Two Reviews of the Literature on Borderlines: An Assessment*

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Abstract

The author discusses Liebowitz's (1979) and Rieder's (1979) reviews of current issues regarding the diagnosis of borderline patients. He cites the need for further research examining the basic characteristics of the borderline syndrome. He also recommends that greater attention be directed toward defining subtypes of the syndrome. The author believes that a combination of the descriptive approach of Gunderson and Kolb (1978) and his own psychostructural approach (Kernberg 1977) would prove fruitful.

Both Liebowitz (1979) and Rieder (1979) provide a review of some relevant recent literature and then offer their opinions on current issues regarding the diagnosis of borderline patients. Rieder's article takes up only one aspect of this subject, and I will return to it after considering Liebowitz's more extensive contributions.

Liebowitz's Article

Liebowitz's succinct review of the confusing and often contradictory recent literature on borderline conditions conveys an enormous amount of information. His objectivity permits the reader to arrive at conclusions that may to some extent differ from those Liebowitz reaches. I would question, however, whether his emphasis on the possible relationship between borderline conditions and the affective disorders is warranted by the data he reviews; I would also question his underemphasis of Gunderson and Kolb's (1978) recent findings regarding the differentiation of the borderline syndrome from schizophrenia and from neurotic depression.

Liebowitz's classification of the various approaches to research and conceptualizations of borderline conditions is empirically helpful but not totally satisfactory. Borderline conditions might well be viewed as he does, as (1) a clinical entity, (2) a milder form of schizophrenia, (3) a group of several atypical affective disorders, and (4) in terms of psychic structure, but, whereas (1) is broadly descriptive and (2) and (3) are diagnostic, (4) is etiological and therefore in an entirely different category. It may well be that (1) can be understood in terms of (4)—that is, a clinical disorder might be understood in terms of psychic structure.

Liebowitz uses the St. Louis approach to diagnostic validity (Guze 1975; Robins and Guze 1970) as a guideline. He cites the St. Louis group's five criteria for the recognition and definition of a valid clinical psychiatric syndrome: clinical description, laboratory studies, delimitation from other disorders, followup studies, and family studies. In theory, these are straightforward criteria; in practice, however, they do not sufficiently consider the complex relationships between a clinical syndrome and the underlying "disease" or "illness" in the sense of a broader psychopathological and/or etiological entity. The definition of "depression" as a clinical syndrome, for example, is

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different from the diagnosis of a bipolar affective or manic-depressive illness as an underlying clinical entity. Depression may also develop cyclically in depressive/masochistic characters and in narcissistic personalities. Here, a special type of character pathology reflects the underlying psychopathological entity. In still other cases, depression as a clinical syndrome may reflect an abnormal grief reaction. In short, the definition of clinical psychiatric syndromes is enhanced by an additional dimension—the relationship between underlying psychobiological, characterological, and psychosocial dispositions or pathology. Although how genetic, biochemical, characterological, and environmentally determined psychological disturbances are interrelated is still a matter of some controversy, a flexible analysis of clinical data in terms of both clinical syndromes and underlying, “structured” predispositions (altered personality structure and/or altered psychophysiological matrix of affective response patterns) should give depth and sophistication to what otherwise might become mechanistic groupings and regroupings of symptoms. Thus, I have suggested (Kernberg 1975, 1977) that the relationships among the complex determinants of psychiatric syndromes (as noted above) are patterned in enduring “structures” that are expressed in the interpersonal activities of patients and can be readily studied and diagnosed in controlled clinical situations and interviews. The groupings of the structures that emerge may well have implications for further biological studies as well as for clinical treatment approaches and outcomes.

