The SCID-II and DIB-R interviews: Diagnostic association with poor outcome risk factors in Borderline Personality Disorder

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This study assesses whether patients diagnosed with Borderline Personality Disorder (BPD) according to the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) or the Revised Diagnostic Interview for Borderlines (DIB-R) present differences in factors associated with risk of poor outcome. Three hundred fifty-two patients were evaluated with SCID-II and DIB-R. Patients diagnosed as BPD according to one or both instruments were compared in BPD poor outcome risk factors. The analysis was conducted on the participants who were assigned to SCID-II (n = 135) and SCID-II/DIB-R (n = 126) groups. The group diagnosed with BPD according the combined SCID-II/DIB-R interview showed a significantly greater association with risk of poor outcome predictors, such as total number of comorbid Axis II disorders, number of BPD criteria, presence of comorbid paranoid personality disorder, and worse occupational status. No differences between groups were found in the affective instability BPD criterion, self-reported impulsivity, post-traumatic stress disorder, major depressive disorder or presence of any cluster C comorbidity. The observed differences were large enough to advise caution in generalizing findings from studies without considering what measurement was used for the BPD diagnosis.

Entrevistas SCID-II y DIB-R: asociación del diagnóstico de Trastorno Límite de la Personalidad con factores de riesgo de mal pronóstico. En el presente estudio se compara si existen diferencias en factores relacionados con mal pronóstico en pacientes diagnosticados de Trastorno Límite de Personalidad (TLP) en función de si cumplían los criterios diagnósticos para el trastorno según la Entrevista Clínica Estructurada para los Trastornos de Personalidad del Eje II del DSM-IV (SCID-II) o la Entrevista Diagnóstica para el Trastorno Límite – revisada (DIB-R). Se evaluó una muestra de 352 pacientes mediante la SCID-II y la DIB-R. Tras el proceso de evaluación, dos grupos fueron comparados: el grupo SCID-II (n= 135) y el grupo SCID-II/DIB-R (n= 126). Comparado con el grupo SCID-II, el grupo SCID-II/DIB-R presentó de forma significativa más predictores de mala evolución, concretamente número total de trastornos comórbidos del Eje II, número de criterios TLP, presencia de trastorno paranoide de la personalidad comórbido y peor situación laboral. No se observaron diferencias significativas en inestabilidad afectiva, impulsividad autoinformada, trastorno por estrés postraumático, trastorno depresivo mayor o trastornos de personalidad del Cluster C comórbidos. Las diferencias observadas fueron lo suficientemente importantes como para recomendar precaución al generalizar los resultados de aquellos estudios que utilizan uno de los instrumentos a los que usan el otro.

Among the available structured interviews to assess Borderline Personality Disorder (BPD), the *Structured Clinical Interview for DSM-IV Axis II Disorders* (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1999) and the *Revised Diagnostic Interview for Borderlines* (DIB-R; Zanarini, Gunderson, Frankenburg, & Chauncey, 1989) are the most widely used semi-structured interviews for both clinical and research purposes (major

pharmacology trials and psychotherapeutic outcome studies as well as in follow up studies) (Bellino, Paradiso, & Bogetto, 2006; Hollander, Swann, Coccaro, Jiang, & Smith, 2005; Linehan et al., 2002; Palmer et al., 2006; Weinberg, Gunderson, Hennen, & Cutter, 2006; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2006; Zanarini, Frankenburg, Hennen, & Silk, 2003). Both interviews diagnose the same construct but there are important differences between them. The SCID-II, based on an atheoretical approach (American Psychiatric Association; APA, 2000), was developed to diagnose all the DSM Personality Disorders. Whereas, the DIB-R is based on a psychoanalytic orientation (Gunderson, Kolb, & Austin, 1981) to diagnose only BPD. Finally, both interviews use different scoring systems. The SCID-II includes the nine DSM polythetic criteria set for BPD. As no specific criterion or

specific set of criteria are required for the diagnosis, the SCID-II often leads to a heterogeneous group of patients being diagnosed with BPD. On the other hand, the DIB-R uses a pyramidal scoring system, used to recognize the limitations of and to minimize the weight given to any single observation, question, or other piece of information (Gunderson et al., 1981).

