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IS THE APPENDIX A USEFUL APPENDAGE? AN EMPIRICAL EXAMINATION OF DEPRESSIVE, PASSIVE-AGGRESSIVE (NEGATIVISTIC), SADISTIC, AND SELF-DEFEATING PERSONALITY DISORDERS

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Decisions about whether to include depressive, passive-aggressive, sadistic, and self-defeating disorders in Axis II have been made difficult by a relative dearth of data. We report the results of a study identifying potential defining features of these diagnoses and assessing their distinctiveness from other Axis II personality disorders (PDs). A national sample of experienced psychiatrists and psychologists used the SWAP-200 to describe a patient with a current axis II disorder or an appendix or deleted PD from DSM-II-R. We examined clinicians' descriptions of patients to identify their most characteristic features, and then applied an empirical clustering procedure, Q-factor analysis, to see whether versions of these disorders would emerge empirically. As currently conceptualized, only passive-aggressive PD was distinct from other PDs. When the data were subjected to Q-factor analyis, the first and largest grouping was a dysphoric (depressive) PD. A hostile-negativistic subcategory emerged that resembled passive-aggressive PD, along with a revised dependent diagnosis that included many self-defeating/masochistic features. The results suggest that a depressive or dysphoric personality may represent an internalizing spectrum of personality pathology, and that a hostile-negativistic PD may be distinct from the disorders in the text of DSM-IV. Sadistic and self-defeating PD do not appear to represent distinct disorders, although they include personality traits (sadism and revictimization) associated with distinct developmental histories.

Developing a clinically and empirically useful classification of personality disorders (PDs) has been a challenging goal. Nowhere can this be seen more clearly than in the disorders included in the appendices to DSM-III-

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R and DSM-IV: depressive, passive-aggressive (negativistic), sadistic, and self-defeating. The decision to keep a disorder in the appendix (or to delete it entirely, as was the case in DSM-IV with self-defeating and sadistic PD) reflects a number of considerations, the most important of which is its incremental validity or "value added": Does it describe a prevalent kind of person not already diagnosable on Axis II? This is clearly a reasonable criterion. However, the lack of empirical procedures for determining which diagnoses should be included prior to testing the incremental utility of a new diagnosis renders this criterion somewhat arbitrary. For example, if a depressive PD is not readily distinguished from borderline, avoidant, and dependent PD, this may suggest that it has minimal incremental utility, that one of these other diagnoses has little utility after including depressive PD, or that these disorders may be subtypes of a depressive, dysphoric, or internalizing spectrum disorder.

A depressive or melancholic personality style has been recognized since the time of the ancient Greeks and posited by numerous theorists (Parker, 2003; Phillips, Hirschfeld, Shea, & Gunderson, 1995; Sass & Junemann, 2003). Most clinicians regularly treat patients who suffer from chronic feelings of inadequacy, self-criticism, worries about being abandoned or unloveable, and so forth but do not meet criteria for any PD (see Westen & Arkowitz-Westen, 1998). The major impediment to the official recognition of depressive PD has been the problem of comorbidity, particularly with dependent, avoidant, and borderline PD on Axis II and with dysthymic disorder on Axis I. Nevertheless, several studies have found support for a distinct depressive PD construct, with distinct family history (e.g., mood and substance use disorders) and developmental history (e.g., interpersonal loss and negative parental perceptions) correlates (Huprich, 2003; McDermut, Zimmerman, & Chelminski, 2003; Phillips, Hirschfeld, Shea, & Gunderson, 1995). Another major question is whether chronic and enduring feelings of depression and their cognitive, motivational, and behavioral concomitants would be better classified as an Axis I disorder (McLean & Woody, 1995; Parker, 2003; Phillips, Hirschfeld, Shea, & Gunderson, 1995; Sass & Junemann, 2003).

Passive-aggressive PD (now with "negativistic" in parentheses in DSM-IV) was demoted from full PD status in DSM-IV. Major questions center on prevalence, discrimination from other PDs, and the core conceptualization of the construct (see Millon & Radovanov, 1995). Studies using structured interviews have produced low prevalence rates, although clinicians report that this is one of the more common PDs they treat (e.g., Wetzler & Morey, 1999). The low prevalence rates may be an artifact of assessment procedures that ask patients direct questions about a disorder defined by qualities that are socially undesirable and largely unconscious (see Westen, 1997). Nevertheless, some research supports the construct validity of this disorder (Fossati et al., 2000; Johnson et al., 1999; Joiner & Rudd, 2002). If passive-aggressive PD were to be reinstated, a major question would be how to redefine the construct. The DSM-III-R criteria essentially presented

nine ways in which a single trait—a tendency to express anger in passive and indirect ways—can be expressed, raising questions about whether passive aggression would be better conceptualized as a personality *trait* than a personality *disorder* (Millon & Radovanov, 1995). The Axis II Work Group broadened the construct to include a negative, sullen attitude and a pessimistic way of experiencing and describing the world and the way one is treated. The new criteria better capture the anger, envy, and feeling of being misunderstood that clinically appear to occur in these individuals, although they may increase its comorbidity with PDs with a depressive bent.

