The authors discuss difficulties in the assumptions that underlie Kernberg's Structural Interview method for diagnosing borderline personality organization and demonstrate methodological limitations in the studies that have reported results from its use. Further data analysis leads to the conclusion that, in the population studied, the Structural Interview diagnosis of borderline personality disorders is essentially equivalent to the clinical diagnosis of the presence of any personality disorder. A predictive formula to determine the presence or absence of clinically diagnosed personality disorder is derived using logistic regression.

Kernberg\(^1\) has developed a complex and influential theoretical system which posits three levels of declining differentiation in personality organization: the neurotic; the borderline; and the psychotic. In this system the borderline personality organization shares the following characteristics with the neurotic: self representations that are sharply delimited, psychologic defenses sufficiently sophisticated so that interpretation improves functioning, and the capacity to test reality. The borderline personality organization shares with the psychotic the following characteristics: poor self cohesion and identity, low level of defensive operations (splitting, projective identification, etc.); and alterations in their relationship with reality and feelings of reality. Kernberg has developed and tested what he calls the Structural Interview in order to distinguish these three specific types of intrapsychic structures which he assumes to be categorically distinct and enduring.

The Structural Interview has commonalities and differences from the standard psychiatric interview. It is similar to standard practice in that the interview

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is conducted in a fairly unstructured manner to collect information on the patient's symptoms, functioning, and interpersonal relations. The Structural Interview is unique in its reliance on confrontation and interpretation during the interview as the primary method of data gathering for making diagnostic decisions. During the Structural Interview careful attention is paid to apparent inconsistencies in the information the patient presents. These inconsistencies are pointed out to the patient (confrontation) and explanations are offered by the interviewer for them (interpretation). The interviewer's evaluation of the patient's response to an interpretation is key to Structural Interview diagnostic decision making. Specific (and cross-sectional) responses within the interview situation are crucial to the diagnostic process within the framework of the structural interviewing technique. Patients who become more integrated in response to confrontations and interpretations receive a neurotic or borderline diagnosis; those who disorganize further are diagnosed psychotic.

In several papers, Kernberg and associates have attempted to test his theoretical assumptions and to determine the performance of the Structural Interview in comparison with other measurement methods (the clinical interview, the DIB, psychological tests, and retrospective DSM III diagnosis). In this paper we will re-examine these data to: (1) determine whether results of the Structural Interview add significantly to the results generated by the clinical interview; and (2) if not, to investigate whether a predictive model for clinically diagnosed personality disorder can be developed from other variables measured in these studies.

METHOD

Results of Structural Interview

Carr et al. studied 32 psychiatric inpatients using the Structural Interview, DIB, WAIS and Rorschach. They found DIB agreement with Structural Interview in 25 of 32 cases (78%) for whom unequivocal diagnoses were available for both methods, and agreement between the Structural Interview diagnosis and WAIS/Rorschach combination diagnosis in 24 of 29 cases (83%) for whom unequivocal diagnoses were present for both measures (both results significant at the .004 level). Kernberg et al. expanded the sample to forty-eight psychiatric patients. The structural diagnosis agreed with the DIB in 34 of the 46 cases where unequivocal diagnoses were available from both methods (74%), with psychological test reports in 32 of 43 cases where unequivocal diagnoses were present in both methods (74%) and with the WAIS/Rorschach combination in 36 of 46 cases (78%) were unequivocal diagnoses were available from both methods. These results are all significant at the .001 level.

Blumenthal, Carr, and Goldstein returned to the clinical charts of these same 48 patients in order to make retrospective DSM III diagnoses. Overall there was agreement between Structural and DSM III diagnosis in 61% of cases. In 5 of the 18 discrepant cases, the structural diagnosis was "borderline" and the patient's DSM III diagnosis was other personality disorder. Seven cases diagnosed as affective disorder by DSM III were diagnosed about equally as psychotic or borderline by structural interview. In 4 cases there was direct discrepancy between structural and DSM III diagnosis - i.e., a DSM III borderline getting a structural psychotic diagnosis or vice versa.