One of the most important issues in BPD research literature is the poor outcome (Chiesa, Fonagy, & Holmes, 2006; Gunderson et al., 2006; Zanarini, et al., 2006). With this in mind, among the main BPD predictors of poor outcome determined by previous studies, those related to psychiatric history have been: a greater length of previous hospitalizations (McGlashan, 1985), an earlier age of first psychiatric contact (Links, Mitton, & Steiner, 1993; Paris, Brown, & Nowlis, 1987; Plakun, 1991), lower scores on the Global Assessment Functioning Scale (GAF) (Najavits, & Gunderson, 1995), higher number of Axis II diagnoses at follow-up (Links, Heslegrave, & Van Reekum, 1998), comorbid schizotypal, antisocial and paranoid personality disorders (Najavits, & Gunderson, 1995; Links et al., 1998; Stone, 1990), substance abuse (Links et al., 1993; Stone, 1990), dysphoria (Paris et al., 1987), depression, number of BPD criteria met (Gunderson et al., 2006; Najavits, & Gunderson, 1995), number of bipolar disorder criteria met (Links et al., 1998), suicidal behaviors (Mehlum, Friis, Vaglum, & Karterud, 1994; Stone, 1990), high impulsivity (Links et al., 1993) and affective instability (McGlashan, 1985). Two interesting follow-up studies have recently analyzed variables associated with poor outcome in BPD (Gunderson et al., 2006) and the BPD course predictor variables (Zanarini et al., 2006). The strongest finding of the Gunderson et al., (2006) follow-up study was that poor outcome is directly related to the severity of dysfunction, measured by the GAF, with a greater total number of personality disorder criteria at baseline in BPD patients. The 10 years follow up study of Zanarini et al., (2006) shows an interesting result, the absence of post-traumatic stress disorder and anxious cluster personality disorders alone with good vocational record, are predictors of BPD symptomatology time remission.

Despite the wide acceptance of both interviews, the differences mentioned above could influence the diagnosis. Both interviews could diagnose different subgroups of BPD patients with different clinical features. However, little is known about the typical features of those patients diagnosed with BPD by the DIB-R, compared with those diagnosed with BPD by the SCID-II. To date no studies have investigated whether there are differences in risk of poor outcome between BPD patients who meet diagnostic criteria according to the SCID-II and/or the DIB-R. Given the severity that usually patients diagnosed with BPD present, the potential identification through diagnostic measures of those with a worse therapeutic prognosis, could help in improving BPD treatment. Moreover, as both instruments are frequently used for clinical research purposes, in case that both interviews diagnose different subgroups of BPD patients, the knowledge of patient's distinctive clinical characteristics would be useful to determine if the results generalization could be adequate.

The aim of this study was to investigate if patients diagnosed with BPD according to the SCID-II and/or the DIB-R present different association to poor outcome risk factors, analyzing the principal clinical predictive factors associated with poor outcome in the literature, such as comorbidity, symptom severity, global functioning, impulsivity, presence of cluster C personality disorder, as well as suicidal and self-harm behaviors and two social factors, social adjustment and occupational status.

Method

Participants

An initial sample of 352 patients who had been referred to our BPD Program, participated into the study; which was approved by Hospital's Ethics Committee. Written consent was obtained from all the participants before entering the study. An initial screening was performed to determine whether they were between the age of 18 and 50, had at least average intelligence, had no history or current symptoms of a serious organic condition that might be associated with the development of psychiatric symptoms, had no current diagnosis of schizophrenia, bipolar I disorder, or substance dependence disorder. However, participants with substance abuse disorder were not excluded from the study.

