The Relatedness of Borderline and Schizophrenic Disorders*

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Abstract

This article is an editor’s introduction to the theme of a special issue of the Schizophrenia Bulletin devoted to borderline conditions. The editor reviews various approaches to defining borderline patients and concludes that these descriptive efforts are now showing considerable consensus. Questions remain, however, about whether borderline patients constitute a diagnostic category that is unrelated to schizophrenia or some other established diagnostic group. The historical origins of these questions are briefly reviewed, and then the multiple interpretations given to the current research efforts to answer them are described.

Two traditionally divergent lines of investigation converge in their focus on the relatedness of borderline and schizophrenic disorders. The first line of investigation is the effort to define specific boundaries for schizophrenia from within the broad range of mentally disturbed persons for whom questions of differential diagnosis arise. The second concerns attempts to understand and prevent unforeseen schizophrenic-like reactions to usually helpful methods of psychiatric treatment.

The diagnostic issue was already evident in the initial descriptive efforts to define a group of patients called latent schizophrenics. Bleuler (1950) used this term in 1911 to classify nonpsychotic individuals with underlying forms of psychopathology similar to those seen in patients diagnosed schizophrenic. In 1921, Rorschach (1942) applied the same label to seemingly adequately functioning persons whose responses to inkblot tests resembled those given by schizophrenic patients. Later, Meehl (1962, 1964) developed a manual for the identification in nonpsychotic individuals of subtle signs and symptoms thought to betray an underlying genetic link with schizophrenia.

The second body of information about these patients is found within the psychotherapeutic literature. Knight (1953) warned against undertaking exploratory therapy with patients whose neurotic defenses were felt to keep their underlying ("latent") primary process in abeyance. Subsequently, Hoch and Cattell (1959, 1962) documented this danger by reporting on a series of neurotic-appearing patients who, in the psychoanalytic situation, went on to a schizophrenic denouement. While Knight (1953) and Hoch and Polatin (1949) used the terms borderline and pseudoneurotic schizophrenia, respectively, the issues they were encountering in therapy are reminiscent of those that earlier gave rise to the diagnosis of latent schizophrenia. Patients of this type—whatever their label—present problems for both practicing therapists and research diagnosticians. Therapists worry about the dangers of underestimating psychopathology, whereas diagnosticians are wary of overdiagnosing schizophrenia. From their different perspectives, therapists and diagnosticians have a common interest in better understanding the boundaries of an amorphous clinical entity.

Added impetus to the study of this clinical conundrum has come

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from three highly influential but widely divergent sources. Kernberg (1967), synthesizing ego analytic and object relations theory, focused attention on a middle-level type of psychopathology, which he called borderline personality organization. Intrigued by Kernberg's approach, many clinicians have become more deeply involved in treating the most severe forms of character pathology, including those hitherto called latent schizophrenic. Kernberg, however, took the position that the potential for psychotic transference reactions did not contraindicate analytically oriented therapy.

The second impetus for work in this field was the landmark series of adoption studies conducted by Kety, Rosenthal, and Wender (see Kety et al. 1975; Rosenthal et al. 1971; Wender et al. 1971). These studies confirmed the etiological importance of genetic factors in at least some cases of schizophrenia, and further indicated a familial relationship between patients with chronic schizophrenia and nonpsychotic individuals with severe character pathology. Hence, an unexpected effect of studies affirming a genetic basis for schizophrenia has been their associated suggestion of a continuous model of psychopathology!

The contributions of Kernberg and of Kety, Rosenthal, and Wender have coincided with a general upsurge of interest in psychiatric diagnosis and with important advances in clinical research methodology. Once again, a pioneering effort by a major investigator, Roy R. Grinker, Sr., in work done with Werble and Drye, demonstrated that clinical research methods could be applied to even this most traditionally ambiguous diagnostic population (Grinker, Werble, and Drye 1968).

