

Convergent Validity of the SWAP-200 Dependency Scales

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Abstract: The present study examined the convergent validity of the Shedler-Westen Assessment Procedure Q-Sort (SWAP-200; Shedler and Westen, 1998; 1999a; 1999b; 2004a) dependency scales (Dependent Personality Disorder [DPD] Clinical Prototype and DPD composite description) by examining links between these variables with Inventory of Interpersonal Problems Circumplex Scales (IIP-C; Alden et al., 1990; Horowitz et al., 2000; Horowitz et al., 1988), and DSM-IV diagnoses of DPD in a clinical sample ($N = 85$). Results showed that SWAP-200 DPD Clinical Prototype was significantly related to a DSM-IV diagnosis of DPD, higher scores on the IIP-C Affiliative/Submissive Quadrant summary scale, and elevations on Nonassertive and Overly-accommodating Octant Scales. Additional analyses revealed significant positive relationships between the DPD composite description with DSM-IV diagnosis of DPD, the Affiliative/Submissive Quadrant summary scale, and the Overly Accommodating and Self-Sacrificing Octant Scales. We discuss the implications of these findings with regard to theoretical, empirical, and clinical aspects of interpersonal dependency.

Key Words: SWAP-200, dependent personality disorder, IIP.

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Historically, the concept of dependent personality disorder (DPD) within DSM nosology has received only scanty attention from researchers. Despite much clinical evidence and the plethora of established theories of this character type (e.g., Abraham, 1927; Fenichel, 1945; Sullivan, 1947; Bowlby, 1969) the DSM-II included no construct that reflects what is currently known as DPD. The DSM-III and DSM-III-R finally provided criteria for this frequently discussed clinical condition, with the DSM-III-R Task Force conceptualizing DPD's core characteristic as the need to consistently be in a relationship with a nurturing and supporting other. This emphasis continued with the DSM-IV where DPD is primarily an interpersonally defined personality disorder (PD): The central characterization of the DPD patient is one who consistently needs to be taken care of, fears separation from their nurturing and supportive other, and evidences over-reliant and clinging behaviors (Millon and Davis, 1996). In clinical settings, patients with DPD have a higher-than-expected number of "pseudo-emergencies," receive a greater number of psychotropic medications than nondependent patients with similar demographic and diagnostic profiles, and have difficulty terminating treatment (a review of research in this area is given in Bornstein, 2005).

Although DPD has now firmly established itself within DSM Axis II, the external validity of these criteria remains open to question. In a review of the empirical literature, Bornstein (1997) noted that DSM-IV criteria for DPD have mixed external validities: 4 of the criteria have been supported empirically (i.e., has difficulty making decisions without reassurance; goes to excessive lengths to

obtain support; feels helpless when alone; is preoccupied with fears of being left to care for him or herself); 2 have been contradicted repeatedly (i.e., has difficulty expressing disagreement with others; has difficulty initiating projects on his own); and 2 have never been empirically assessed (i.e., needs others to assume responsibility for most areas of his life; when close a relationship ends will urgently seek out an alternate relationship as a source of support). Clearly, several areas of the current DSM nosology of PDs need further revision and refinement to create a more clinically derived, empirically based PD taxonomy.

Assessment instruments for Axis II disorders, including those used to assess DPD, also have been criticized for questionable construct validity and low retest reliability. To help explain these limitations, Westen (1997) demonstrated empirically that clinicians most often diagnose personality pathology by evaluating patients' descriptions of interpersonal interactions and by observing patients' interview behaviors, rather than by using criteria taken directly from Axis II. In addition, Westen and Arkowitz-Western (1998), in a random national survey, asked clinicians to describe nonpsychotic patients whom they had treated "for enduring patterns of thought, feeling, motivation, or behavior that are functional or lead to distress. Their personality problems may or may not be serious enough to qualify for a personality disorder diagnosis." Results indicated that only 39.4% of the 714 patients treated for personality problems met criteria for DSM-IV diagnosis, suggesting the inadequacy of current Axis II nosology to aid actual clinical practice. The Shedler-Westen Assessment Procedure Q-Sort (SWAP-200; Shedler and Westen, 1998; 1999a; 1999b; 2004a; 2007) emerged from these efforts to create a more valid and clinically useful tool for assessing PDs. The SWAP-200 is a clinically derived, empirically based diagnostic tool (Shedler and Westen, 1999a; 1999b; 2004a) that has been shown to have excellent retest reliability, as well as good interrater, discriminant, and convergent validities with a range of external criterion measures (Diener and Hilsenroth, 2004; Shedler and Westen, 2004a; Westen and Shedler, 2007; Marin-Avellan et al., 2005; Westen and Muderrisoglu, 2003; Shedler and Westen, 1999a; Westen et al., 2003; Westen and Weinberger, 2004). The SWAP-200 is both a diagnostic tool and a means by which to begin to develop a possible alternate nosological system to the DSM.