Of the initial sample of 352 patients, 262 (74.43%) met BPD diagnostic criteria in one or both interviews, did not meet exclusion criteria and participated in the study. Excluded participants 90 (25.57%) did not meet BPD diagnostic criteria and differed only in that they had a higher educational level (Z= 3.75; p<0.001).

Procedure

Participants underwent three interviews on three separate days to be evaluated for Axis I and Axis II disorders using the SCID-I (First, Spitzer, Gibbon, & Williams, 1999), the SCID-II (First et al., 1999), and the DIB-R (Zanarini et al., 1989). These tests were administered by three psychologists specially trained to use these instruments. Excellent mean interrater reliability was found for Axis I (kappa >.73) and Axis II disorders (kappa= .71-.91), particularly for antisocial personality disorder (kappa= 1.00).

Following the interviews' cut-off score (Barrachina et al., 2004; First et al., 1999), participants were placed to the SCID-II diagnosis group if they met five or more DSM-IV-TR BPD criteria but scored under the cut-off value of 6 on the DIB-R. Participants who scored 6 or more in DIB-R but did not meet more than four DSM-IV-TR BPD criteria were placed in the DIB-R group. Patients that met both conditions were placed in the SCID-II/DIB-R group.

Instruments

The Spanish version of the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II; First et al., 1999) and the Revised Diagnostic Interview for Borderlines (DIB-R; Zanarini et al., 1989) were used to assess BPD. Two different DIB-R cut-off scores have been proposed to define BPD, the typical cut-off of 8 (Zanarini et al., 1989), and the cut-off of 6, according to the Spanish validation (Barrachina et al., 2004). In this study, the Spanish cut-off of 6 was used to determine the disorder presence. DIB-R reliability and validity were established in previous studies (Zanarini et al., 1989) and confirmed in the Spanish version (Barrachina et al., 2004).

Suicidal and self-harm behaviors were assessed using the corresponding items of the DIB-R. Affective instability was assessed by its presence as a criterion in BPD diagnosis, according to the SCID-II. Current occupational status was registered during the first psychiatric interview by asking patients about their occupation.

Axis I comorbid disorders were assessed by the Spanish version of the Structured Clinical Interview for DSM-IV Axis I Disorder (SCID-I; First, Spitzer, Gibbon, & Williams, 1999). Impulsivity was evaluated using the Spanish validation of the Barratt Impulsivity Scale-11 (BIS-11; Oquendo, Baca-García, Graver, Morales, Montalbán, & Mann, 2001). The social adaptation was assessed by the Spanish version of the Social Adaptation Self-evaluation Scale (SASS; Bobes, González, Bascarán, Corominas, Adan, & Sánchez, 1999). Global functioning was measured with the Global Assessment Functioning scale (GAF; Hall, 1995).

Lastly, general severity of psychopathology was assessed by the Clinical Global Impression (CGI; Guy, 1976), and the Spanish validation of the General Symptomatic Index of the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1999).

Data analysis

Between-group comparisons involving association between categorical data were analyzed using the Chi-square tests, and between-group comparisons involving continuous and normally distributed data were analyzed using Student's t-tests. When variables did not show a normal distribution, a non parametric test was used. To test for normal distribution, a Kolmogorov-Smirnov test was conducted for each variable. Because of multiple comparisons involved in the analyses, Bonferroni-type corrections were applied to the p-values for the main effects of poor therapeutic outcome. As there were 17 such comparisons, these corrections resulted in an adjusted p-value of .05/17= .003.

Results

As an unexpected result was observed, with only one participant falling into the DIB-R group, the analysis was conducted on the participants who were in SCID-II (n= 135) and SCID-II/DIB-R groups (n= 126). The SCID-II and SCID-II/DIB-R groups did not differ with regard to demographic characteristics other than for occupational status (χ^2 [3]= 23.39; p<.001) (Table 1).

