Under the Axis II Radar

Clinically Relevant Personality Constellations That Escape DSM-IV Diagnosis

Pavel S. Blagov, MA, Rebekah Bradley, PhD, and Drew Westen, PhD

Abstract: Research suggests that personality pathology lies on a continuum from relatively severe to less severe and that subthreshold variants may not be adequately captured by axis II of DSM-IV. In this study, we used a measure of personality and psychopathology designed for experienced clinical observers (the SWAP-200) to derive subthreshold personality constellations in a sample of 159 psychotherapy patients who were high functioning but nevertheless suffered from maladaptive personality patterns. Using Q-factor analysis (an empirical clustering procedure), we identified 4 diagnostic groupings or SPC, which resembled the clinical concept of "neurotic styles": depressive, hostile-competitive, obsessive, and hysterical. The results of this study should stimulate further research on subthreshold personality configurations.

Key Words: Classification, diagnosis, personality disorders, axis II, Q-factor analysis.

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Axis II of the DSM-IV (APA, 1994) offers categorical Personality Disorder (PD) diagnoses. However, evidence has emerged that personality pathology exists on a spectrum and that even subthreshold levels predict important aspects of functioning (Johnson and Bornstein, 1991; Perry, 1993). Subthreshold disturbances in personality are highly prevalent and clinically significant: 46%–60% of patients in clinical practice may have personality difficulties deserving clinical attention that cannot be diagnosed by the DSM (Westen and Arkowitz-Westen, 1998; Zimmerman et al., 2005).

Subthreshold levels of existing DSM PDs may affect mental health, social adaptation, and quality of life (Bagge et al., 2004; Cadoret et al., 1995; Daley et al., 1999; Gustafson and Ritzer, 1995; Lilienfeld, 1999; Moffitt, 1987). Similarly, research that views personality pathology as the extreme of continuously distributed normal traits suggests that such pathology can influence adaptation and quality of life (Costa and Widiger, 1994; John et al., 1994; Kendler et al., 2004; Mount et al., 1998). Similar findings emerge from studies of adult attachment (Carlson, 1998; Crowell et al., 2002; Klohnen and Bera, 1998; Vasquez et al., 2002). The literature on insecure attachment in nonclinical samples may be tapping into subthreshold personality pathology's negative life outcomes (see Bartholomew et al., 2001; Nakash-Eisikovitz et al., 2003).

We undertook this study to identify empirically *subthreshold personality constellations* (SPC), forms of personality pathology that are not severe enough to warrant a PD diagnosis in the DSM-IV-TR (APA, 2000) but that may nevertheless require therapeutic attention. SPC are related conceptually to the "neurotic styles" that fell off the diagnostic radar screen in the 1960s. The notion dates back to Freud (1931–1959), Abraham (1921–1927, 1924–1927, 1925–1927), and Reich (1933–1978), who wrote about character styles that predisposed individuals to respond to life challenges with particular symptoms. Shapiro (1965) described such types of character pathology as the obsessive-compulsive, paranoid, hysterical, psychopathic, and passive character, moving into the realm of pathology that affected adaptation but did not necessarily meet criteria for PDs in what became DSM-III. To clarify the relationship between character type and level of disturbance, Kernberg (1967, 1996) proposed a severity axis (ranging from psychotic through borderline to neurotic) orthogonal to an axis of personality characteristics. Most PDs as currently defined in DSM-IV-TR fall in Kernberg's borderline range of severity.

Until DSM-III (APA, 1980), personality pathology did not receive much research attention. The multiaxial system listed PDs on axis II and encouraged clinicians to consider the effects of personality on the course and treatment of axis I disorders (Spitzer et al., 1980; Widiger and Kelso, 1983), but it introduced high diagnostic thresholds defined by arbitrary cutoffs (Widiger, 1993). The notions that personality pathology is distributed on a severity continuum (Brown and Barlow, 2005) and that other symptoms need to be understood in the context of personality have recently seen a "comeback" in research on personality traits and spectra (see Clark et al., 1994; Krueger and Tackett, 2003; Watson et al., 1994).