The articles in this issue of the *Schizophrenia Bulletin* explore the implications of the studies alluded to above, as well as those of other investigations aimed at delineating the still indistinct boundaries between borderline and schizophrenic disorders. To orient the reader to the various diagnostic schemes and terms used in this group of articles, figure 1 illustrates my view of the interrelationships among them. In understanding the figure, the reader should recognize the borderline syndrome as a category defined by Grinker, Werble, and Drye (1968). Based on a recent updating of that study (Grinker and Werble 1977), Grinker now gives added weight to brief psychotic episodes and suicidal ideation, so his view of borderlines may be closer to my own (i.e., borderline personality disorder) than the figure indicates. Borderline personality organization, the term applied to the group of patients described by Kernberg (1967), would seem in theory to be a relatively inclusive diagnostic category. However, Kernberg reports that in practice the patients he assigns to this category are very similar to those identified as borderline personality disorder. The latter category, at least theoretically, describes a narrower group of patients similar to Knight's (1953) and encompassing those Frosch (1964) called psychotic characters. I have described its defining characteristics in articles with Singer and Kolb (Gunderson and Singer 1975; Gunderson and Kolb 1978), and these characteristics were a major source from which Spitzer, Endicott, and Gibbon (1979) subsequently developed criteria for the diagnosis of borderline personality disorder proposed for DSM-III. Borderline schizophrenia was the diagnosis used in the adoptive studies of Kety, Wender, and Rosenthal, and has its historical antecedents in the latent schizophrenia of Bleuler and Rorschach and in pseudoneurotic schizophrenia as described by Hoch and Polatin. These diagnoses are incorporated in the forthcoming DSM-III as schizotypal personality disorder, a term first used by Rado (1962) and Meehl (1962), and recently given further definition by Spitzer, Endicott, and Gibbon (1979). The atypical affective disorders category has been proposed by Klein (1975) to define borderline patients who might better be grouped with the affective disorders. Stone's (in press) conception of borderlines would encompass borderline schizophrenia and atypical affective disorders, but would not recognize borderlines as a separate diagnostic category.

In this issue, the borderline theme is introduced by two review articles (Liebowitz 1979; Rieder 1979). Liebowitz (1979) concludes in his comprehensive review that while it is still unclear whether borderlines constitute a distinct diagnostic group, the evidence firmly supports their being distinct from schizophrenia. A relationship between this group of patients and the affective disorders, however, is viewed as a distinct possibility. Based on his review of the literature, Liebowitz advocates directing greater research attention to establishing validating criteria based on course, drug response, and family prevalence studies.

The review by Rieder (1979) has a narrower focus. He believes there is a group of nonpsychotic patients who are genetically related to, but clinically distinguishable from, schizophrenics. In Rieder's view,
research evidence favors the use of a diagnostic category that, while neither schizophrenic nor borderline, would nonetheless be called borderline schizophrenia. Rieder stands alone in his preference for this particular diagnostic term, but other authors represented in this issue of the Bulletin support his position favoring the introduction of a new intermediate category (called schizotypal personality disorder).

The reviews by Liebowitz and Rieder are accompanied by two discussions (Grinker 1979; Kernberg 1979). Kernberg (1979) accepts the idea that the borderline category may contain important subgroups, but contends that existing evidence has not as yet demonstrated a strong link between borderline conditions and either affective disorders or schizophrenia. Agreeing that further research will be required to support any subdivisions of the borderline category, Kernberg adds an important validating criterion overlooked...
by Liebowitz: the underlying psychological coherence of a diagnostic category and the response of patients to psychotherapy. Grinker (1979), in his discussion, is vehement that there is already sufficiently strong evidence to document the existence of borderline personality disorder as a distinct diagnostic group. Like Kernberg, Grinker feels supporting validation can be found in patients' underlying psychopathology, although he prefers to describe it in the language of ego analytic theory. He is clearly opposed to the introduction of an intermediate borderline schizophrenia or schizotypal personality disorder category.