For poor outcome risk factor variables, the SCID-II/DIB-R group showed a significantly higher number of Axis I disorders (Z= 4.24; *p*<.001), Axis II disorders (Z= 5.84; *p*<.001), and number of BPD criteria (Z= 9.47; *p*<.001) than the SCID-II group (Table 2). When specific disorders associated with poor outcome were compared between groups, the SCID-II/DIB-R group showed significantly higher rates of antisocial personality disorder (4.4% vs. 14.3%; χ^2 [1]= 7.56; *p*=.006), paranoid personality disorder (20.0% vs. 51.6%; χ^2 [1]= 28.49; *p*<.001), substance abuse disorder (37.0% vs. 55.6%; χ^2[1]= 8.99; *p*= .003) and post-traumatic stress disorder (14.3% vs. 25.8%; χ^2 [1]= 5.14; *p*= .02). After Bonferroni correction, only the number of comorbid Axis II disorders, the number of BPD criteria, and the presence of comorbid paranoid personality disorder remained significant. The comorbid schizotypal personality disorder was also found to be more prevalent in SCID-II/DIB-R group, but the χ^2 test was not performed because of its low frequency in the SCID-II group. The two groups did not differ importantly for major depressive disorder or the rate of BPD DSM affective instability criterion (Table 2).

No significant differences between groups were found in social functioning and social adjustment measures, neither in GAF (*t*

Table 1
Demographic differences between SCID-II and SCID-II/DIB-R groups

	SCID-II group (n= 135)	SCID-II/ DIB-R group (n= 126)		
	M (SD)	M (SD)	t (df)	p
Age (years)	26.23 (6.65)	25.98 (6.74)	.30 (259)	.77
Sex	n (%)	n (%)	χ^2 (df)	p
Female	111 (82.2)	104 (82.2)	.18 (1)	.67
Education			χ^2 (df)	p
Did not complete primary education*	0 (.0)	6 (4.8)		
Completed primary education	104 (77.0)	100 (79.4)	3.06 (1)[a]	.08
High School Diploma	30 (22.2)	16 (12.7)		
University Degree	1 (.7)	4 (3.2)		
Marital status				
Never married	107 (79.3)	97 (77.0)		
Married or Cohabiting	14 (10.4)	21 (16.7)	3.22 (2)	.20
Divorced, separated or widowed	14 (10.4)	8 (6.3)		
Occupation				
Student	19 (14.3)	24 (19.0)		
Never employed	35 (25.6)	39 (30.4)	23.39 (3)	**<.001**
Unemployed or on disability	13 (9.8)	33 (26.4)		
Employed	68 (50.4)	30 (24.0)		

* In Spain, "primary education" lasts until age 16
[a] Patients were regrouped in two categories (Primary Education or less and High School Diploma or higher) so that the original distribution in the table was maintained in order to conduct the Chi-square test correctly

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Table 2
Comparison of SCID-II and SCID-II/DIB-R groups regarding Axis I and Axis II disorders associated with poor outcome

	SCID-II group (n= 135)	SCID-II/ DIB-R group (n= 126)		
	M (SD)	M (SD)	Z	p
Number of Axis II Disorders*	1.00 (0.75)	1.00 (1.30)	5.84	**<.001**[a]
Number of BPD criteria	7.00 (1.31)	9.00 (2.36)	9.47	**<.001**[a]
	n (%)	n (%)	χ^2(1)	p
Major Depressive Disorder	57 (42.1)	52 (40.8)	.04	.84
Substance Abuse Disorders	50 (37.0)	71 (55.6)	8.99	.003
Antisocial Personality Disorder	6 (4.4)	18 (14.3)	7.56	.006
Schizotypal Personality Disorder[b]	2 (1.5)	15 (11.9)	11.63	–
Paranoid Personality Disorder	27 (20.0)	65 (51.6)	28.49	**<.001**[a]
Any Cluster C Disorder	53 (39.3)	58 (46.0)	1.22	.28
Post-Traumatic Stress Disorder	19 (14.3)	33 (25.8)	5.14	.02
DSM-IV-TR/SCID-II Affective instability criterion	129 (95.6)	124 (97.6)	.33	.57