Department of Psychology, Emory University, Atlanta, Georgia.
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Send reprint requests to Drew Westen, PhD, Department of Psychology, Emory University, 532 North Kilgo Circle, Atlanta, GA 30322. E-mail: dwesten@emory.edu.

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Constellational approaches to PDs that do not assume categorical diagnosis have also fostered renewed interest in less severe forms of personality disturbance (Westen et al., 2006). Today most research on PDs, which are constellational diagnoses comprising multiple traits believed to covary, treats PD data dimensionally (typically using number of symptoms met for each disorder as a dimensional index, e.g., Skodol et al., 2005). Although this captures substantially more variance in pathology than categorical (present/absent) diagnoses, it may not account for distinct constellations in the subthreshold range of character pathology that are not recognized in DSM-IV.

In this study, we used a cluster-analytic procedure (Q-factor analysis) that does not assume mutually exclusive types to identify unique SPCs. We first applied the procedure to personality and psychopathology data regarding 692 patients from 2 previous studies (Westen and Shedler, 1999a,b, and an unpublished study) and identified 4 overarching constellations of psychopathology: Internalizing, Externalizing, Emotionally Dysregulated/Borderline, and High Functioning. For the purposes of the present study, we selected those patients whose data best matched the High Functioning constellation and subjected them to further Q-factor analysis to identify a set of SPCs.

METHOD

Participants

Clinicians

Participants were psychiatrists and clinical psychologists who responded (approximately 25% response rate) to a mailing sent out to a random selection of members of the American Psychological and Psychiatric Associations as part of 2 larger studies on personality pathology.

Patients

Clinicians from the first study (Westen and Shedler, 1999a,b) received instructions to describe a patient from their practice who had 1 of 14 PDs from DSM-IV or its appendices or who was high functioning and had no PDs. Thus, 496 clinicians received instructions to describe a patient with a specific PD (roughly equal numbers for each PD) and 28 described a high-functioning patient. Clinicians from a second sample, designed for this study ($N = 168$), received instructions to select a random patient from their practice with personality pathology not diagnosable on axis II. All clinicians were asked to select the last patient they saw on the previous week (to produce a random sample) who was nonpsychotic, had been in therapy for at least 8 sessions (to ensure the clinician knew the patient well) but no more than 2 years (to exclude substantial personality changes due to therapy), and had "enduring maladaptive patterns of thought, feeling, motivation, or behavior." Approximately half of these clinicians received instructions to select a patient whose maladaptive patterns did not meet criteria for a DSM-IV PD, and the other half received the additional instruction that the pathology should not be severe enough to warrant a PD diagnosis. Our goal was to ensure that the combined sample appropriately included a range of personality pathology severity, including patients whose pathology might not be represented in DSM-IV.

Measures

The Clinical Data Form

The Clinical Data Form asks for demographic data on the clinician and the patient, including theoretical orientation, years of experience, sex, and race; as well as patient age, sex, race, SES, education, and axis I diagnoses. Clinician ratings of adaptive functioning tend to correlate strongly ($r = 60–80$) with the same variables obtained by interview (Hilsenroth et al., 2000; Westen et al., 1997).

PD Rating

Clinicians rated on a 7-point scale the extent to which the patient was prototypical of each PD. The scale anchors indicated that ratings of 7 should correspond to "meets full criteria" of the disorder.