In what follows, I shall comment more specifically on some aspects of Liebowitz’s presentations in the light of these considerations. His summary of Grinker, Werble, and Drye’s (1968) and Werble’s (1970) research and the criticism raised about it are clear and satisfactory. Grinker’s delimitation of subgroups of borderline patients highlights the problem of research on the borderline conditions—a problem deriving from the fact that these patients, from whatever viewpoint, reveal severe character disturbances that can be grouped in various ways. The work of Gunderson, Carpenter, and Strauss (1975), Carpenter, Gunderson, and Strauss (1977), and Gunderson and Kolb (1978) is also well summarized. Liebowitz appropriately points out that the characteristics that discriminated borderlines from both neurotic depressives and from schizophrenic patients were mainly character traits, such as impulse-action patterns, a past history of regressions in therapy, and interpersonal difficulties; in contrast, specific affective and psychotic symptoms had less discriminating power in this study. The growing importance of Gunderson’s work is, as I mentioned before, somewhat underemphasized by Liebowitz.

The review of research that considers borderline conditions a mild expression of schizophrenia is also and more exclusively the focus of Rieder’s (1979) article. Liebowitz is appropriately critical of the older studies of Hoch and Polatin (1949), Hoch and Cattell (1959), and Hoch et al. (1962). One major criticism that could be leveled at many studies comparing borderline conditions with schizophrenia (and with psychoses in general) is that they have been carried out mainly in inpatient settings. This may artificially foster the selection of a subgroup of borderline patients more related to the psychoses than would be true for patients with the common features of the borderline syndrome who have not been hospitalized.

Gunderson and Singer (1975) point out how the selection of borderline patients with initial psychotic symptoms (such as in the studies of Hoch et al.) or the absence of psychotic symptoms (such as in the studies of Grinker et al.) influences findings and conclusions. Liebowitz indirectly touches on this issue in reviewing the work of Kety, Rosenthal, and their co-workers (Kety et al. 1968, 1971, 1975; Rosenthal 1975; Rosenthal et al. 1968, 1971). Liebowitz appropriately focuses on the Shields and Gottesman (1972) critique of Kety and Rosenthal’s conclusions, and on the Spitzer, Endicott, and Gibbon (1979) clarification that “schizotypal personality,” rather than representing pseudoneurotic schizophrenia or borderline conditions in a broader sense, may correspond to a “genetically dilute form of schizophrenia.” Spitzer, Endicott, and Gibbon’s conclusion has as its counterpart Wender’s (1977) statement that his definition of borderline schizophrenia does not include affective lability, impulsivity, or fluctuating reality testing, all of which are generally considered to be characteristic of other borderline patients. This implies that there may be other types of borderline conditions which are not related genetically to schizophrenia and should not be called “borderline schizophrenia.” I believe that the method of searching for borderline conditions in the family of schizophrenic
patients may selectively highlight a subgroup of borderline conditions that is not representative of the entire spectrum of the borderline syndrome. I shall focus on the section of Liebowitz’s paper that deals with the relationship of borderline conditions to affective disorders. Liebowitz’s particular interest in Klein’s (1975, 1977) work makes him perhaps somewhat less critical in evaluating the evidence. In reviewing Klein’s and others’ comparative drug studies with several subtypes of borderline patients, for example, Liebowitz lists the phobic-anxious, the emotionally unstable character disorder, and the hysteroid-dysphoric among such groups described by Klein, without asking what made Klein decide in the first place that these were borderline subgroups. The phobic-anxious patients described by Klein (1977), whom Klein regards as resembling Grinker’s group IV patients, might as easily be compared to typical neurotic—rather than borderline—patients. It is for these phobic patients that Liebowitz thinks the strongest case could be made for an unrecognized affective disorder.

Regarding the emotionally unstable character disorders, Liebowitz acknowledges that their relationship to primary affective disorder is unclear, and that this is even more so for the hysteroid-dysphorics. Liebowitz rightly points out that the several patient types described by Klein showed differences in degree of homogeneity of drug response, and in the amount of data available on their diagnostic overlap with the borderline syndrome. Liebowitz neglects to mention the “histrionic states,” one additional major group of assumed borderline conditions described by Klein (1977) for which, according to Klein himself, psychopharmacological treatment is not helpful. All of this, in my opinion, raises questions regarding Liebowitz’s emphasis on the overall relationship of borderline conditions to affective illness. While this dimension of the differential diagnosis certainly needs to be explored, in my view, it is emphasized to the neglect of the much more important differentiation of borderline conditions from character pathology in general. This leads us to the last section of his paper, the focus on borderline conditions as a psychic-structural entity.