* Borderline personality disorder was not included
[a] Significant with Bonferroni correction
[b] Chi-square test was not performed due the variable distribution between groups

[259]= 1.70; p= .09) nor in SASS (t [259]= 0.78; p= .43). The SCID-II/DIB-R group presented more severe symptomatology according to clinical evaluation in the CGI (t [259]= 4.38; p<.001) and self-reported in the General Symptomatic Index scale of the SCL-90-R (t [259]= 5.40; p<.001). When personality variables were studied, the SCID-II/DIB-R group scored higher on the BIS-11 (t [259]= 2.77; p= .006), but this difference did not remain significant after Bonferroni correction (Table 3).

Between-group differences in suicide and self-harm behaviors remained significant after Bonferroni correction. Specifically, multiple suicide attempts (χ^2 [2]= 46.17; p<.001) and self-harm behaviors (χ^2 [2]= 50.55; p<.001) were significantly more frequent in the SCID-II/DIB-R group (Table 3).

Finally, a post-hoc logistic regression analysis was performed to study the association of poor outcome risk factors between SCID-II and SCID-II/DIB-R groups. Between the seventeen studied outcome factors, only eight maintained statistical significance after Bonferroni correction and were included in the stepwise regression analysis to study which of them predicted BPD diagnoses with the DIB-R. Four factors were significant predictors of SCID-II/DIB-R group diagnoses: greater number of BPD criteria (Wald= 45.84; p<.001; OR= 2.81), more suicidal behaviors (Wald= 6.77; p= .009; OR= 3.53), more self-harm behaviors (Wald= 15.48; p<.001; OR= 5.52), and worse occupational status (Wald= 4.54; p= <.001; OR= 3.16) (Table 4). Moreover, when the accuracy of the model was studied using the default probabilistic cut-off point (.05), it showed a sensibility of 84.7% (76.8% - 90.2%), a specificity of 82.7% (75.6% - 88.1%), a predictive positive value of 79.7% (71.5% - 85.9%) and a predictive negative value of 87.1% (80.3% - 91.8%).

Table 4
Poor outcome risk factors predictors of SCID-II/DIB-R diagnosis[a]

Variable	B	Wald	p	Odds ratio	C.I. 95%	
					Lower	Upper
Suicidal behaviors	1.26	6.77	.009	3.53	1.36	9.15
Self-harm behaviors	1.71	15.48	<.001	5.52	2.36	12.94
Number of BPD criteria	1.03	45.84	<.001	2.81	2.07	3.80
Current occupation	1.15	4.54	<.001	3.16	1.10	9.10

[a] The dependent variable was the diagnosis of borderline personality disorder according to the DIB-R. Only between-group variables significant after Bonferroni correction were included in the regression analysis as independent variables

Discussion

The aim of this study was to investigate the different association of poor outcome risk factors in BPD patients diagnosed with BPD according to the SCID-II, the DIB-R or both interviews. Only 48% of those patients meeting BPD criteria on the SCID-II were also diagnosed as having BPD according to the DIB-R in our study. An important question arises from this result: were BPD patients diagnosed on the SCID-II and not on the DIB-R false positives or were they false negatives for the DIB-R? Unfortunately, there is not an easy answer to this question because BPD SCID-II criteria are the gold standard for personality disorders. However, it would more acceptable from our analysis that they are more likely to be false negatives, given that they did not differ appreciably from the cases diagnosed by both instruments on a number of significant variables. This supports the idea that DIB-R diagnoses a group of clinically more homogeneous BPD patients and with a higher severity (Zanarini, Frankengurg, & Vujanovic, 2002). Therefore, BPD patients diagnosed by the DIB-R would be diagnosed by the SCID-II too, but not vice versa. Moreover, our results are consistent with the concordance observed between both interviews in the DIB-R Spanish validation study (Barrachina et al., 2004).