The Shedler-Westen Assessment Procedure-200

The Shedler-Westen Assessment Procedure-200 (SWAP-200; Westen and Shedler 1999a,b, 2000) is a Q-sort for assessing personality and its pathology. An experienced clinician rank-orders 200 items into categories from nondescriptive (0) to highly descriptive (7) of the patient. Thus, the SWAP-200 yields a 0–7 score for each of 200 items developed using standard psychometric methods. Research supports its reliability and validity predicting objective indicators of personality dysfunction such as suicide attempts, history of psychiatric hospitalizations, GAF scores, clinician diagnoses, and developmental and history variables (Westen and Harnden-Fischer, 2001; Westen et al., 2003, 2004). The adolescent version predicts behavior ratings (Dutra et al., 2004) and attachment (Nakash-Eisikovitz et al., 2002). Correlations between treating clinicians and independent interviewers average >0.70 for both dimensional PD and trait measures derived from the SWAP-200 (Westen and Muderrisoglu, 2003).

Statistical Analyses

Q-Factor Analysis

Q-factoring procedures help identify such naturally occurring groups as people who share personality features (Block, 1978; Colvin et al., 1995; Shedler and Block, 1990) or personality pathology (Westen and Shedler, 1999a,b). Q-factor analysis with the SWAP-200 follows factor-analytic convention familiar from trait research, but instead of correlating items across cases it correlates people across items. In other words, it intercorrelates SWAP-200 profiles to extract groups of patients who resemble one another and differ from others in the sample. An initial extraction is performed and components with eigenvalues of 1 or higher are retained (Keiser's criteria). Examination of the scree plot, percent of variance accounted for, and parallel analysis help determine the number of factors to extract. Factors can be rotated to create orthogonal or oblique solutions, using different esti-

mation procedures and algorithms to converge on solutions that are not only conceptually coherent but also robust to differences in methods of identification. Large groupings of patients can be subfactored to identify subtypes or diagnoses at a subordinate level, much like the relation between the DSM-IV PD "clusters" and the specific PDs. SWAP-200 items with the highest loadings on a factor can be used to create a 200-item prototype that describes the latent construct or personality constellation, and patients can then be diagnosed dimensionally by degree of match to each prototype using a simple correlation coefficient (a Q-correlation; see Block, 1978). For simplicity of interpretation, for assessing construct validity of obtained diagnosis, we assigned each patient to a particular SPC (categorical diagnosis) by selecting their highest Q-correlation (i.e., the prototype to which they best matched).

RESULTS

Demographics and Validity Check

To identify high-functioning patients who might have SPC, we first applied Q-factor analysis to the entire sample of 692 patients. We will describe this analysis in greater detail elsewhere, but briefly, we used standard factor analytic procedure to identify naturally occurring groups of patients with the Unweighted Least Squares (ULS) estimation procedure. Based on existing research, replicability of the Q-factors, and clinical coherence of the Q-factors that emerged, we rotated 5 factors, retaining 4 (Internalizing, Externalizing, Borderline/Emotionally Dysregulated, and High Functioning), which accounted for 45% of the variance. These findings fit remarkably well with recent research by Krueger and his colleagues (e.g., Krueger and Tackett, 2003), using an entirely different methodology and set of statistical procedures, identifying internalizing and externalizing spectra of personality pathology that underlie most nonpsychotic axis I disorders.

Of the 692 patients, 159 loaded had their highest loadings on the High Functioning Q-factor and loaded >0.40. (In Q-factor analysis, also called inverted factor analysis, patients, rather than items, load on factors, indicating the extent to which they are good exemplars of the latent personality construct.) Table 1 contains descriptive statistics on the 159 clinicians and patients. Over 90% of the patients were whites, and 60% of clinicians reported a psychodynamic orientation, with the remainder primarily eclectic or cognitive-behavioral. (The skew in orientation likely reflects the greater interest among dynamic clinicians in the notion of "neurotic styles," given that we have not found it in our prior studies using this method.)

Of the 159 patients, only 9 received a "7" on any of the PD Ratings. Of these, the majority were on provisional DSM-IV PDs from the appendix or on obsessive-compulsive PD, which has not shown to be associated with functional deficits, unlike the other PDs. The items with the highest factors scores on the High Functioning Q-factor (indicating the degree to which these items define the construct) were all health items (e.g., "Tends to be conscientious and responsible," "Has moral and ethical standards and strives to live up to them"), indicating that although (as we describe shortly) these patients had clear pathology, what united them was their lack of the kind of severe pathology that defines PDs in DSM-IV.

