continues well into middle age. The results do not support earlier concerns that outcome may follow the pattern of an “inverted U.” By the age of 50, BPD patients were functioning much better than they had been 12 years earlier, even though about a quarter of them had residual affective symptoms.

MECHANISMS OF REMISSION

Several mechanisms lie behind the remission process in BPD. It is well established in community populations that impulsivity tends to decrease with age, a process that could reflect biological maturation. In this context, BPD patients seem to improve in much the same way as those with other impulsive disorders, including alcohol abuse, antisocial personality disorder, and bulimia nervosa.

A second mechanism could involve social learning. Although individuals with BPD are slow to learn from experience, they can still increase their skills over time. Improvement could also come from finding supportive relationships and choosing partners who exhibit less pathology.

Long-term outcome data on BPD suggest another mechanism: avoidance of intimacy. Many BPD patients drop out early from school, have difficulty in establishing a career, experience periods of unemployment, and have problems finding stable friendships. Yet those who improve eventually overcome most of these difficulties. As we have seen, most subjects in the follow-up cohorts obtained employment and established social networks.

Intimacy, however, is more difficult to achieve. Bardenstein and McGlashan observed gender differences in outcome among BPD patients in the Chestnut Lodge cohort. Women with BPD had a somewhat poorer long-term outcome than did men. Whereas men benefited from strong commitments to work, intimacy for borderline women was problematic; many women became increasingly symptomatic when their marriages broke down.

The success of marriage in BPD patients may depend in part on the personality characteristics of their partners. Although no systematic studies have been conducted on choice of partners in individuals with BPD, some women with the disorder seem to be attracted to narcissistic men, who initially find them attractive and later become abusive or abandoning. Marriage with a spouse who assumes a caretaking role might be more stable, although clinical experience suggests that this dyad can also run into trouble due to insufficient limit-setting on impulsive behavior.

As shown in Table 1, in the Columbia cohort only 52% of the women and 29% of the men had ever been married; only 25% of the women and 15% of the men had ever had children. Among the patients who had married, the divorce rate was 33%. Although this figure is not excessive compared to the national average, when marriages broke down, only 10% remarried—a rate much lower than the national average. In the Montreal study, the marriage rate was 67% (similar to the 70% observed in the Chestnut Lodge cohort), and the divorce rate was 36%. But at 27-year follow-up, only 42% were then living in a stable relationship; 41% remained childless.

We lack systematic data to confirm the hypothesis that
BPD patients can achieve symptomatic improvement by avoiding intimacy. Nonetheless, clinical interviews with individuals who no longer meet criteria for the disorder often elicit descriptions of learning not to fall in love. Highly charged relationships create numerous problems for young patients with BPD. Over time, some learn that intimacy is dangerous for them. For these patients, being comfortably alone and finding other, less conflictual ways of establishing social support networks and contacts reduces the chance of serious difficulty.

Therapists may benefit from taking these observations into account. The success of treatment is not determined solely by the attainment of stable intimacy. On the contrary, some patients with BPD might be encouraged to avoid such involvement. Many who improve find that having less-intimate friends, belonging to a social community, or having a pet provides more stability than could have been achieved through intimacy.

Little research has been done on the effects of parenthood on women with BPD. A surprisingly large number remain childless. Parenthood also requires the management of intimacy, and it is possible that some mothers can develop “borderline relationships” (i.e., clinging dependency) with their children. In one study45 the children of mothers with BPD were found to be highly symptomatic, and family life was observed to be very dysfunctional.46 Although systematic observations on the subject are lacking, the author’s clinical experience suggests the possibility that some women give up impulsive behaviors for the sake of their children. In such cases, they may no longer meet criteria for a diagnosis of BPD; they “graduate” to a DSM diagnosis of “personality disorder, not otherwise specified,” or their symptoms are diminished.

**CHRONICITY, TREATMENT, AND REMISSION**

Since BPD is chronic but improves with time, treatment response must be assessed in the context of naturalistic remission. Thus, when clinicians claim that patients with BPD improve after many years of treatment, one cannot know whether the positive outcomes are the result of therapy or of “waiting out” the pathology until it remits.

