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Guest Editorial

The Natural History of Personality Disorders: Recovery and Residual Symptoms

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It used to be thought that personality disorders (PDs) were incurable and untreatable. Both of these assumptions turned out to be wrong. Patients with different types of PD usually improve with time.[1] As shown by large-scale prospective research,[2] recovery is particularly striking in borderline personality disorder (BPD). There is also good evidence for the efficacy of psychotherapy for many patients with BPD.[3] As Biskin[4] describes, most patients either recover entirely, or improve to a point when they graduate to a diagnosis of PD, unspecified. And as Black[5] describes, even patients with antisocial personality disorder (ASPD) show some degree of recovery.

Patients with PD have a better prognosis than many patients with mood disorders. This suggests that the practice of targeting mood symptoms, while failing to make PD diagnoses (as so often happens in clinical settings), is profoundly mistaken. This is a particular problem in adolescence, a stage at which most PDs are diagnosable. (The exception is ASPD, but the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, rules to only make this diagnosis after age 18 are arbitrary.) In adolescent BPD, a wide range of impulsive symptoms are associated with unstable mood,[4] creating a classical clinical picture. It is also an error to see adolescent PD as a passing phase in development, which it is not.

Most patients with ASPD and BPD are young, and, as they age, we see fewer of them. This creates the impression that patients are more chronic, which has been called "The Clinician's Illusion."[6] However, people who continue to return to clinical settings still have significant problems. We do not know how to predict these outcomes, and there can be many surprises, both positive and negative, when patients are followed up. The most consistent finding in the literature is that these patients do much better if they can get their substance abuse under control.[7]

How should clinicians address residual dysfunction in these patients? I have proposed a rehabilitation model,[8] but we currently lack firm evidence that such measures would be effective. That could be a subject for the next stage of PD research, on treatment in the context of long-term outcome.

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