In creating the SWAP-200, Shedler and Westen (1999a) asked 530 clinicians to use the measure to describe an actual patient in their practice that met DSM-IV criteria for a PD. Next, 267 clinicians were asked to use the SWAP-200 to describe a hypothetical, prototypical patient that ideally embodied a specific PD. To create empirically derived personality groupings, Shedler and Westen (2004b) then aggregated SWAP-200 personality descriptions across multiple patients to produce composite personality descriptions for particular diagnostic groupings. The results were 2 empirically derived, aggregated personality descriptions: The Clinical Prototype (the aggregate PD description-based on clinician ratings of hypothetical, prototypical patients) and the composite description (the aggregated descriptions of actual patients with specified PDs).

Although the names of these aggregated descriptions resemble PDs of the current Axis II nosology, the SWAP-200 descriptions were developed independently. As such, although the SWAP-200 Clinical Prototype and composite description groupings resemble

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current Axis II categories to some degree, they remain conceptually and empirically distinct. As an example, the Narcissistic composite description correlated $r = 0.51$ with clinician ratings of Axis II Narcissistic PD, indicating a significant but nonredundant relationship with the current DSM category. Additionally, the Narcissistic composite description demonstrated substantial discriminant validity, because the remaining correlations between the Narcissistic composite description and clinician ratings of other Axis II disorders are modestly correlated. The taxonomy of Shedler and Westen (2004a), therefore, has shown promising results in the effort to minimize diagnostic overlap that is common to current measures of Axis II psychopathology (see Bornstein, 1998; 2003, for detailed discussions of Axis II diagnostic overlap and comorbidity).

In the present study, we examine the validity of the SWAP-200 DPD Clinical Prototype and composite description characteristic criteria. The DPD Clinical Prototype and composite description represent an empirically derived personality disorder—one that does not exist in the DSM-IV—rather than merely a cluster of affective, behavioral, or cognitive symptoms. Therefore, many of the items that are rated on the DPD Clinical Prototype and composite description clearly indicate personality tendencies rather than discrete symptoms. Nevertheless, it is reasonable to assume that people who manifest enduring dependent tendencies may also demonstrate dependency-related symptoms. Thus, significant relationships between the SWAP DPD Clinical Prototype and composite description with additional indices of dependent symptoms represent theoretically coherent and meaningful evidence of construct validity (see Tables 1 and 2 for listings of the mostly highly characteristic SWAP-200 DPD Clinical Prototype and composite description items).

The current study examines the DPD Clinical Prototype and composite description and their convergent validities with a self-report measure of interpersonal functioning and an externally rated diagnosis of DPD. Thus, this is the first study to assess multimethod, convergent validity of DPD utilizing the SWAP-200. Our goal was to compare dimensional measures of DPD using the SWAP-200,

TABLE 1. SWAP-200 DPD Composite Description Items (Shedler and Westen, 2004b)

Tends to be overly needy or dependent; requires excessive reassurance or approval.
Tends to fear s/he will be rejected or abandoned by those who are emotionally significant.
Tends to feel s/he is inadequate, inferior, or a failure.
Tends to feel unhappy, depressed, or despondent.
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).
Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.
Tends to feel guilty.
Tends to be passive and unassertive.
Tends to be anxious.
Tends to blame self or feel responsible for bad things that happen.
Has difficulty acknowledging or expressing anger.
Tends to feel ashamed or embarrassed.
Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect.
Has trouble making decisions; tends to be indecisive or to vacillate when faced with choices.
Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential.

TABLE 2. SWAP-200 DPD Clinical Prototype Items (Shedler and Westen, 2004b)

Tends to be overly needy or dependent; requires excessive reassurance or approval.
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).
Tends to fear s/he will be rejected or abandoned by those who are emotionally significant.
Appears to fear being alone; may go to great lengths to avoid being alone.
Tends to be passive and unassertive.
Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.
Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect.
Tends to feel s/he is inadequate, inferior, or a failure.
Tends to be suggestible or easily influenced.
Has trouble making decisions; tends to be indecisive or to vacillate when faced with choices.
Tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused.
Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.
Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves.
Fantasizes about finding ideal, perfect love.
Seems to know less about the ways of the world than might be expected, given his/her intelligence, background, etc.; appears naïve or innocent.

with ratings on a self-report measure of interpersonal dysfunction—the Inventory of Interpersonal Problems (IIP-64)—in addition to clinician observer-rated diagnosis of DPD.

METHOD

Participants

All participants were seeking outpatient-treatment at a suburban, university-based community clinic located in the northeastern United States. Cases were assigned to treatment practices and clinicians in an ecologically valid manner based on aspects of clinician availability, caseload, etc. And, patients were accepted into treatment regardless of disorder or comorbidity. Eighty-five patients were consecutively admitted for individual psychotherapy to a psychodynamic psychotherapy treatment team based at the clinic (Hilsenroth, 2007). No patients were excluded based on diagnosis or comorbidity.