TABLE 1. Demographic Characteristics of the High-Functioning Patient Sample

Clinicians	
Discipline (%)	
Psychiatry	17.3
Psychology	82.7
Sex (%)	
Women	42.8
Men	57.2
Experience, mean ± *SD* (yr)	20.7 ± 8.94
Patients	
Age, mean ± *SD* (yr)	42.4 ± 10.6
Sex (%)	
Women	61.8
Men	38.2
Global functioning (GAF), mean ± *SD*	71.0 ± 11.3
Socioeconomic status (%)	
Poor	2.0
Working class	26.1
Middle class	54.9
Upper/upper middle class	17.0

Identifying Personality Constellations Using Q-Factor Analysis

We applied Q-factor analysis to the SWAP-200 data on these 159 patients as described above. The most coherent solution was a ULS extraction of 6 factors with a Promax rotation. The Promax rotation is an oblique rotation appropriate when factors are intercorrelated, and it is more likely to reflect the realities of personality than an orthogonal rotation; to insure maximum discriminability among the personality prototypes defined by Q-factor analysis, however, we set the *kappa* value for the procedure at 2 to minimize diagnostic overlap. The solution explained 55.8% of the variance.

Table 2 lists in descending order the 18 items most descriptive of each Q-factor (the items with the highest factor scores among the 200 items). The top 18 items represent the items clinicians can place in the top two, "most descriptive," categories of the Q-sort (i.e., items assigned a score of 6 or 7).

The first diagnostic grouping, Depressive Personality, consisted of items describing a responsible and morally principled person who suffers from self-criticism as well as feelings of guilt, shame, inferiority, anxiety, and fatigue. It best described 37 of the patients. We labeled the second diagnostic grouping Hostile-Competitive because it contained items pointing to high achievement motivation and energy combined with a tendency to seek power, seek to control others, to be critical, to be competitive, and to have outbursts of anger. It best described 30 patients. The next Q-factor, Obsessive Personality, described a pattern of overemphasis