Nonetheless, therapy for BPD can hasten the natural process of remission. A meta-analysis of treatment studies of patients with personality disorders47 found that whereas a model of the natural history of BPD shows 3.7% of patients with BPD to remit each year, active psychotherapy improves this rate sevenfold. Although this figure is encouraging, it is probably overly optimistic. The meta-analysis was drawn from a small data set that included uncontrolled or partially controlled studies of varying provenance. As noted earlier, even in patients who receive consistent therapy, remission rarely occurs within the first 5 years. Moreover, although making comparisons among samples is impossible, the results in high-treatment and low-treatment follow-up cohorts were quite similar.

To assess the long-term impact of therapy on the course of a disorder with many remissions and relapses, patients need to be followed over time. Most treatment studies last for a year or less—sufficient for major depression but not for BPD. This caution applies particularly to psychopharmacological studies, which have demonstrated short-term symptomatic improvement in BPD (mainly in relation to impulsivity) with a variety of agents, including neuroleptics, selective serotonin-reuptake inhibitors, and mood stabilizers.48 However, research has not shown whether such improvements are stable over time.

Time is also important in measuring the effects of psychotherapy. For example, Linehan’s cohort of patients in a randomized controlled trial of dialectical behavior therapy conducted in the 1980s49 was treated for a year and followed up a year later.50 At the end of therapy, the patients who received dialectical behavior therapy were overdosing less, slashing less, and requiring less hospital care than were controls, who received “treatment as usual,” but they did not achieve full remission. Most continued to suffer from high levels of dysphoria—symptoms that were still present at follow-up. It is unfortunate that this cohort, treated about 15 years ago, has never received long-term follow-up.

Nonetheless, the likelihood of eventual improvement should be reassuring for therapists. It has been suggested that patients with BPD should be told to expect remission over time. Clinicians clearly do take outcome into account when they provide supportive therapy that offers a “hold” for patients until they improve.

Despite the chronicity of BPD, it may not always be necessary to treat patients continuously for years. Many move in and out of therapy, and only about a third remain in long-term treatment, even when it is offered.51,52 We do not know whether patients who remain in therapy fare differently from those who do not. But clinicians can capitalize on trajectories of instability. Several outcome researchers,53–55 aware of the chronicity of BPD, have recommended intermittent treatment, as long as reentry is readily available when crises occur.

**OUTCOME AND AFFECTIVE INSTABILITY**

Affective instability (AI) is a central feature of BPD. Individuals with this disorder can be anxious in the morning, angry in the afternoon, and suicidally depressed in the evening. Linehan46 has hypothesized that emotional dysregulation (a concept essentially equivalent to AI) is associated with a rapid response to environmental stimuli and a slow recovery time. She suggests that this trait is the core feature of BPD and that it is constitutional.
Often confused with depression or mania, AI has important phenomenological differences from these conditions.\(^7,^8\) It is highly responsive to environmental cues and involves inconsistency of mood over time. Moreover, although mood stabilizers and antidepressants in BPD often lead to declines in impulsivity, they have fewer effects on affective symptoms.\(^9\) These observations suggest that AI could have a unique biology.

Although much research has been done on the biology of impulsivity, much less exists on that of affective instability. Jang and colleagues\(^60\) used behavioral genetic methods to measure genetic and environmental contributions to AI. As with most traits, about 40% of the variance was genetic, whereas another 50% was attributable to unshared environment. Yet even when traits are genetically influenced, they may be modified by psychotherapy.\(^53,^62\)

Long-term outcome findings suggest that most patients with BPD improve more slowly on the affective than on the impulsive dimension. Although both traits are influenced by genetic factors, impulsivity may be more likely to change with age and life experience. These observations have clinical implications.

When treating patients with BPD, therapists can establish a hierarchy of goals for different traits. (A similar strategic framework has been recommended in clinical guides to treatment by Linehan\(^56\) and Gunderson.\(^63\)) Impulsivity is usually the first target, since acting out prevents treatment from addressing other goals. Once the patient is calm enough to work in therapy, treatment can address AI in a number of ways. These methods involve developing tolerance of emotions, decentering emotions, and modifying cognitive appraisals.\(^56,^64\) Even if AI never entirely disappears from the picture, it can be tamed. This happens when the circumstances that provoke such responses occur less often and when patients learn to modulate emotions before they become overwhelming.

