trolled prospective maintenance studies have been conducted with patients discharged from state hospitals where the length of stay is usually much longer than in acute wards in general hospitals. Again, our data lead us to question the very short stays currently accorded acute psychosis in most general hospital psychiatric wards. Although economically sound, the practice may be clinically unwise.

Susan M. Matthews, B.A.
Loren R. Mosher, M.D.
Center for Studies of Schizophrenia
National Institute of Mental Health
Rockville, MD 20857

Margaret T. Roper, M.S.
Food and Drug Administration
Rockville, MD 20857

Alma Z. Menn, A.C.S.W.
Mental Research Institute
Palo Alto, CA 94301

Another View of the Borderline

To the Editor:

In response to your issue on The Borderline Syndrome (Schizophrenia Bulletin, Vol. 5, No. 1, 1979), I would like to propose a different approach based on my experiences in child psychiatry. The most discouraging children to work with are characterized by concretistic thinking and by an inability to form mutual lasting relationships. The two characteristics always seem to appear together. These are the deficits that our "best outcome" grownup autistics show.

These deficits may be recognized during infancy and can elicit very intense and even bizarre responses from parents. When the child is seen later, psychodynamic explanations seem obvious; yet psychotherapy is fruitless, since a relationship—the foundation of psychotherapy—cannot be established. In other children, the deficit is not noticed until adolescence. These children get by in school through rote learning, and the parents do a good job of "habit training." They can read fact books but cannot deal with novels built around subtle plays of emotion.

This deficit of unknown cause can appear in association with any other psychiatric symptomatology. The picture seen will be influenced by the child's temperamental profile and the environmental response, plus any superimposed syndrome like schizophrenia, manic depressive illness, or minimal brain dysfunction (MBD). Many will show schizophrenia-like symptoms in response to stress. Those with MBD are especially difficult to manage. Medication usually can control the symptoms of these complications, but has no effect on the basic deficit.

I propose that some people are born with an inability to relate, which secondarily leads to an inability to deal with high-level abstractions. These individuals will develop additional psychiatric symptoms depending on environmental, genetic, and organic insult factors. Drug therapy can improve symptoms but not the ability to relate. Those patients can often make excellent superficial impressions. Drugs and social training are the only treatments available to at least raise the quality of life for these people. Is this the basis of the borderline syndrome?

Hans R. Huessy, M.D., M.S.
Section of Child, Adolescent and Community Psychiatry
University Associates in Psychiatry
Medical Center Hospital of Vermont
Deggosbruand Memorial Unit
Burlington, VT 05401