The origins of the sadistic PD construct themselves are controversial, with some claiming that it emerged from the observations of forensic psychiatrists, and others viewing it as a political gesture aimed at opponents of the self-defeating diagnosis who (appropriately) complained about inclusion of a diagnosis for women who stay in abusive relationships but not for the men who abuse them (Fiester & Gay, 1995; Widiger, 1995). Political issues aside, a major question is again whether sadism constitutes a syndrome or a trait, and whether it occurs in individuals who would not already be diagnosed with antisocial PD. The little existing research has produced a range of estimates of comorbidity with other PDs, with most finding high comorbidity with antisocial and narcissistic PD (e.g., Fuller, Blashfield, Miller, & Hester, 1992; Holt, Meloy, & Strack, 1999). Given that not all antisocial and narcissistic individuals are sadistic (Fiester & Gay, 1991), an open question is whether sadistic features define a meaningful subgroup of antisocial or psychopathic individuals (e.g., Berger, Berner, Bolterauer, Gutierrez, & Berger, 1999; Murphy & Vess, 2003).

The exclusion of self-defeating PD (initially masochistic PD) from the official psychiatric nomenclature represents a combination of scientific concerns about comorbidity and concerns about both gender bias and the potential for victim blaming (see Caplan, 1987; Fiester, 1995; Kass, Spitzer, Williams, & Widiger, 1989; Widiger, 1995). Empirically, a subgroup of individuals with a history of PTSD and childhood sexual abuse does appear to show self-defeating features, including a tendency to enter into multiple abusive relationships in adulthood (e.g., Coolidge & Anderson, 2002; Shea et al., 2000). Despite concerns about gender bias, some research has found both construct and incremental validity for self defeating PD symptoms, which predict impairment beyond other PD symptoms and do not appear to be limited to women (Cruz et al., 2000). However, data on comorbidity are more problematic, with most patients diagnosed with the disorder also receiving either a borderline or dependent PD diagnosis (see Fiester, 1995; Huprich & Fine, 1997; Skodol, Oldham, Gallaher, & Bezirganian, 1994).

AIMS OF THE STUDY

In this study we report data on PD patients described by a random national sample of experienced psychiatrists and psychologists using a Q-

sort instrument for assessing personality pathology designed for expert observers, the Shedler-Westen Assessment Procedure-200 (SWAP-200) (Shedler & Westen, 2004b; Westen & Shedler, 1999a). The instrument includes not only items reflecting the various diagnostic criteria in Axis II for DSM-III through DSM-IV but also descriptors of personality taken from the clinical and empirical literatures on personality and PDs and from clinical observation and pilot studies designed to maximize its comprehensiveness. For the present purposes, the instrument can be used for taxonomic research in two ways. The first is to identify the most characteristic features of existing or proposed disorders, by aggregating the Q-sort descriptions of patients diagnosed with each disorder and creating composite portraits of patients with each disorder. The second is to cluster patients' profiles across cases, irrespective of current diagnoses, to identify nonredundant diagnostic groupings. (A third taxonomic approach, which groups together items to identify common factors, is described elsewhere (Shedler & Westen, 2004a; Westen, Dutra, & Shedler, 2005).) In prior publications, we have applied these analyses to the disorders in the text of DSM-IV. This paper represents the last in this series of publications, focusing on the appendix disorders.

MATERIAL AND METHODS

Data collection methods and sample characteristics have been described in detail previously (Westen & Shedler, 1999a); here we summarize those aspects relevant to the present report.

PARTICIPANTS

A national sample of 530 experienced psychiatrists and psychologists recruited from the rosters of the American Psychiatric Association and the American Psychological Association contributed data to the study. Each clinician used the SWAP-200 to provide a psychological portrait of a single patient. Clinician participants averaged 18.1 years practice experience post-training. Approximately 1/3 were psychiatrists and 2/3 psychologists.

PROCEDURES

We focused in this study on both current and recent DSM Axis II diagnoses, including the 4 appendix disorders. We surveyed clinicians to determine which PD diagnoses were represented in their practices. Based on their responses, we asked them to describe a patient with one of the 14 PDs.

MEASURES

Shedler-Westen Assessment Procedures (SWAP-200). The SWAP-200 is a set of 200 personality-descriptive statements or items, each printed on a separate index card. To describe a patient, a clinician sorts the statements

into eight categories, from those that are least descriptive of the patient (assigned a value of 0) to those that are most descriptive (assigned a value of 7), using a fixed distribution (see 32). An emerging body of research supports the validity and reliability of the SWAP-200. Both adult and adolescent versions of the instrument have predicted criterion variables such as measures of adaptive functioning and developmental and family history variables (Bradley, Jenei, & Westen, 2005; Russ, Heim, & Westen, 2003; Shedler & Westen, 2004a; Westen & Shedler, 1999a; Westen, Shedler, Durrett, Glass, & Martens, 2003). Several recent studies have shown that SWAP data have good interrater reliability ($r > .80$) and converge with data from independent informants (Bradley, Hilsenroth, & Westen, 2005; Marin-Avellan, McGauley, Campbell, & Fonagy, 2005; Westen & Muderrisoglu, 2003).

Dimensional Axis II Ratings. Clinicians rated the extent to which the patient met criteria for each Axis II disorder using a 7-point rating scale (1 = not at all, 4 = has some features, 7 = fully meets criteria). Validity of such ratings are supported by data from a recent study in which clinicians made similar ratings as well as present/absent ratings for each of the Axis II criteria for all disorders randomly ordered (unpublished data). Clinicians' global ratings correlated $r = .73$ with number of criteria met for each disorder.

Clinical Data Form (CDF). The CDF assesses a range of variables including demographic, diagnostic, adaptive functioning, developmental and family history variables. Prior studies suggest that clinicians' judgments on these variables predict theoretically relevant criterion variables (e.g., Dutra, Eddy, & Westen, 2003; Nakash, Dutra, & Westen, 2002) and show high interrater reliability and validity (e.g., correlations with the same data obtained by independent interview $r > .60$) (Hilsenroth et al., 2000; Westen, 1997; Westen & Muderrisoglu, 2003). (For a more detailed description of the CDF see Dutra, Campbell, & Westen, 2004; Zittel & Westen, 2005.)