TABLE 2. Subthreshold Personality Constellations

Items	Factor Score
Depressive Personality (N = 37)	
189 Tends to feel unhappy, depressed, or despondent.	3.87
54 Tends to feel s/he is inadequate, inferior, or a failure.	3.05
57 Tends to feel guilty.	2.98
149 Tends to feel like an outcast or outsider; feels as if s/he does not truly belong.	2.86
1 Tends to blame self or feel responsible for bad things that happen.	2.70
36 Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.	2.54
91 Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects.	2.52
86 Tends to feel ashamed or embarrassed.	2.44
98 Tends to fear s/he will be rejected or abandoned by those who are emotionally significant.	2.40
175 Tends to be conscientious and responsible.	2.22
127 Tends to feel misunderstood, mistreated, or victimized.	2.13
30 Tends to feel listless, fatigued, or lacking in energy.	2.06
35 Tends to be anxious.	1.92
174 Expects self to be "perfect" (e.g., in appearance, achievements, performance, etc.).	1.87
103 Tends to react to criticism with feelings of rage or humiliation.	1.84
88 Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves.	1.82
120 Has moral and ethical standards and strives to live up to them.	1.68
60 Tends to be shy or reserved in social situations.	1.68
Hostile-Competitive (Type A) Personality (N=30)	
182 Tends to be controlling.	3.02
179 Tends to be energetic and outgoing.	2.82
84 Tends to be competitive with others (whether consciously or unconsciously).	2.79
92 Is articulate; can express self well in words.	2.64
8 Tends to get into power struggles.	2.57
63 Is able to assert him/herself effectively and appropriately when necessary.	2.44
16 Tends to be angry or hostile (whether consciously or unconsciously).	2.23
12 Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc.	2.20
19 Enjoys challenges; takes pleasure in accomplishing things.	2.15
2 Is able to use his/her talents, abilities, and energy effectively and productively.	2.09
95 Appears comfortable and at ease in social situations.	2.08
114 Tends to be critical of others.	2.00
48 Seeks to be the center of attention.	1.97
43 Tends to seek power or influence over others (whether in beneficial or destructive ways).	1.94
4 Has an exaggerated sense of self-importance.	1.90
68 Appreciates and responds to humor.	1.74
196 Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.	1.72
190 Appears to feel privileged and entitled; expects preferential treatment.	1.65
Obsessive Personality (N = 17)	
100 Tends to think in abstract and intellectualized terms, even in matters of personal import.	3.41
144 Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential.	3.40
66 Is excessively devoted to work and productivity, to the detriment of leisure and relationships.	3.08
119 Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.	3.04
131 Has difficulty allowing self to experience strong pleasurable emotions (e.g., excitement, joy, pride).	2.51
175 Tends to be conscientious and responsible.	2.48
25 Has difficulty acknowledging or expressing anger.	2.41
192 Tends to be overly concerned with rules, procedures, order, organization, schedules, etc.	2.33
174 Expects self to be "perfect" (e.g., in appearance, achievements, performance, etc.).	2.32
126 Appears to have a limited or constricted range of emotions.	2.28
173 Tends to become absorbed in details, often to the point that s/he misses what is significant in the situation.	2.17
2 Is able to use his/her talents, abilities, and energy effectively and productively.	2.03
120 Has moral and ethical standards and strives to live up to them.	2.02
91 Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects.	2.00
114 Tends to be critical of others.	1.95

(*Continued*)

TABLE 2. (*Continued*)

Items	Factor Score
159 Tends to deny or disavow own needs for caring, comfort, closeness, etc., or to consider such needs unacceptable.	1.87
158 Appears afraid of commitment to a long-term love relationship.	1.87
60 Tends to be shy or reserved in social situations.	1.68
Hysterical Personality (N = 12)	
128 Fantasizes about finding ideal, perfect love.	3.87
46 Tends to be suggestible or easily influenced.	3.27
25 Has difficulty acknowledging or expressing anger.	3.08
77 Tends to be overly needy or dependent; requires excessive reassurance or approval.	2.99
17 Tends to be ingratiating or submissive (e.g., may consent to things s/he does not agree with or does not want to do in the hope of getting support or approval).	2.98
98 Tends to fear s/he will be rejected or abandoned by those who are emotionally significant.	2.52
45 Tends to idealize certain others in unrealistic ways; sees them as "all good," to the exclusion of commonplace human defects.	2.42
11 Tends to become attached quickly or intensely; develops feelings, expectations, etc., that are not warranted by the history or context of the relationship.	2.40
93 Seems to know less about the ways of the world than might be expected, given his/her intelligence, background, etc.; appears naive or innocent.	2.34
34 Tends to be overly sexually seductive or provocative, whether consciously or unconsciously (e.g., may be inappropriately flirtatious, preoccupied with sexual conquest, prone to "lead people on," etc.).	2.02
78 Tends to express aggression in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).	1.94
158 Appears afraid of commitment to a long-term love relationship.	1.83
33 Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential.	1.81
110 Tends to become attached to, or romantically interested in, people who are emotionally unavailable.	1.80
86 Tends to feel ashamed or embarrassed.	1.77
171 Appears to fear being alone; may go to great lengths to avoid being alone.	1.66
187 Tends to feel guilty or ashamed about his/her sexual interests or activities (whether consciously or unconsciously).	1.66
97 Tends to use his/her physical attractiveness to an excessive degree to gain attention or notice.	1.59

on intellect, logic, rules, and detail to the detriment of emotional experience, and work at the expense of intimacy. Seventeen patients matched most closely to this profile. The fourth diagnostic grouping, Hysterical Personality, was characterized by romantic idealization, sexualization, dependency, rejection sensitivity, suggestibility, and naiveté; 12 patients most strongly matched this prototype.