Liebowitz’s summary of my (Kernberg 1975, 1977) approach is both comprehensive and precise, with the exception of his exaggeration of the relationship between structural criteria and affective illness. In fact, preliminary clinical evidence in the evaluation of structural characteristics of manic-depressive patients indicates that between their psychotic episodes, these patients, in contrast to typical borderline patients, often revert to a neurotic personality structure (rather than to a borderline structure or to maintaining their psychotic structure per se). This contrasts with many (although not all) chronic schizophrenic patients who maintain their psychotic structure during periods of apparent remission or latency, and with borderline patients whose borderline personality organization is typically stable throughout the years. The typical manic-depressive patient can show a much better level of functioning, i.e., neurotic personality organization, between psychotic episodes.

As mentioned before, one important issue missing in Liebowitz’s review is the relationship between Gunderson’s research on borderline conditions as a clinical syndrome and my own ongoing research on the differential diagnosis of neurotic, borderline, and psychotic structures. Preliminary findings (Kernberg et al. 1978) indicate that the structural diagnosis of patients carried out on the basis of an initial structural interview (Kernberg 1977), without previous information about the patient (except name and age), correlates highly with the diagnosis of borderline syndrome arrived at independently by means of Gunderson’s Diagnostic Interview for Borderline (DIB), on the one hand, and psychological testing applying the Gunderson/Singer hypothesis (Gunderson and Singer 1975; Singer 1977) on the other. Although Gunderson’s borderline syndrome may be more restrictive than that I have postulated—and probably corresponds to the subgroup of infantile and narcissistic personalities within my description of borderline character pathology—our approaches complement each other. In addition, structural diagnosis (Kernberg 1975, 1977) may permit the differentiation of schizophrenic from “pseudo-schizophrenic,” schizoid (or “schizotypal”) personality structures, thus expanding the mapping of the boundaries of the borderline syndrome.

Although Liebowitz does mention treatment response as one type of validating criterion, further emphasis needs to be given to the fact that the present controversy regarding borderline conditions stems from the development, not only of new instruments for differential diagnosis, but also of new psychotherapeutic approaches that may offer hope in the treatment of these patients with severe character distortions. In this
connection, Klein’s efforts to arrive at diagnostic subgroups on the basis of psychopharmacological response need to be complemented by efforts to validate the diagnosis of the borderline syndrome and possibly also its subgroups on the basis of responses to differentiated psychotherapeutic techniques. In this respect, the clinical studies of patients in long-term therapy may provide helpful indicators of prognostic differences between patients who originally appear to have a similar syndrome. There are, of course, important methodological problems involved in using either drug response or psychotherapy outcome as validating criteria for subgroups within the borderline syndrome; an examination of these issues would transcend the necessary limitations of the present discussion.

The importance of Gunderson and Kolb’s (1978) recently reported findings resides both in their stress on the value of character features as differentiating criteria of borderline conditions, and the important step of differentiating borderline conditions from neurotic depression. Spitzer, Endicott, and Gibbon’s (1979) differentiation of two subtypes of borderline conditions—the “schizotypal” and “borderline personality” cases—also points to the importance of identifying subgroups within the borderline syndrome. Clinically speaking, their schizotypal subgroups probably correspond to the schizoid personality, and the unstable subgroup to the infantile personality. Such subgroups may be relevant for research on treatment response, and may also lend themselves to evaluating the etiological impact of genetic predispositions to borderline conditions (in terms of the influence of schizophrenic and/or manic-depressive predisposition to character structure).