STATISTICAL ANALYSIS

To examine the characteristics of the four appendix PDs, we created composite profiles of patients diagnosed by their treating clinicians with each disorder by averaging the rank given each item across all patients sharing a diagnosis. This allowed us to identify the items (candidate diagnostic criteria) that best described patients within each diagnostic group. To assess convergent and discriminant validity and incremental utility, we correlated composite profiles with clinicians' 7-point ratings of the extent to which the patient met DSM-IV criteria for each disorder 4 disorders plus the 10 PDs in the text of DSM-IV. We then examined whether nonredundant versions of any of these diagnoses would emerge when applying Q-factor analysis to the entire dataset ($N = 530$); this data set included patients diagnosed with all 10 current Axis II PDs as well as the 4 appendix

disorders. We have reported the results for the 10 primary PDs elsewhere (Westen & Shedler, 1999b).

RESULTS

DEMOGRAPHICS

Patient age averaged 40.9 (s.d. 11.6), with no significant differences among diagnoses. The sample was 53.1% female and 93.8% Caucasian, with roughly half described as poor or working class and the other half, middle or upper class. Sample size and gender composition of the four diagnoses examined here were as follows: depressive, $N = 39$ (70.3% female); passive aggressive, $N = 37$ (28.6% female); sadistic, $N = 19$ (36.8% female); and self-defeating PD, $N = 37$ (79.4% female). Composites for each disorder showed high internal consistency, with Cronbach's alpha > .80 in all 4 cases. Thus, the aggregated profiles are adequate for obtaining reliable results with these sample sizes.

COMPOSITE DESCRIPTIONS OF APPENDIX DISORDERS

Tables 1–4 report composite descriptions of patients diagnosed with each disorder. The items are arranged in descending order of descriptiveness, that is, by how highly they were placed on average in the Q-sort for patients diagnosed with the disorder. Tables 1–4 include the SWAP 200 items most central to the descriptions of the 4 PDs (i.e., with the highest average ranking). (For parsimony, we only include items with rankings above 4.5 to 5.0.) As described in the existing literature, patients diagnosed with depressive PD are characterized by a range of dysphoric emotions and cognitions. Patients with passive-aggressive PD share many fea-

TABLE 1. Depressive PD Composite

Item	Mean
Tends to feel unhappy, depressed, or despondent.	6.94
Tends to feel she/he is inadequate, inferior, or a failure.	6.69
Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities.	6.56
Tends to feel guilty.	6.50
Tends to blame self or feel responsible for bad things that happen.	6.38
Tends to feel listless, fatigued, or lacking in energy.	6.31
Tends to feel life has no meaning.	6.31
Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects.	5.81
Struggles with genuine wishes to kill him/herself.	5.69
Tends to be preoccupied with death and dying.	5.38
Tends to "catastrophize"; is prone to see problems as disastrous, unsolvable, etc.	5.31
Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.	5.25
Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things she/he deserves.	5.13
Appears to want to "punish" self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification.	5.13

TABLE 2. Passive-Aggressive PD Composite

Item	Mean
Tends to express aggression in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).	6.94
Has difficulty acknowledging or expressing anger.	6.06
Tends to be angry or hostile (whether consciously or unconsciously).	5.94
Tends to get into power struggles.	5.82
Tends to be conflicted about authority (e.g., may feel she/he must submit, rebel against, win over, defeat, etc.).	5.71
Tends to hold grudges; may dwell on insults or slights for long periods.	5.29
Tends to be controlling.	5.24
Appears to gain pleasure or satisfaction by being sadistic or aggressive toward others (whether consciously or unconsciously).	5.12
Tends to be competitive with others (whether consciously or unconsciously).	5.00
Tends to feel misunderstood, mistreated, or victimized.	4.88
Tends to elicit dislike or animosity in others.	4.82
Tends to be passive and unassertive.	4.76

tures of the disorder as defined in DSM-III and DSM-III-R, but they are also characterized by authority conflicts, sadism, competitiveness, a vulnerability to feelings of helplessness, and a tendency to alternate between control battles and an ingratiating, submissive posture. Sadistic PD is best characterized by items associated with sadism, psychopathy, narcissism, and hostility toward the opposite sex (which is likely to emerge in abusive intimate relationships). Patients with self-defeating PD have a number of characteristics common to borderline, dependent, and histrionic PD but are distinguished by a tendency to find themselves in punishing situations, to choose partners who are inappropriate or abusive, and to lack sufficient concern for their own needs.

VALIDITY

To assess the convergent and discriminant validity and incremental utility of the 4 appendix disorders vis-a-vis the current 10 axis II PDs, we corre-

TABLE 3. Sadistic PD Composite

Item	Mean
Appears to gain pleasure or satisfaction by being sadistic or aggressive toward others (whether consciously or unconsciously).	6.83
Seeks to dominate an important other (e.g., spouse, lover, family member) through violence or intimidation.	6.83
Tends to seek power or influence over others (whether in beneficial or destructive ways).	6.56
Tends to be angry or hostile (whether consciously or unconsciously).	6.44
Tends to be controlling.	6.33
Has little empathy; seems unable to understand or respond to others' needs and feelings unless they coincide with his/her own.	5.56
Takes advantage of others; is out for number one; has minimal investment in moral values.	5.44
Appears to experience no remorse for harm or injury caused to others.	5.39
Tends to be critical of others.	5.22
Tends to get into power struggles.	5.11
Tries to manipulate others' emotions to get what she/he wants.	5.11
Tends to react to criticism with feelings of rage or humiliation.	5.00