According to our hypothesis, most of the variables analyzed in this study indicated that SCID-II/DIB-R group had a higher risk of poor outcome. Those clinical variables previously found in the literature as indicators of risk of poor outcome in BPD patients were more strongly associated with the SCID-II/DIB-R group. The SCID-II/DIB-R group exhibited poorer outcome comorbid variables, with a higher rate of Axis II comorbid disorders, and a greater comorbidity with those disorders found to be predictors of poor outcome, such as substance abuse disorder, post-traumatic stress disorder, antisocial personality disorder, schizotypal personality disorder, and paranoid personality disorder. Only the total number of comorbid personality disorders and the presence of paranoid personality disorder remained significant at the conservative Bonferroni p value. The comorbid disorders previously associated with poor outcome that did not differ between groups were major depressive disorder (Gunderson et al., 2006; Najavits, & Gunderson, 1995) and presence of any cluster C comorbid disorder (Zanarini et al., 2006).

Impulsivity has been the principal personality variable previously associated with poor outcome in BPD (Gunderson et al., 2006; McGlashan, 1985). In the current study, significantly higher scores on the BIS-11 were found in the SCID-II/DIB-R group,

Table 3
Comparison of SCID-II and SCID-II/DIB-R groups by clinical, adaptation and severity indicators

	SCID-II group (n= 135)	SCID-II/DIB-R group (n= 126)	χ^2 (2)	p
Suicidal behaviors*	n (%)	n (%)		
None	72 (53.0)	25 (20.1)		
1	37 (27.6)	26 (20.3)		
2 or more	26 (19.4)	75 (59.6)	46.17	<.001[a]
Self-harm behaviors*				
None	75 (55.2)	22 (17.6)		
1	15 (11.2)	5 (4.2)		
2 or more	45 (33.6)	99 (78.2)	50.55	<.001[a]
	Mean (SD)	Mean (SD)	t (259)	p
GAF	51.60 (8.13)	49.27 (8.85)	1.70	.09
SASS	30.23 (7.72)	29.20 (5.57)	.78	.43
GCI	4.16 (0.82)	4.71 (0.74)	4.38	<.001[a]
SCL-90-R:GeneralSymptomatic Index scale	1.85 (0.74)	2.51 (0.48)	5.40	<.001[a]
BIS-11	69.81 (15.18)	75.38 (13.59)	2.77	.006

* During the year before the entry into the study
[a] Significant after Bonferroni correction
GAF: Global Assessment Functioning Scale. SASS: Social Adaptation Self-evaluation Scale. GCI: Global Clinical Impression. SCL-90-R: Symptoms Checklist-90-Revised. BIS-11: Barratt Impulsivity Scales-11

but the differences did not remain significant after Bonferroni correction. This result is consistent with the lack of differences between groups observed for comorbid antisocial personality disorder and substance abuse disorder, as indicators of impulsive behaviors. However, other impulsive behaviors previously studied and related to poor outcome in BPD, such as suicide attempts and self-harm behaviors (Mehlum et al., 1994; Stone, 1990), presented a strong association to the SCID-II/DIB-R group. These results are consistent with the identification of impulsivity as only a modest predictor of 2 year outcome in BPD patients (Gunderson et al., 2006). Finally, affective instability, as personality variable previously associated with poor outcome, did not show differences between groups in our study.

Our results indicate that BPD patients diagnosed with both interviews have stronger associations with poor outcome risk factors than those diagnosed only by the SCID-II. However, SCID-II/DIB-R group did not show a lower GAF score or presence of any comorbid Cluster C personality disorder, important predictors of bad prognosis described in recent follow-up studies (Gunderson et al., 2006; Zanarini et al., 2006). Although the SCID-II/DIB-R group showed a higher number of poor outcome risk factors than those patients included in the SCID-II group, no between groups' differences were observed in some measures of functional impairment (e.g. GAF; SASS). These results , are in accordance with a recent follow-up study over 10 years, a BPD sample has shown like the improvement in social function was not associated with reductions in psychopathology, compared to a group of patients with other Personality Disorders (PDs) and another group of patients with Major Depressive Disorder (MDD) (Gunderson et al., 2011). In the same line, in our study between groups' differences were observed in the General Symptomatic Index of the SCL-90-R and in the CGI but not in the GAF and SASS. These results could be indicating that BPD patients improve their symptomatology earlier and slower in their social functioning.