DISCUSSION

Previous research has demonstrated the significance of subthreshold personality pathology. The current study demonstrates the possibility of empirically deriving SPC unrepresented on axis II in the DSM-IV because of their relatively low severity. In a sample of 159 high-functioning patients (average GAF = 71.0, *SD* = 11.3) with personality difficulties, Q-factor analysis identified 4 groups that we named Depressive, Hostile-competitive, Obsessive, and Hysterical.

The Depressive, Obsessive, and Hysterical constellations were familiar from the clinical descriptions provided by Shapiro (1965) and McWilliams (1994). The Hostile/Competitive one has some of the features of McWilliams' (1994) psychopathic and narcissistic types but most closely resembles a "Type A personality" (Rodin and Salovey, 1989). That we did not find constellations corresponding to Shapiro's paranoid and psychopathic characters is not surprising, as clinicians would have likely judged those patients as meeting the definition for a full-blown PD (and in prior research using the first 2 of the samples used here, we did identify paranoid and psychopathic PDs empirically; see Westen and Shedler, 1999b).

Limitations and Future Directions

The study's limitations reflect its preliminary nature. One concern is the reliance on a single informant (the clinician) for each patient. Although the rationale for clinician-report data of this sort has been addressed elsewhere (Westen and Weinberger, 2004), subsequent larger studies should use multiple informants. Second, the clinician sample overrepresented psychodynamic therapists (61%) relative to surveys of practice patterns. However, our prior studies using similar methods have not found links between findings and theoretical orientation (Betan et al., 2005). Research should also aim at informant and patient samples with greater ethnic heterogeneity. SPC that naturally occur in people who rarely seek therapy or have low base rates may also be underrepresented in a clinical sample.

The present study should be seen as the first step toward a more empirically rigorous classification of SPCs. Larger studies in the future may be able to examine the predictive validity of SPC as related to longitudinal life outcomes or psychotherapy outcome. Studies should also test the incremental validity of SPC over measures of temperament, basic

traits, or attachment in predicting variables related to therapy outcome and social-emotional adjustment.

REFERENCES

Abraham K (1921–1927) Contributions to the theory of the anal character. In *Selected Papers of Karl Abraham.* London (UK): Hogarth.

Abraham K (1924–1927) The influence of oral eroticism on character formation. In *Selected Papers on Psychoanalysis.* London (UK): Hogarth.

Abraham K (1925–1927) Character-formation on the genital level of the libido. In *Selected Papers on Psychoanalysis.* London (UK): Hogarth.

APA (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th ed). Washington (DC): American Psychiatric Association.

APA (1980) *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed). Washington (DC): American Psychiatric Association.

APA (2000) *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, text revision). Washington (DC): American Psychiatric Association.

Bagge C, Nickell A, Stepp S, Durrett C, Jackson K, Trull TJ (2004) Borderline Personality Disorder features predict negative outcomes 2 years later. *J Abnorm Psychol*. 113:279–288.

Bartholomew K, Kwong MJ, Hart SD (2001) Attachment. In WJ Livesley (Ed), *Handbook of Personality Disorders: Theory, Research and Treatment* (Chapter 9, pp 196–230). New York: Guilford.

Betan E, Heim A, Zittel C, Westen D (2005) Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *Am J Psychiatry*. 162:890–898.

Block J (1978) *The Q-Sort Method in Personality Assessment and Psychiatric Research* (pp 161). Palo Alto (CA): Consulting Psychologists Press.

Brown TA, Barlow DH (2005) Dimensional versus categorical classification of mental disorders in the fifth edition of the diagnostic and statistical manual of mental disorders and beyond. *J Abnorm Psychol*. 114:551–556.