TABLE 4. Self-Defeating PD Composite

Item	Mean
Appears to want to "punish" self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification.	5.89
Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential.	5.67
Tends to become attached to, or romantically interested in, people who are emotionally unavailable.	5.61
Tends to get drawn into or remain in relationships in which she/he is emotionally or physically abused.	5.50
Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.	5.44
Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things she/he deserves.	5.11
Tends to feel she/he is inadequate, inferior, or a failure.	4.94
Tends to feel misunderstood, mistreated, or victimized.	4.83
Tends to express aggression in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).	4.78
When romantically or sexually attracted, tends to lose interest if other person reciprocates.	4.72
Tends to be ingratiating or submissive (e.g., may consent to things she/he does not agree with or does not want to do, in the hope of getting support or approval).	4.67
Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.	4.67
Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered).	4.61

lated patients' dimensional SWAP-200 PD scores for each of the 4 disorders with clinicians' 7-point PD ratings of the 14 text and appendix PDs across the entire sample ($N = 530$). (SWAP-200 dimensional PD scores are calculated by correlating the patient's profile with the composite prototype for each disorder, yielding an index of the match between the patient and prototype. On the use of Q-correlations of this sort, see Block, 1978.) Boldfaced numbers along the diagonal in Table 5 represent con-

TABLE 5. Correlations between SWAP-200 Dimensional Diagnoses and Clinician PD Ratings ($N = 449–458$)

	SWAP-200 Dimensional PD Score			
7-point PD Ratings	Depressive	Passive Aggressive	Sadistic	Self-defeating
Depressive	**.48***	.10	–.20*	.45*
Passive Aggressive	–.05	**.44***	.27*	.20*
Sadistic	–.49*	.26*	**.62***	–.31*
Self-defeating	.27*	.13	–.05	**.42***
Paranoid	–.19*	.26*	.43*	–.09
Schizoid	.15*	.07	–.04	.08
Schizotypal	.00	–.02	.04	.01
Antisocial	–.52*	.21*	.59*	–.25*
Borderline	–.06	.07	.22*	.12
Histrionic	–.16	–.09	.11	.02
Narcissistic	–.42*	.18*	.48*	–.25*
Avoidant	.49*	.05	–.28*	.40*
Dependent	.33*	.09	–.18*	.42*
Obsessive-Compulsive	.17*	–.06	–.16*	–.05

*$p < .01$

vergent validity coefficients, whereas numbers off the diagonal index discriminant validity.

As can be seen from the table, only passive-aggressive PD shows evidence of incremental utility vis-a-vis the disorders currently in the text of DSM-IV, with correlations along the diagonal substantially greater than correlations off the diagonal. As expected, and confirming the judgment of axis II work groups, depressive and self-defeating PDs showed high overlap with avoidant and dependent PD. Sadistic PD was largely indistinguishable from antisocial PD.

Another way to assess the distinctiveness of these diagnoses is to examine their etiological correlates (see Robins & Guze, 1970). Although space limitations preclude any thorough examination of etiological correlates, the following are of note. Depressive and passive-aggressive PDs showed no distinct patterns of family or developmental history relative to any other group. The same was not the case, however, for sadistic and self-defeating PD. These two disorders had the highest rates of reported family history of major depressive disorder (52.6% and 45.9%, respectively), as compared, for example, with depressive and narcissistic patients (38.5% and 27.0%, respectively). Sadistic PD, like antisocial and borderline, also had elevated rates of alcohol and substance abuse among first- and second-degree relatives. For example, 68.4% of sadistic PD patients, like 70.0% of antisocial patients, had relatives with a history of alcohol abuse, as compared with 15.4% for depressive, 35.14% for passive-aggressive, and 42.11% for self-defeating PD.

The same two disorders (sadistic and self-defeating) showed distinct developmental history correlates as well. Like borderline PD, sadistic and self-defeating patients tended to have a childhood history of sexual abuse, with reported prevalence rates at 47.1%, 35.5%, 41.4%, respectively. Of particular note is the high rate of sexual abuse in the predominantly male diagnosis of sadistic PD. In comparison, clinicians reported a history of sexual abuse in 14.8% of passive-aggressive, 15.0% of antisocial, and 9.4% of narcissistic PDs. These differences were statistically significant for the overall sample at $p < .0001$ ($\chi^2[14] = 43.16$). A similar, though slightly different pattern emerged for physical abuse, which was reported in 64.7% of sadistic patients and in 41.2% of self-defeating, 48.5% of borderline, 40.0% of antisocial, and 37.5% of depressive PDs. In comparison, only 17.2% of clinicians described physical abuse in the history of passive-aggressive patients. Once again these findings were significant at $p < .0001$ ($\chi^2[14] = 43.43$).

These data suggest that individuals who are treated sadistically as children are more likely to develop sadistic PD. The difference between antisocial and sadistic patients seems to lie in the differential rate of sexual sadism in their childhood histories. A history of both physical and sexual abuse is also common among patients diagnosed with self-defeating, borderline, and to a slightly less extent depressive PD. Certain qualities of sexual abuse, however, appear to distinguish self-defeating from other abused PD patients. Reported age at first sexual abuse was considerably

lower in self-defeating ($M = 5.5$) than in sadistic ($M = 8.7$) and borderline ($M = 9.0$) PDs. Duration was also substantially longer: $M = 8.1$ vs. 4.2 and 3.5 years, respectively. The same was true of 7-point ratings of severity ($M = 6.2$ vs. 5.4 and 5.0, respectively, s.d. approximately 1.3) and frequency (4.2 for self-defeating vs. 3.6 for sadistic and borderline PD, s.d. approximately 1.2) of sexual abuse.

