Roy R. Grinker, Sr.

Abstract

In a discussion of two reviews of the literature on borderline conditions by Liebowitz (1979) and Rieder (1979), the author briefly describes his own research on clinical aspects of the borderline syndrome. Each of the investigators involved in the study of borderline conditions seems to have his own theoretical position and diagnostic evaluation procedures. There seems to be a consensus, however, that the syndrome represents a basic developmental defect with relatively “stable instability” within four subcategories.

Liebowitz (1979) extols the St. Louis approach to diagnosis outlined by Robins and Guze (1970). This approach, however, is no different from the universal methods of modern clinical research, which consist of observation, description, rating, analysis of data, and conclusions. Long-term followup of patients both in outpatient clinics and after reentry into hospitals, family studies, and investigations of biological functions and genetic markers must be added when possible.

Clinical investigators have a responsibility to indicate the nature of their clinical sample, the number of their cases, the methods employed in their research, the analytic methods, and their conclusions. In this discussion I will first look at each of the approaches to the diagnosis of borderlines reviewed by Liebowitz. I will then expand on the methods and results of my own work. Finally, I will discuss some of the implications of our work for etiology and diagnosis.

Work by Others

Among the various approaches to the borderline reviewed by Liebowitz (1979) and Rieder (1979), there is clearly little difference between the approaches of Grinker, Werble, and Drye (1968) and Gunderson and Singer (1965). On the other hand, the approaches of Hoch and Polatin (1949), Kety et al. (1968, 1971, 1975), Rosenthal et al. (1968, 1971), and Spitzer, Endicott, and Gibbon (1979) link the borderline to schizophrenia. Klein (1977) calls the borderline an atypical affective disorder, and Kernberg’s (1977) approach concerns the so-called psychostructural distinctions.

Several times I have written that there is no borderline schizophrenia—a patient either is or is not schizophrenic. He may be a borderline psychotic, which includes schizophrenic, manic-depressive, traumatic, toxic, febrile, and drug-induced psychoses. The approaches of Hoch and Polatin, Kety et al., Rosenthal et al., and Spitzer, Endicott, and Gibbon describe the elements of schizophrenia, not the borderline.

Hoch and Polatin’s pseudoneurotic schizophrenics are not borderlines. In 5 to 20 years, at least 20 percent are hospitalized for a schizophrenic break, yet Hoch wrote me that he could not accept the concept of a borderline.

The extended family study of Kety et al. and Rosenthal et al. includes a wide variety of different diagnoses and symptoms that bear little resemblance to my own defini-

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Ricoeur's 1977 article of borderline personality organization. His personally preferred psychoanalytic approach has the least amount of transference necessary for psychoanalytic interpretations. Kernberg's drug approach follows the basic tenets of clinical research. It links the borderline to atypical affective disorders. But schizophrenics, manic-depressives, neurotic depressives, and character disorders (especially psychopathic or asocial persons) also have strong underlying anxiety and depression.

Finally, Kernberg's psychodynamic formulations regarding splitting of ego introjections are confusing. They are not based on empirical data, nor can I believe they derive from psychoanalytic techniques or results, since the borderline does not form an effective transference necessary for psychoanalytic interpretations. Kernberg's approach has the least amount of data and produces the most confusion. His assertions are born out of his personally preferred psychoanalytic theoretical constructs. He includes far too wide a variety of clinical syndromes under the rubric of borderline personality organization.

In this connection I have recently read Paul Ricoeur's 1977 article "The Question of Proof in Freud's Psychoanalytic Writings." He states that for verification of processes, definitions must become operational and generate procedures for verification or falsification by (1) what is said as a report, (2) what is said to another person, and (3) what is observed and described as desire (wish) in behavior and other aspects of transference. This indeed was our own research method.

Ricoeur states clearly what most analysts know—that there is a difference between psychological and material reality (the pleasure principle of psychoanalysis versus the reality principle of academic psychology) and that the "facts" are different. Unfortunately, these are not integrated except by some still vague overarching regulating force of "self." Each must be studied by different methods, but I share Ricoeur's doubts about discerning the truth in interpretations of the subject's reports. At least the behaviors representing ego functions in action are observable.

My Work

Gunderson and Singer originally criticized my work for dealing with milder cases and not controlling for schizophrenia. Liebowitz also makes these same points. Rieder misunderstands me when he states that I "put almost all nonorganic, not-definitely-schizophrenic young adults hospitalized after an emergency room visit into [my] borderline syndrome category" (p. 40). Not only he, but also many others have misunderstood my study (Grinker, Werble, and Drye 1968). To clarify this, the subjects of the study were taken from a County Psychopathic Hospi-
bursts, sometimes so overwhelming ego controls that they become temporarily psychotic for an hour, a day, or a week, but rarely more. They have a deficient sense of self and are often depressed.