Cadoret RJ, Yates WR, Troughton E, Woodworth G, Stewart M (1995) Geneticênvironmental interaction in the genesis of aggressivity and conduct disorders. *Arch Gen Psychiatry*. 52:916–924.

Carlson E (1998) A prospective longitudinal study of attachment disorganization/disorientation. *Child Dev*. 69:1107–1128.

Clark LA, Watson D, Mineka S (1994) Temperament, personality and the mood and anxiety disorders. *J Abnorm Psychol*. 103:103–116.

Colvin R, Block J, Funder D (1995) Overly positive self-evaluations and personality: Negative implications for mental health. *J Personal Soc Psychol*. 68:1152–1162.

Costa P, Widiger TA (1994) *Personality Disorders and the Five-Factor Model of Personality*. Washington (DC): American Psychiatric Association.

Crowell JA, Treboux D, Waters E (2002) Stability of attachment representations: The transition to marriage. *Dev Psychol*. 38:467–479.

Daley SE, Hammen C, Burge D, Davila J, Paley B, Lindberg N, Herzberg DS (1999) Depression and axis II symptomatology in an adolescent community sample: Concurrent and longitudinal associations. *J Personal Disord*. 13:47–59.

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. *J Clin Psychol*. 60:65–85.

Freud S (1931–1959) Libidinal types. In *Collected Papers*. New York: Basic Books.

Gustafson SB, Ritzer DR (1995) The dark side of normal: A psychopathy-linked pattern called aberrant self-promotion. *Eur J Personal*. 9:147–183.

Hilsenroth MJ, Ackerman SJ, Blagys MD, Baumann BD, Baity MR, Smith SR, Price JL, Smith CL, Heindselman TL, Mount MK, Holdwick DJ (2000) Reliability and validity of DSM-IV axis V. *Am J Psychiatry*. 157:1858–1863.

John OP, Caspi A, Robins RW, Moffitt TE, Stouthamer-Loeber M (1994) The "little five": Exploring the nomological network of the five-factor model of personality in adolescent boys. *Child Dev*. 65:160–179.

Johnson JG, Bornstein RF (1991) Personality Diagnostic Questionnaire—Revised (PDQ–R) personality disorder scores and negative life events independently predict changes in Hopkins Symptom Checklist (SCL-90) psychopathology scores. *J Psychopathol Behav Assess*. 13:61–72.

Kendler K, Kuhn J, Prescott CA (2004) The interrelationship of neuroticism, sex and stressful life events in the prediction of episodes of major depression. *Am J Psychiatry*. 161:631–636.

Kernberg O (1967) Borderline personality organization. *J Am Psychoanal Assoc*. 15:641–685.

Kernberg O (1996) A psychoanalytic theory of personality disorders. In J Clarkin, M Lenzenweger (Eds), *Major Theories of Personality Disorder* (pp 106–140). New York: Guilford.

Klohnen EC, Bera S (1998) Behavioral and experiential patterns of avoidantly and securely attached women across adulthood: A 31-year longitudinal perspective. *J Personal Soc Psychol*. 74:211–223.

Krueger RF, Tackett JL (2003) Personality and psychopathology: Working toward the bigger picture. *J Personal Disord*. 17:109–128.

Lilienfeld SO (1999) The relation of the MMPI-2 Pd Harris-Lingoes subscales to psychopathy, psychopathy facets and antisocial behavior: Implications for clinical practice. *J Clin Psychol*. 55:241–255.

McWilliams N (1994) *Psychoanalytic Diagnosis.* New York: Guilford.

Moffitt T (1987) Parental mental disorder and offspring criminal behavior: An adoption study. *Psychiatry*. 50:346–360.

Mount MK, Barrick MR, Stewart GL (1998) Five-factor model of personality and performance in jobs involving personal interactions. *Hum Perform*. 11:145–165.