EMPIRICALLY DERIVED COMPOSITE DESCRIPTIONS

The data presented thus far assume the diagnoses included in the text and appendices to axis II. An important question is whether diagnoses resembling any of these might emerge empirically if we were to derive nonredundant PD diagnostic groupings empirically. Elsewhere (Westen & Shedler, 1999b) we report the general results of such efforts using the entire sample collected in this study; here we report analyses relevant to the appendix disorders in greater detail. In these analyses, rather than starting with DSM categories, we examined the profiles of 530 patients irrespective of DSM-IV diagnosis to see how they naturally cluster using Q-factor analysis. The first, largest factor emerging from this analysis was dysphoric PD, which accounted for 20.2% of the variance in the dataset. Similar to the construct underlying depressive personality disorder, the central features of this the dysphoric factor (presented in Westen & Shedler, 1999b) reflect a global internalizing style, including depression, shame, guilt, self-blame, fear of rejection, anxiety, low assertiveness, and emptiness.

Because the dysphoric diagnosis was the largest that emerged and appeared to be heterogeneous, we subfactored the patients who loaded on this factor to see if any discrete subfactors could be detected (see Block, 1978). This procedure yielded five dysphoric or internalizing subfactors: avoidant, high-functioning dysphoric, emotionally dysregulated, dependent/masochistic, and hostile-negativistic (Westen & Shedler, 1999b). We focus here on the final two, whose highest-ranking items are presented in Tables 6 and 7. The rankings presented in these tables represent factor scores (obtained by multiple regression) for each item, arranged in descending order of magnitude. These scores reflect the extent to which the item is central to the construct, and are analogous to factor scores that can be generated for each subject in conventional factor analysis. The factor scores are presented in standard deviation units, which indicate the extent to which a given item is more or less central to the construct than the average item from the item set. For parsimony, we include here only items with factor scores of 1.5 and above.

Table 6 presents the items that best define a diagnosis we called hostile-negativistic. Patients who loaded high on this sub-factor have many of the classic features of passive-aggressive PD, including the tendency to get into power struggles, the general hostility, the tendency to feel mistreated, a critical attitude toward others, conflict around authority issues, and a

TABLE 6. Empirically Derived Hostile-Negativistic PD

Item	Score
Tends to get into power struggles.	3.70
Tends to be angry or hostile (whether consciously or unconsciously).	3.45
Tends to blame others for own failures or shortcomings; tends to believe his/her problems are caused by external factors.	3.29
Tends to feel misunderstood, mistreated, or victimized.	3.15
Tends to be critical of others.	2.96
Tends to be conflicted about authority (e.g., may feel she/he must submit, rebel against, win over, defeat, etc.).	2.81
Tends to hold grudges; may dwell on insults or slights for long periods.	2.63
Tends to express aggression in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).	2.58
Tends to be oppositional, contrary, or quick to disagree.	1.97
Is quick to assume that others wish to harm or take advantage of him/her; tends to perceive malevolent intentions in others' words and actions.	1.93
Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.	1.90
Tends to be hostile toward members of the opposite sex, whether consciously or unconsciously (e.g., may be disparaging, competitive, etc.).	1.63
Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential.	1.60
Tends to be controlling.	1.57
Tends to react to criticism with feelings of rage or humiliation.	1.57
Tends to see own unacceptable feelings or impulses in other people instead of in him/herself.	1.55

TABLE 7. Empirically Derived Dependent/Masochistic PD

Item	Score
Tends to get drawn into or remain in relationships in which she/he is emotionally or physically abused.	3.28
Tends to be ingratiating or submissive (e.g., may consent to things she/he does not agree with or does not want to do, in the hope of getting support or approval).	3.24
Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.	2.93
Tends to be suggestible or easily influenced.	2.89
Tends to become attached to, or romantically interested in, people who are emotionally unavailable.	2.81
Tends to be overly needy or dependent; requires excessive reassurance or approval.	2.70
Fantasizes about finding ideal, perfect love.	2.68
Appears to fear being alone; may go to great lengths to avoid being alone.	2.67
Tends to fear she/he will be rejected or abandoned by those who are emotionally significant.	2.42
Tends to express aggression in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).	2.36
Lacks a stable image of who she/he is or would like to become (e.g., attitudes, values, goals, and feelings about self may be unstable and changing).	2.28
Tends to idealize certain others in unrealistic ways; sees them as "all good," to the exclusion of commonplace human defects.	1.96
Has trouble making decisions; tends to be indecisive or to vacillate when faced with choices.	1.86
Tends to be passive and unassertive.	1.60
Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect.	1.59

tendency to behave passive-aggressively. The items on this factor move in precisely the direction proposed by the DSM-IV axis II Work Group as they attempted to broaden the passive-aggressive diagnosis.

Table 7 describes a sub-factor of patients with dependent and self-defeating features. These individuals are substantially more troubled than patients currently diagnosed as dependent, and are characterized by a number of features consistent with a history of problematic attachment to primary caregivers and sexual abuse. In fact, clinicians reported that these patients had poor relationships with their mother (similar to the emotionally dysregulated, borderline group) and tended, like the self-defeating patients described above, to have traumatic histories.

DISCUSSION

The results of this study are complex, and the extent to which they lead to one set of conclusions or another depends on the extent to which one finds the current axis II nosology compelling. If we maintain the current 10 categories as given, the main question regards the incremental validity of the four appendicized disorders, and the findings lead to some fairly clear conclusions. As several prior studies of depressive PD have shown, this PD has substantial overlap with dependent, avoidant, borderline, and self-defeating PDs. In contrast, a substantially refined passive-aggressive diagnosis may merit consideration, given its relative non-overlap with the 10 DSM-VI PDs. Further, the DSM-IV axis II Work Group arrived at a diagnosis quite similar to what a purely empirical procedure, Q-analysis, produced here, namely a hostile-negativistic PD that includes passive-aggressive features as one of the most salient criteria.