As the only one patient diagnosed with BPD by the DIB-R was excluded from the statistical analysis, a comparison with a DIB-R group was no available; so a logistic regression analysis was performed to identify the predictive risk of poor outcome variables of DIB-R diagnosis. The logistic regression analysis determined that general indicators of severity such as GAF and General Symptomatic Index scale of the SCL-90-R scores, and presence of Axis II comorbid disorders were not factors in the model of DIB-R diagnosis predictors. The variables included in the model with predictive capacity of DIB-R diagnosis were number of suicidal and self-harm behaviors, number of BPD criteria and good vocational status. It was strongly contrasted by the optimal adjustment of the model, indicating high sensibility, specificity and predictive values.

There were two principal limitations in our study. Firstly, we did not study all the variables associated with poor outcome previously referred to it in the literature, but the most extensively studied variables that predict outcome were included. Secondly, we were not able to study a DIB-R group because only one patient was diagnosed with BPD by the DIB-R only. However, we consider that the sample size is large enough to be representative of BPD patients. To these, our results are in the same line of Zanarini et al.

(2002) indicating that DIB-R diagnoses a more homogeneous and severe subgroup of BPD patients.

Our study results indicate that BPD patients diagnosed with either interview presented important clinical differences. Differences observed between both groups could be a reflection of BPD clinical heterogeneity. In this line, our results rather than show than different disorder category diagnosed by both interviews indicate than the DIB-R diagnoses a subgroup of BPD patients with higher symptom severity and worse therapeutic prognosis compared to those BPD patients diagnosed by the SCID-II. Regarding to that, the group differences observed in our study could be reflecting the recognized BPD clinical heterogeneity (Skodol, Gunderson, Pfhol, Widiger, Livesley, & Siever, 2002) and/or be a consequence of the different time interval used in the DIB-R to diagnose BPD patients. Related to the DIB-R interval of time used to diagnose BPD patients (symptoms are evaluated for last two years), 39.3% of a BPD sample from a follow-up study over 10 years achieved remission by the 2-year follow-up (Zanarini et al., 2006). BPD symptoms' remission recognized in the recent years (Zanarini et al., 2006) could be captured with the DIB-R but not with the SCID-II, which evaluates the presence of BPD symptomatology along patients' lifespan (from age 18). Although BPD has been traditionally considered a stable lifespan condition, recent findings indicate that the disorder could be less stable than it has been previously considered. The stability of BPD symptomatology, as well as BPD clinical heterogeneity must be further studied and taken into consideration in future BPD conceptualizations to better understand this complex disorder.

Three general conclusions can be drawn from our results. First of all, patients diagnosed as having BPD with the SCID-II and the DIB-R together, present a greater association to risk of poor outcome indicators than those diagnosed by the SCID-II only. Second, findings of this study suggest that DIB-R could be generating a high number of false negative BPD patients, and caution must be taken when this interview is used alone for BPD diagnosis. Third, patients who meet the more homogeneous DIB-R BPD diagnosis have greater severity of symptoms, particularly those associated with BPD, such as suicide attempts, self-harm behaviors and number of BPD criteria. Furthermore, our results suggest that the disparity observed between patients diagnosed with BPD according to the SCID-II or according to both interviews is great enough to recommend caution, especially in clinical trials, in generalizing findings from studies employing one measure to those employing both. Taking into consideration our results, a general recommendation could be followed when diagnosing BPD patients. During the diagnostic procedure, in a first step the use of a more sensitive instrument like the SCID-II could be recommended. In a second phase, the use of a more specific tool like the DIB-R could be of considerable utility for the detection of those BPD patients with higher psychopathological severity and higher risk of poor prognosis.

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