The major questions, of course, are: Are there common characteristics that span the spectrum of the entire borderline syndrome, that have discriminating value for both inpatient and outpatient patients, and that still can permit a delimitation of the borderline syndrome from schizophrenia, nonborderline character pathology, and the affective disorders? And will such discriminative characteristics of the borderline syndrome say something about the specific response of patients to a certain treatment and their prognosis?

A major emphasis for the study of borderline conditions came from the need to study the schizophrenic spectrum from a genetic viewpoint; another major impetus came from the need to differentiate schizophrenic from pseudopsychotic patients; a third focus of interest derives from the complications and failures in treating patients with character pathology with psychoanalysis and psychoanalytic psychotherapy on an outpatient basis. This last group probably represents the most frequent and clinically the most challenging part of the borderline syndrome. The lack of sufficient emphasis on outpatient populations so far has seriously limited our research in this area. The definition and clarification of a common borderline structure cutting across various subgroups and constituting an underlying personality structure that determines, fixes, or modifies the specific character constellations of all these patients may have practical relevance for treatment and prognosis within the vast, confusing group of characterological illnesses that exceed the ordinary field of the neuroses without being part of the major psychoses.

In conclusion, Dr. Liebowitz’s paper is a brief but thoughtful review of the present literature on borderline conditions, and is very helpful for researchers in this area even if one does not agree with all of the conclusions.

Rieder’s Article

Rieder’s article might be considered an amplification of one of the sections of Liebowitz’s review, namely, that dealing with the consideration of borderline conditions as a milder form of schizophrenia. In consonance with Liebowitz’s analysis, Reider acknowledges that the old diagnosis of “borderline schizophrenia” may be best described by the Spitzer, Endicott, and Gibbon (1979) criteria for schizotypal personality.

Rieder, however, wishes to maintain the term borderline schizophrenic, rather than the usage of “schizotypal personality.” He does not refer to the relationship of the Shields and Gottesman (1972) analysis to his conclusions, and, in general, reviews only scantily the literature on borderline conditions.

From a broader perspective, if the patients who were called borderline schizophrenic in the past (on the basis of the limited differential diagnostic criteria available at such time) included both schizophrenic patients and borderline patients (as described in the recent literature by Grinker, Gunderson, Kernberg, and others), then retaining the name seems unfortunate. It would be preferable to use different labels for the nonschizophrenic borderline personality group and for that subgroup of these patients that
seems genetically or otherwise related to schizophrenia. Those who prefer to maintain the term borderline schizophrenia would otherwise also have to accept the term “borderline affective illness.” The problem then would become quite confusing one of differentiating the core borderline syndrome from both borderline schizophrenia and borderline affective illness as subgroups of the borderline syndrome! The major reason, however, for which I favor abandoning the old-fashioned term “borderline schizophrenia” is that it unnecessarily confuses an area in which so much clarity has been introduced, namely, the differential diagnosis of schizophrenia and the schizoid and paranoid personalities. I think that it is best to describe subgroups of borderline patients in as restrictive and clearly defined terms as possible. This will facilitate the ongoing study of the relations among such subgroups as well as the broader category of the borderline syndrome, and the various etiological, prognostic, and treatment implications that such subgroups have. Spitzer, Endicott, and Gibbon’s subgroups of schizotypal and borderline personalities, for example, may be a significant step in the clarification of subgroups within the borderline syndrome. Perry and Klerman (1978), after critically reviewing the literature on borderline conditions, express their concern over the lack of overlap or agreement regarding many of the criteria for the diagnosis of the borderline patient. Among the various interpretations that this relative lack of agreement allows is their thought that there are a number of subtypes within the group of borderline patients, requiring an adequate test of existing diagnostic criteria.

In conclusion, I would stress the need for research differentiating subtypes. At the same time, the question of the basic characteristics of the borderline syndrome (and its prognostic and therapeutic implications) also needs further research. I believe that a combination of the approach of Gunderson and his group, stressing descriptive, particularly character features, and a psychostructural one focusing on identity integration, defensive organization, and reality testing as basic borderline characteristics (Kernberg 1977) offers one road toward these goals.

References


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