Sadistic personality disorder appears to be a subtype of antisocial PD associated with a history of abuse, particularly sexual abuse in males. As in the few previous studies of these patients, individuals with this diagnosis were largely indistinguishable from antisocial patients except for a single attribute, namely an exaggerated sadism. They share with antisocial and borderline patients a family history of alcohol and drug abuse (and likely externalizing pathology more generally), but unlike other antisocial patients, they tend to have been sexually abused, almost always by their parents. These findings support both psychoanalytic and social learning explanations, which would assert that sadistic treatment in childhood is a breeding ground for sadistic behavior in adulthood. Although we did not collect the necessary data to do more than speculate here, we suspect these findings may be of relevance for forensic purposes, in that these individuals are likely to express their sadism in sexual violence (spouse abuse, rape, or both). The data do not, however, support an independent diagnosis based on one defining feature, which is better understand as a trait or dynamic.

Like sadistic PD, self-defeating PD is highly correlated with existing diag-

noses, notably borderline and dependent. If we assume the current nosology, the value added by this diagnosis is minimal. Rather, these patients represent a depressive-borderline-dependent hybrid whose pathology appears to be shaped by particularly early, severe, and malignant abuse of long duration, likely in interaction with genetic variables. Once again, the distinct feature of the disorder—self-defeating and masochistic behavior and choice of relationship partners—is better understood as a clinically important trait or dynamic related to developmental experiences. The items most descriptive of this disorder suggest that a tendency to choose abusive partners, if unconsciously, and to express anger passively (a coping strategy presumably learned early to escape abuse but express the rage that stems from it) contribute to these patients' repetitive experiences of violence in intimate relationships.

A less conservative interpretation of the data begins instead with the results of the Q-factor analysis and leads to somewhat different conclusions. A purely empirical clustering procedure finds that a substantial number of patients are best described by their chronic dysphoric feelings and related personality attributes such as passivity, helplessness, self-blame, abandonment fears, and behavior that appears to reflect a need for self-punishment. As the SWAP-200 description of these patients makes clear, these patients are characterized by a constellation of personality variables—enduring ways of thinking, feeling, behaving, wishing, fearing, and regulating affects—that are not readily captured by the current axis I diagnosis of dysthymic disorder. On the other hand, these patients are not simply depressed, so that *depressive PD* does not adequately describe their pathology, either. Perhaps a hierarchically organized *internalizing spectrum PD* more adequately reflects the constellation of unpleasant emotions with which these patients constantly wrestle. This would be consistent with research using both axis I symptoms of mood and anxiety disorders (Krueger, Markon, Patrick, & Iacono, 2005) and research focusing on normal and abnormal personality traits (e.g., Clark, Livesley, Schroeder, & Irish, 1996; Livesley, 2005; Markon, Krueger, & Watson, 2005; Watson, 2005; Widiger, Simonsen, Krueger, Livesley, & Verheul, 2005), that identifies an internalizing spectrum characterized by negative affectivity. We are beginning now to analyze data from a sample of 1201 patients not selected for any particular PD, and the first large Q-factor that is emerging across rotations and estimation procedures is once again an internalizing spectrum PD that strongly resembles the dysphoric PD identified here.

In the present study, a hostile-negativistic and self-defeating/masochistic PD emerged as sub-factors within this superordinate dysphoric or internalizing diagnosis. Whether these diagnostic groupings will replicate, or whether they are in part an artifact of a study design that requested patients with each of the 10 axis II PDs and the 4 appendix disorders, is unclear.

LIMITATIONS

The study has two primary limitations. We address these briefly here, as we have addressed them more thoroughly elsewhere (e.g., Shedler & Westen, 2004b; Westen & Shedler, 1999a, 1999b; Westen & Weinberger, 2004). First, all data were provided by clinicians, who, like all observers, have biases that can limit the reliability of the information they provided. The alphas indexing the internal consistency of clinicians' descriptions of patients sharing a diagnosis suggest considerable reliability to the composite descriptions, however, and the fact that these alphas are so high despite the fact that clinicians varied substantially in theoretical orientation and professional training (psychiatry vs. psychology) gives us greater confidence in the findings. In our prior research, clinician theoretical orientation and training have accounted for little variance in any variable we have examined, and data from clinicians with different theoretical orientations has tended to yield highly similar factor structures (Shedler & Westen, 2004a). Nevertheless, future research should clearly rely on multiple informants.

A second limitation is the possibility that clinicians may have used implicit prototypes of the disorders to guide their descriptions. Although we cannot completely rule out this possibility, we asked another sample of clinicians to describe their mental prototypes of patients with these disorders, and as in research with the 10 PDs in the text of axis II, descriptions of actual patients diverged substantially from descriptions of clinicians' mental prototypes of patients with the same disorders (Shedler & Westen, 2004b). Nor did clinicians simply reproduce current diagnostic criteria in their descriptions of actual patients, often ranking items not included in DSM-IV above items taken from the criterion sets. Further, in other research, clinicians' descriptions of patients of this sort using the SWAP-200 have converged substantially with SWAP-200 descriptions of independent interviewers blind to the treating clinicians' diagnostic judgments (Westen & Muderrisoglu, 2003, 2006). Nevertheless, in subsequent research, we have minimzed the possibility of biases of this sort by not asking clinicians to select patients with particular PDs and instead giving them procedures to select a random patient in their care.