Group II patients show vacillating involvement with others, moving toward and quickly away from object relations—back and forth like a yo-yo. Group III patients show adaptive and appropriate behavior achieved by “as if” complementary behavior, little spontaneity, and defenses of withdrawal. Group IV patients have more anxiety and a childlike, clinging depression.

The variances within the subcategories overlap, yet are sufficiently discriminating so that within the characteristics of the general category there are differences that permit both an overall borderline diagnosis and the more specific subtyping.

Grunewald (1970) performed an extensive battery of psychological tests on 10 of these borderline subjects. These tests supported the diagnosis in all essential points and confirmed the characteristics of the subgroups for the syndrome. There was no movement from one subgroup to another. Structural defects of the ego were present, and there was evidence for early disturbances in object relations and tenuous impulse control.

The differential diagnosis of the borderline has hitherto not been attempted. The syndrome has been considered to be a latent schizophrenia, chronic undifferentiated schizophrenia, pseudoneurotic schizophrenia, depression, and variously named personality and character disorders. Over and above the essential core process a broad variety of neurotic, personality, and delinquent defensive symptoms can be seen including alcoholism, drug abuse, sexual promiscuity, and perversions.

The borderline, with his defects in affectionate relations, anger as the main affect, and lack of consistent self-identity, does not include the characteristics of schizophrenic disturbances in associations, autistic thinking, defects in language and logical thought, delusions, or hallucinations. The borderline does not even have the thought disorders characteristic of latent schizophrenia and lacks the capacity to develop schizophrenia present in the pseudoneurotic schizophrenia. Group I patients, sometimes termed “psychotic characters,” have only brief periods of disorganization associated with rage attacks. In fact, the borderline is a disease sui generis.

Perry and Klerman (1978) have written:

The research reported by Grinker and his associates merits high praise for a number of reasons. First, it builds on previous work. Their review of the literature is comprehensive and sophisticated. Second, the research is empirical and systematic. They studied a series of 51 patients, moderate in size in comparison to the literature of usual research in psychopathology but enormous by comparison to the literature on the borderline patient. Third, they used advanced methods of quantitative rating scales and multivariate statistical analysis. Fourth, they delineated four subtypes by cluster analysis and related the subtypes to clinical experience. And fifth, they have attempted to validate their typology by follow-up study and by correlations with family dynamics. . . . No other workers in the field of the borderline patient have approached these achievements of the Grinker group. [p. 145]

Since the time these remarks were written, Gunderson has also joined in doing systematic research on a sample of borderline patients (Gunderson and Kolb 1978). Some of that work is reviewed by Liebowitz, but he apparently has not seen the results of some further research completed by our group (Grinker and Werble 1977).

As a result of careful study of 14 new hospitalized borderline cases made available through current research on a blind pool of 360 undiagnosed young adults hospitalized for our schizophrenia program, we have been able to add the following observations. Of 14 patients:

Nine were rated high on anhedonia (lacked early experiences of pleasure); 10 were rated high on depression or anger; 12 dated the onset of their problems to childhood; 12 had school problems, often being expelled or dropping out; 10 reported suicidal thoughts or attempts; 11 were rated high on identity problems; 10 showed emotional attachments to their family or surrogates (dependency); 10 were rated as having little or no affection for peer group or nonfamily members; 9 were rated as confused; and all 14 were rated as lacking organization. There have been a number of additional observations. The first, on the basis of family studies, is that anorexia nervosa in these patients seems to be a means of indirectly expressing anger at the family.

Two additional empirical findings about the family of origin for borderline patients revealed that in 10 of the 14 cases there was a family history of unclear, undiagnosable
mental problems of various types. Also, a much higher incidence of divorce and parental loss was observed in this group than in a comparison group of schizophrenics. Aspects of this family information are summarized below:

<table>
<thead>
<tr>
<th>Borderline patients</th>
<th>Schizophrenic</th>
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<tbody>
<tr>
<td>Intact</td>
<td>42.9%</td>
</tr>
<tr>
<td>Divorced</td>
<td>35.7%</td>
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<tr>
<td>Parent death</td>
<td>21.4%</td>
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By contrasting borderline patients with schizophrenic patients in the present research program, we have found evidence that the following characteristics distinguish the borderline from the schizophrenic. Unlike the schizophrenic, the borderline does not have:

- Disturbances in intellectual associational processes
- Autistic or regressive thinking
- Family characteristics of pseudomutuality or skewing
- Delusions or hallucinations
- Deficit in connotative aspects of language

In addition, we have recently reported that the character of psychotic (or psychotic-like) behavior, when it does occur, is different from that observed in schizophrenic psychoses because it is brief, quickly reversible, and not ego-syntonic. In particular, psychotic episodes in borderlines seem to be induced by quantities of rage, unmanageable by the deficient defensive functions of the ego. When borderline patients have a brief psychotic episode precipitated by a storm of rage, they constitute what Frosch (1964) called psychotic characters, although this state is time-limited. Finally, the borderline patients frequently remembered childhood dreams of violence directed toward themselves or others.