The second group of articles more specifically addresses two major questions: Do some borderlines have genetic determinants in common with schizophrenics? Are these patients clinically discernible? Rosenthal (1979) believes, based on research reviewed by Rieder (1979), that such a group does exist. Using Thomas Wolfe as an example, however, he suggests that the criteria used by Spitzer, Endicott, and Gibbon (1979) to identify this group may be inadequate. In a detailed review of the genetic literature, Siever and I conclude that even if there is an identifiable subgroup of borderlines who share a genetic factor with chronic schizophrenics, this factor may be nonspecific to either category and is probably weaker than that found in a chronic schizophrenic group (Siever and Gunderson 1979). Like Rosenthal, we question the feasibility of clinically discriminating such a group as proposed by Spitzer, Endicott, and Gibbon (1979). In response, Spitzer and Endicott (1979) strongly argue that schizotypal personality disorder can be distinguished from borderlines and that their method of identifying patients of each type is a viable one. In the final discussion, Stone (1979) accepts the idea of genetic heterogeneity among borderline patients, but indicates that such patients need to be sorted out and diagnosed according to their affiliation with either the schizophrenic or affective disorder parent category.

I expect that most readers will be surprised by the variety of recent approaches to the problem of borderline diagnoses and the interesting new directions the field is taking. Although a few authors prefer to leave open the question of whether borderlines represent a distinct diagnostic group, only Stone seems skeptical about this idea. Moreover, there appears to be considerable overlap in the way that most authors would identify borderline patients. Consensus is now more evident in the narrower question of whether a new category of schizotypal personality should be introduced. Here, the opinions seem equally divided. While Rieder and Rosenthal believe there is a subgroup of borderlines with a strong genetic relationship to schizophrenics, most other authors, including Spitzer and Endicott, question the strength and significance of this affiliation. Hence, even among those who favor the formation of this category, a curious division exists. Rieder feels schizotypal patients are identifiable and have a genetic relationship with schizophrenics. Rosenthal feels that nonschizophrenic persons having an important genetic relationship to schizophrenia exist but are not identifiable. Spitzer and Endicott feel that schizotypal patients are identifiable but that their genetic relationship to schizophrenia is unclear.

As a group, these articles illustrate the variety of interpretations that can be given to the same body of evidence by thoughtful scholars. Some of these differences may result from the differing patient samples that the various authors include under the common rubric borderline. This possibility is suggested by figure 1 and is discussed by Stone. More critical in my view than this sampling issue, however, are the differing weights that each author gives to the various bodies of evidence as indicators of diagnostic validity. Stone, for example, places much emphasis on family prevalence studies, whereas Liebowitz is impressed by the significance of possible drug responsiveness.

Grinker and Kernberg—and I would include myself here—suggest important validating data lie within the internal psychological coherence of the group. Spitzer, Endicott, and Rieder emphasize the importance of clinical discriminability of the syndromes. I trust that readers will find the exchanges among these authors—for all their differences—illuminating and sophisticated.

Many of the authors have themselves made important contributions to the understanding of borderline conditions. Here they are asked to respond to sometimes critical reviews of these contributions and to examine the implications of their work in the light of work by others. The degree to which this sort of exchange is allowed by the authors reflects directly upon their scientific investment in the issues and augurs well for the continued advancement of knowledge in this area. The reviews and the accompanying discussions lay out for the reader
what the existing data consist of, what the possible interpretations of these data are, and what gaps in knowledge still exist. They also suggest a number of approaches by which the continuing controversies might ultimately be resolved.

The final article in the issue returns to the type of clinical problems borderline patients present—problems that are, in the final analysis, the reason for all the interest and argument reflected in the preceding articles. Teitelman et al. (1979) are not concerned primarily with differentiating their patients from schizophrenics or even with preventing them from becoming schizophrenic. They are interested in whether a new form of conjoint therapy using the mothers of borderline patients can help reverse the impairments in reality testing and object relationships that characterize these patients. Their preliminary effort to document positive change from therapy is both encouraging and provocative. It suggests that a schizophrenic denouement may now be less common for borderline patients than in the past when the nature of their disorder was unrecognized. It is a reminder of the still largely neglected research area of treatment responsivity, which should now prove more attractive to investigators, given the current narrowing of debates about diagnosis.

References

Rosenthal, D.; Wender, P.H.; Kety, S.S.; Welner, J.; and Schulsinger, F. The adopted-away offspring of


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**Seventh International Congress of Group Psychotherapy**

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