REFERENCES

Berger, P., Berner, W., Bolterauer, J., Gutierrez, K., & Berger, K. (1999). Sadistic personality disorder in sex offenders: Relationship to antisocial personality disorder and sexual sadism. *Journal of Personality Disorders, 13,* 175–186.

Block, J. (1978). *The Q-Sort method in personality assessment and psychiatric research.* Palo Alto, CA: Consulting Psychologists Press.

Bradley, R., Hilsenroth, M., & Westen, D. (2005). *Convergence of clinician- and*

self-reports in the assessment of personality disorders. Unpublished manuscript, Emory University.

Bradley, R., Jenei, J., & Westen, D. (2005). Etiology of borderline personality disorder: Disentangling the contributions of intercorrelated antecedents. *Journal of Nervous and Mental Disease, 193,* 24–31.

Caplan, P. J. (1987). The Psychiatric Association's failure to meet its own standards: The dangers of self-defeating personality disorder as a category. *Journal of Personality Disorders, 1,* 178–182.

Clark, L. A., Livesley, W., Schroeder, M. L., & Irish, S. L. (1996). Convergence of two systems for assessing specific traits of personality disorder. *Psychological Assessment, 8,* 294–303.

Coolidge, F. L., & Anderson, L. W. (2002). Personality profiles of women in multiple abusive relationships. *Journal of Family Violence, 17,* 117–131.

Cruz, J., Joiner, T. E., Johnson, J. G., Heisler, L. K., Spitzer, R. L., & Pettit, J. W. (2000). Self-defeating personality disorder reconsidered. *Journal of Personality Disorders, 14,* 64–71.

Dutra, L., Campbell, L., & Westen, D. (2004). Quantifying clinical judgment in the assessment of adolescent psychopathology: Reliability, validity, and factor structure of the Child Behavior Checklist for Clinician-Report. *Journal of Clinical Psychology, 60,* 65–85.

Dutra, L., Eddy, K., & Westen, D. (2003). *A multidimensional meta-analysis of psychotherapy for obsessive-compulsive disorder*. Unpublished manuscript, Emory University.

Fiester, S. J. (1995). Self-defeating personality disorder. In W. Livesley (Ed.), *The DSM-IV personality disorders: Diagnosis and treatment of mental disorders* (pp. 341–358). New York, NY: Guilford Press.

Fiester, S. J., & Gay, M. (1991). Sadistic personality disorder: A review of data and recommendations for DSM-IV. *Journal of Personality Disorders, 5,* 376–385.

Fiester, S. J., & Gay, M. (1995). Sadistic personality disorder. In W. Livesley (Ed.), *The DSM-IV personality disorders diagnosis and treatment of mental disorders* (pp. 329–340). New York, NY: Guilford Press.

Fossati, A., Maffei, C., Bagnato, M., Donati, D., Donini, M., Fiorilli, M., et al. (2000). A psychometric study of DSM-IV passive-aggressive (negativistic) personality disorder criteria. *Journal of Personality Disorders, 14,* 72–83.

Fuller, A., Blashfield, R. K., Miller, M., & Hester, T. (1992). Sadistic and self-defeating personality disorder criteria in a rural clinic sample. *Journal of Clinical Psychology, 48,* 827–831.

Hilsenroth, M. J., Ackerman, S. J., Blagys, M. D., Baumann, B. D., Baity, M. R., Smith, S. R., et al. (2000). Reliability and validity of DSM-IV axis V. *American Journal of Psychiatry, 157,* 1858–1863.

Holt, S. E., Meloy, J., & Strack, S. (1999). Sadism and psychopathy in violent and sexually violent offenders. *Journal of the American Academy of Psychiatry & the Law, 27,* 23–32.

Huprich, S. K. (2003). Depressive personality and its relationship to depressed mood, interpersonal loss, negative parental perceptions, and perfectionism. *Journal of Nervous & Mental Disease, 191,* 73–79.

Huprich, S. K., & Fine, M. A. (1997). Diagnoses under consideration—self-defeating and depressive personality disorders: Current status and clinical issues. *Journal of Contemporary Psychotherapy, 27,* 303–322.

Johnson, J. G., Cohen, P., Skodol, A. E., Oldham, J. M., Kasen, S., & Brook, J. S. (1999). Personality disorders in adolescence and risk of major mental disorders and suicidality during adulthood. *Archives of General Psychiatry, 56,* 805–811.

Joiner, T. E., Jr., & Rudd, M. (2002). The incremental validity of passive-aggressive personality symptoms rivals or exceeds that of other personality symptoms in suicidal outpatients. *Journal of Personality Assessment, 79,* 161–170.

Kass, F., Spitzer, R. L., Williams, J. B., & Widiger, T. (1989). Self-defeating personality disorder and DSM-III—R: Development of the diagnostic criteria. *American Journal of Psychiatry, 146,* 1022–1026.

Krueger, R. F., Markon, K. M., Patrick, C. P., & Iacono, W. (2005). Externalizing psychopathology in adulthood: A di-

mensional-spectrum conceptualization and its implications for DSM-V. *Journal of Abnormal Psychology, 114,* 537–550.

Livesley, W. (2005). Behavioral and Molecular Genetic Contributions to a Dimensional Classification of Personality Disorder. *Journal of Personality Disorders, 19,* 131–155.

Marin-Avellan, L., McGauley, G., Campbell, C., & Fonagy, P. (2005). Using the SWAP-200 in a personality-disordered forensic population; Is it valid, reliable and useful? *Journal of Criminal Behaviour and Mental Health, 15,* 28–45.