As a result of the data from our coordinated studies, we have begun to elaborate and qualify the character of depression in the borderline patient by contrasting it with that observed in depressive patients (Grinker 1961). Thus, we have observed, “In general it can be stated that although depression as an affect is found in several of the borderline categories it does not correspond with that seen in the depressive syndrome” (Grinker, Werble, and Drye 1968, p. 95).

In our recent book (Grinker and Werble 1977) we separated the core problems in our important four subcategories of the borderline from defenses and substitute gratifications for affection (alcoholism, drug addiction, homosexuality, etc.). The followup shows that once past a short difficult period after hospitalization, borderline patients do better than schizophrenics over a longer period of time. We attribute their better prognosis to a capacity to learn under the process of educational psychotherapy. They certainly do show less flat affect, and even learn to control their rage attacks and hence their temporary mild psychotic episodes. But their social awkwardness and difficulty in object relations persist, with the result that most therapists are reluctant to maintain long-term therapeutic contacts with them.

Etiological Issues

In summary, the borderline syndrome may be caused by some unknown developmental variants. The early mother-infant transactions are usually blamed for borderline and other disturbances, but there is no sound proof for such an assumption. The borderline personality is characterized by a life style of vacillating eccentricity. What pushes it into the overt syndrome or back into a state of remission is not known.

Like the causes of most other psychiatric disturbances, the etiology of the borderline cannot be pinpointed either from a specific or a systems approach. All we can say is that “the borderline, like health and illness, is a system in process occurring in time: Developing, progressing and regressing as a focus in a large biopsychosocial field” (Grinker and Werble 1977, p. 15). Many aspects of the biogenetic, experiential, psychological and social parts of the system are unknown. Yet the borderline is increasing in incidence. More reports are being published in the foreign literature, and important articles now indicate that the borderline syndrome may appear in childhood and in chronic, lifelong psychiatric patients—suggesting, as does all the other evidence, that the syndrome represents a defect in development.

Borderline as a Diagnosis

Currently we have separated three large categories within our broad psychiatric nosology. These are neuroses, personality or characterological problems, and psychoses. The neuroses are named and classified by their major defenses against anxiety: The two major psychoses (depressions and schizophrenias) are still involved in questions of defini-
tion, etiology, and teleology. It is the middle category that seems to be increasing as we observe more constricted, restricted, impulse-ridden, and acting-out behaviors. I have chosen only one aspect of this vast category to study and have used behavioral techniques to define ego functions (despite the fact that psychiatrists are poor observers of behavior). We badly need further research, not speculations, on other types of personality and character disorders.

At the Second Rochester Conference on Schizophrenia, Spitzer et al. (1978) apparently had eliminated latent and borderline schizophrenia from *DSM-III*, a decision for which I congratulated them. The addition of a schizotypal category to replace latent and borderline schizophrenia, as recommended by Rieder, is not satisfactory. Certainly in our cases, borderline patients did not become schizophrenic by the criteria of followup and psychological tests. They showed no movement toward schizophrenia, but they did remain "socially awkward." And in our borderline family studies, mental illness was found, but not a family distribution of schizophrenia; thus, a genetic relationship to schizophrenia cannot be claimed.

After a decade of scientific and clinical studies on the borderline syndrome and the borderline patient, I strongly disagree with Liebowitz’s statement: “Available data do not weigh conclusively for or against borderline’s status as an independent entity” (p. 35). I believe the available evidence does indicate that the *borderline syndrome represents an independent entity deriving from* a developmental defect, the source (etiology) of which is not yet known.

References


Kety, S.S.; Rosenthal, D.; Wender, P.H.; and Schulsinger, F. The types and prevalence of mental illness in the biological and adoptive families of adopted schizophrenics. In:


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**Silver Jubilee Psychiatric Research Meeting**

A multidisciplinary psychiatric research meeting will be held on May 9–11, 1979, in Saskatoon, Canada. Entitled "From Molecules to Community: Multifaceted Mental Health Research," the meeting is sponsored by the Psychiatric Research Division of the Saskatchewan Department of Health and the Department of Psychiatry, University of Saskatchewan. The meeting will mark the 25th anniversary of the establishment of psychiatric research as an integral part of the program of the Saskatchewan Department of Health, and in honor of this occasion, a number of distinguished guest speakers will participate and discuss recent advances in biological, clinical, and psychosocial research in psychiatry. Additional information can be obtained from D.G. Irvine, Psychiatric Research Division, University Hospital, Saskatoon, Saskatchewan, Canada S7N 0W8.