Nakash-Eisikovitz O, Dierberger A, Westen D (2002) A multidimensional meta-analysis of pharmacotherapy for bulimia nervosa: Summarizing the range of outcomes in controlled clinical trials. *Harv Rev Psychiatry*. 10:193–211.

Nakash-Eisikovitz O, Dutra L, Westen D (2003) The relationship between attachment patterns and personality pathology in adolescents. *J Am Acad Child Adolesc Psychiatry*. 41:1111–1123.

Perry CJ (1993) Longitudinal studies of personality disorders. *J Personal Disord*. 7(Suppl 1):63–85.

Reich W (1933–1978) *Character Analysis* (3rd ed). New York: Simon and Schuster.

Rodin J, Salovey P (1989) Health psychology. *Ann Rev Psychol*. 40:533–579.

Shapiro D (1965) *Neurotic Styles.* New York: Basic.

Shedler J, Block J (1990) Adolescent drug use and psychological health: A longitudinal inquiry. *Am Psychol*. 45:612–630.

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

Skodol AE, Oldham JM, Bender DS, Dyck IR, Stout RL, Morey LC, Shea TM, Zanarini MC, Sanislow CA, Grilo CM, McGlashan TH, Gunderson JG (2005) Dimensional representations of DSM-IV personality disorders: Relationships to functional impairment. *Am J Psychiatry*. 162:1919–1925.

Spitzer RL, Williams JBW, Skodol AE (1980) DSM-III: The major achievements and an overview. *Am J Psychiatry*. 137:151–164.

Vasquez K, Durik AM, Hyde JS (2002) Family and work: Implications of adult attachment styles. *Personal Soc Psychol Bull*. 28:874–886.

Watson D, Clark LA, Weber K, Assenheimer JS, Strauss ME, McCormick RA (1994) Testing a tripartite model. II. Exploring the symptom structure of anxiety and depression in student, adult and patient samples. *J Abnorm Psychol*. 104:15–25.

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

Westen D, Gabbard G, Blagov PS (2006) Back to the future: Personality structure as a context for psychopathology. In R Krueger, J Tackett (Eds), *Personality and Psychopathology: Building Bridges.* New York: Guilford.

Westen D, Harnden-Fischer J (2001) Personality profiles in eating disorders: Rethinking the distinction between Axis I and Axis II. *Am J Psychiatry*. 165:547–562.

Westen D, Muderrisoglu S (2003) Reliability and validity of personality disorder assessment using a systematic clinical interview: Evaluating an alternative to structured interviews. *J Personal Disord*. 17:350–368.

Westen D, Muderrisoglu S, Fowler C, Shedler J, Koren D (1997) Affect regulation and affective experience: Individual differences, group differences and measurement using a Q-sort procedure. *J Consult Clin Psychol*. 65:429–439.

Westen D, Shedler J (1999a) Revising and assessing Axis II, Part 1: Developing a clinically and empirically valid assessment method. *Am J 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. *Am J Psychiatry*. 156:273–285.

Westen D, Shedler J (2000) A prototype matching approach to diagnosing personality disorders toward DSM-V. *J Personal Disord*. 14:109–126.

Westen D, Shedler J, Bradley R (2004) A prototype matching alternative for diagnosing personality disorders in clinical practice. Atlanta (GA): Emory University. Unpublished manuscript.

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. *Am J Psychiatry*. 160:952–966.

Westen D, Weinberger J (2004) When clinical description becomes statistical prediction. *Am Psychol*. 59:595–613.

Widiger T (1993) The DSM-III–R categorical personality disorder diagnoses: A critique and an alternative. *Psycholog Inq*. 4:75–90.

Widiger T, Kelso K (1983) Psychodiagnosis of Axis II. *Clin Psychol Rev*. 3:491–510.

Zimmerman M, Rothschild L, Chelminski I (2005) The prevalence of DSM-IV Personality Disorders in psychiatric outpatients. *Am J Psychiatry*. 162:1911–1918.