**SUICIDALITY IN BPD**

Suicidality in patients with BPD can be frightening. Concern might seem to be justified by a 10% completion rate, yet 90% of BPD patients do not die by suicide. Even though most make multiple threats and attempts, exactly which individuals will eventually succeed in killing themselves cannot be predicted.

Outcome research on BPD offers a surprising degree of reassurance about the danger of completion. Suicide usually occurs surprisingly late in the course of the illness—generally after age 30. This contrasts with the alarmingly high levels of suicide threats and attempts seen in younger patients. Thus, suicide in BPD does not necessarily occur in the midst of a crisis. Although younger patients do commit suicide, the fact that outcome studies\(^7,^13,^31\) found a mean age of 30–37 years among completers supports the clinical observation that suicide becomes most likely in a state of withdrawal and hopelessness, often after a series of failed treatments.

In light of these conclusions, the management of suicide threats and gestures in BPD can be conservative and less interventive. Alarmed clinicians tend to go out of their way to “prevent” suicide, but there is no evidence that therapy actually prevents completion.\(^56\) Hospitalization, the most common intervention, may provide temporary relief but can also lead to regressive complications.\(^65\) Although managed care has made the option of admission less available, there is no definite evidence that patients with BPD are suffering as a result of this trend.

Experts on suicide\(^65\) and on the treatment of BPD\(^63,^66,^67\) have taken the position that constant concern about suicide completion can derail therapy. Linehan,\(^56\) whose training is behavioral, emphasizes the reinforcing quality of hospitalization or increasing the frequency of contact. Thus, interventions intended to respond to suicidal behaviors can implicitly reward them. Hospital treatment was originally designed to manage acute episodes of suicidality in patients with a mood disorder. In such cases, admission allows clinicians to provide effective interventions such as antidepressants and electroconvulsive therapy. But hospital stays are much less appropriate for chronically suicidal patients with BPD, for whom medical treatment is rarely definitive, and among whom suicidality tends to continue after discharge.

Therapists might do better to manage suicidality by focusing on the implicit communication of distress behind thoughts and actions.\(^55\) Since suicidality “goes with the territory” of BPD, therapists must tolerate these patients’ anxiety. By and large, threats of suicide can be understood as an individual’s attempt to “raise the volume,” in the belief that this is the only way to be heard. When patients discover that therapists respond empathically to inner suffering and can offer ways of reducing their pain, suicidality may decline. Moreover, since BPD patients have difficulty breaking the links between thought and action, therapists can model this capacity by tolerating and resisting the contagion of despair and anxiety, and not acting on these feelings (e.g., by sending patients to the emergency room).

In some situations hospitalization of BPD patients is unavoidable—for example, after a life-threatening suicide attempt, or to treat a psychotic episode.\(^68\) However, admitting patients every time they become suicidal works against the goals of therapy. Linehan\(^56\) advises her patients to avoid the hospital; if they end up there nonetheless, they can be held overnight, but no longer.

Clinicians often justify their fear that patients with BPD will commit suicide as a concern about “medical-legal issues.” The implication is that a therapist whose patient commits suicide will be held responsible for his or her death through litigation. Yet, as reviewed elsewhere,\(^55\) the majority of lawsuits after suicide do not concern the treatment of chronically
suicidal patients with BPD, but of acutely suicidal patients with Axis I disorders.

Borderline patients may need more containment than is possible in outpatient therapy. In such cases, there is strong evidence for the value of day treatment. Unlike full admission, partial hospitalization provides structure that limits regressive complications; it is also more cost effective.

**DIRECTIONS FOR FUTURE RESEARCH**

The remission of BPD, a disorder whose effects on functioning can be as serious as those of a psychotic illness, remains something of a mystery. Yet BPD is only one of many mental disorders that improve over time. Many impulsive disorders show similar recovery with age; even schizophrenia has a pattern of relative remission of positive symptoms by age 50. (Severe mood disorders, which often continue into old age, are an exception.)

The main limitation of existing research is that it provides only a “snapshot” of BPD at different time points rather than a continuous assessment that could pinpoint mechanisms of remission. For this reason, the ongoing work at McLean and the Collaborative Longitudinal Personality Disorders Study have the potential to shed more light on the course and outcome of BPD and to provide more-precise guidelines for treatment.

**REFERENCES**

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