Markon, K. E., Krueger, R. F., & Watson, D. (2005). Delineating the structure of normal and abnormal personality: An integrative hierarchical approach. *Journal of Personality & Social Psychology, 88,* 139–157.

McDermut, W., Zimmerman, M., & Chelminski, I. (2003). The construct validity of depressive personality disorder. *Journal of Abnormal Psychology, 112,* 49–60.

McLean, P., & Woody, S. (1995). Depressive personality disorder: A false start. In J. Livesley (Ed.), *The DSM-IV Personality Disorders.* New York: Guilford Publications.

Millon, T., & Radovanov, J. (1995). Passive-aggressive (negativistic) personality disorder. In W. Livesley (Ed.), *The DSM-IV personality disorders: Diagnosis and treatment of mental disorders* (pp. 312–325). New York, NY: Guilford Press.

Murphy, C., & Vess, J. (2003). Subtypes of psychopathy: Proposed differences between narcissistic, borderline, sadistic, and antisocial psychopaths. *Psychiatric Quarterly, 74,* 11–29.

Nakash, O., Dutra, L., & Westen, D. (2002). Relationship between attachment patterns and personality pathology in adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 41,* 1111–1123.

Parker, G. (2003). Modern diagnostic concepts of the affective disorders. *Acta Neurologica Scandinavica, 108,* 24–28.

Phillips, K. A., Hirschfeld, R. M. A., Shea, M., & Gunderson, J. G. (1995). Depressive personality disorder. In W. Livesley (Ed.), *The DSM-IV personality disorders diagnosis and treatment of mental disorders* (pp. 287–302). New York, NY: Guilford Press.

Robins, E., & Guze, S. (1970). The establishment of diagnostic validity in psychiatric illness: Its application to schizophrenia. *American Journal of Psychiatry, 126,* 983–987.

Russ, E., Heim, A., & Westen, D. (2003). Parental bonding and personality pathology assessed by clinician report. *Journal of Personality Disorders, 17,* 522–536.

Sass, H., & Junemann, K. (2003). Affective disorders, personality and personality disorders. *Acta Psychiatrica Scandinavica, 108,* 34–40.

Shea, M., Zlotnick, C., Dolan, R., Warshaw, M. G., Phillips, K. A., Brown, P., et al. (2000). Personality disorders, history of trauma, and posttraumatic stress disorder in subjects with anxiety disorders. *Comprehensive Psychiatry, 41,* 315–325.

Shedler, J., & Westen, D. (2004a). Dimensions of personality pathology: An alternative to the Five Factor Model. *American Journal of Psychiatry, 161,* 1743–1754.

Shedler, J., & Westen, D. (2004b). Refining personality disorder diagnoses: Integrating science and practice. *American Journal of Psychiatry, 161,* 1350–1365.

Skodol, A. E., Oldham, J. M., Gallaher, P. E., & Bezirganian, S. (1994). Validity of self-defeating personality disorder. *American Journal of Psychiatry, 151,* 560–567.

Watson, D. (2005). Rethinking the mood and anxiety disorders: A quantitative hierarchical model for DSM-V. *Journal of Abnormal Psychology, 114,* 522–536.

Westen, D. (1997). Divergences between clinical and research methods for assessing personality disorders: Implications for research and the evolution of Axis II. *American Journal of Psychiatry, 154,* 895–903.

Westen, D., & Arkowitz-Westen, L. (1998). Limitations of Axis II in diagnosing personality pathology in clinical practice. *American Journal of Psychiatry, 155,* 1767–1771.

Westen, D., Dutra, L., & Shedler, J. (2005). Assessing adolescent personality pathology: Quantifying clinical judgment. *British Journal of Psychiatry, 186,* 227–238.

Westen, D., & Muderrisoglu, S. (2003). Reli-

ability and validity of personality disorder assessment using a systematic clinical interview: Evaluating an alternative to structured interviews. *Journal of Personality Disorders, 17,* 350–368.

Westen, D., & Muderrisoglu, S. (2006). Clinical assessment of pathological personality traits. *American Journal of Psychiatry, 163,* 838–848.

Westen, D., & Shedler, J. (1999a). Revising and assessing Axis II, Part 1: Developing a clinically and empirically valid assessment method. *American Journal of Psychiatry, 156,* 258–272.

Westen, D., & Shedler, J. (1999b). Revising and assessing Axis II, Part 2: Toward an empirically based and clinically useful classification of personality disorders. *American Journal of Psychiatry, 156,* 273–285.

Westen, D., Shedler, J., Durrett, C., Glass, S., & Martens, A. (2003). Personality diagnosis in adolescence: DSM-IV Axis II diagnoses and an empirically derived alternative. *American Journal of Psychiatry, 160,* 952–966.

Westen, D., & Weinberger, J. (2004). When clinical description becomes statistical prediction. *American Psychologist, 59,* 595–613.

Wetzler, S., & Morey, L. C. (1999). Passive-aggressive personality disorder: The demise of a syndrome. *Psychiatry: Interpersonal & Biological Processes, 62,* 49–59.

Widiger, T. A. (1995). Deletion of self-defeating and sadistic personality disorders. In W. Livesley (Ed.), *The DSM-IV personality disorders: Diagnosis and treatment of mental disorders* (pp. 359–373). New York, NY: Guilford Press.

Widiger, T. A., Simonsen, E., Krueger, R. F., Livesley, W., & Verheul, R. (2005). Personality Disorder Research Agenda for the DSM-V. *Journal of Personality Disorders, 19,* 315–338.

Zittel, C., & Westen, D. (2005). Borderline personality disorder as seen in clinical practice: Implications for DSM-V. *American Journal of Psychiatry, 162,* 867–875.