The final sample consisted of 61 females and 24 males, 54 of whom were single, 16 married, and 14 separated or divorced. The mean age of patients was 28.98 ($SD = 10.86$). There was a range of DSM-IV Axis I and Axis II diagnoses in the sample, the largest subgroup manifesting mood disorder (major depressive disorder, depressive disorder not otherwise specified, dysthymia, bipolar), which consisted of 46 patients. Sixteen patients were diagnosed with V-code relational problems, 11 had an anxiety disorder, 9 patients were diagnosed with an adjustment disorder, 2 suffered from eating disorders, whereas 1 met criteria for substance abuse. Forty-seven patients were diagnosed with an Axis II PD and 17 patients sought treatment with subclinical PD features. Thus, this sample consisted of primarily mood disordered patients with relational problems manifested in either Axis II PDs, or subclinical PD traits or features.

Additionally, 12 of these patients were determined to have DPD or prominent DPD traits or features. The severity of pathology was in the mild to moderate range, which is consistent with what one would expect from a sample of a university-based, community outpatient clinic. Interrater reliability for the classification of personality pathology across 3 dimensions: (a) presence of a PD, (b) presence of subclinical traits or features, and (c) absence of a PD was excellent (i.e., ICC: $1.2 > 0.74$; Fleiss, 1981) for this project (Hilsenroth et al., 2000; Peters et al., 2006). For the present study, the diagnoses of DPD by independent clinician raters were made on a categorical basis (presence or absence), where "1" designated the presence of DPD and "0" indicated its absence. Interrater reliability in the present study for the presence or absence of DPD pathology was quite high (ICC: $1 = 0.70$). Finally, each participant provided written informed consent to be included in this research.

Procedure

Advanced graduate students (13 men and 13 women) in an American Psychological Association-approved clinical PhD program conducted the assessment, feedback sessions, treatment, and rated the clinical measures. Each clinician completed graduate course training in descriptive psychopathology and was supervised by a licensed PhD clinical psychologist for a minimum of 3.5 hours per week (1.5 hours individually and 2 hours in a group treatment team meeting). Clinicians completed structured training on the clinical rating scales before rating their patients. They used a number of assessment tools after meeting with patients for a semistructured clinical interview lasting approximately 2 hours and an interpretive feedback interview lasting approximately 1.5 hours. The clinical interview centered on presenting problems, history, and relational episodes. The clinician conducting the interview assessed for DSM-IV symptoms of schizophrenia, major depressive/manic/mixed episode, dysthymia, and many anxiety symptoms. The feedback sessions followed a therapeutic model of assessment (Finn and Tonsager, 1992; 1997), which emphasizes fostering of alliance and a relational focus in the collaborative work of identifying factors deleteriously affecting the patient and potential ways of addressing these issues (Hilsenroth et al., 2000; Hilsenroth et al., 2004; Hilsenroth 2007). After the feedback session, clinicians diagnosed patients using DSM-IV Axis I, II, and V. Patients were also classified using the Personality Disorder Index (PDI) (Hilsenroth et al., 2000; Peters et al., 2006), which provides a dimensional measure of Axis II psychopathology. A value of 2 was assigned if the patient met criteria for an Axis II diagnosis, 1 if the patient had subclinical features of Axis II diagnoses, and 0 if the patient demonstrated no evidence of Axis II psychopathology. Independent observers were graduate students (as described) who had undergone training on the different measures and, in some cases, the clinical supervisor. They completed ratings of Axis I, II, and V after watching videotape of the therapeutic assessment. With regard to the present study, Axis II diagnoses were made by the independent, clinical raters on a presence or absence basis (i.e., categorical) of a PD.

Measures

During the evaluation process, patients filled out the Inventory of Interpersonal Problems (IIP-64) (Horowitz et al., 2000), a 64-item self-report measure used to assess an individual's most salient interpersonal difficulties along 8 subscales: Domineering/Controlling; Vindictive/Self-Centered; Cold/Distant; Socially Inhibited; Nonassertive; Overly Accommodating; Self-Sacrificing; Intrusive/Needy). Dysfunctional interpersonal styles are considered an important aspect of both Axis I and Axis II disorders (Benjamin, 2003; Horowitz, 2004; Kiesler, 1996; Pincus, 2005a; 2005b; Widiger and Frances 1985; Widiger and Kelso, 1983). The interpersonal problems circumplex is a 2-dimensional circular model of interper-

sonal dysfunction arising from the major interpersonal dimensions of personality (Alden et al., 1990; Horowitz et al., 2000; Kiesler, 1996; Pincus and Gurtman, 2006) where the vertical axis represents problems with Dominance (or more broadly, Agency) and the horizontal axis represents problems with Nurturance (or more broadly, Communion).

As a measure of relational functioning, the Inventory of Interpersonal Problems-Circumplex (IIP-C; Alden et al., 1990; Horowitz et al., 2000) may provide a potentially nuanced view of the dynamics involved in DPD and is a focus of the current investigation. The present study specifically examined the IIP scales that would be most convergent with DPD pathology, the Affiliative/Submissive (AS) Scale and its constituent Octant subscales (Overly-Accommodating, Non-Assertive, Self-Sacrificing). A high score on the Overly-Accommodating Octant subscale suggests someone who: (a) reports an excess of friendly submissiveness and deference; (b) is easily persuaded and hesitant to express anger for fear of others' retaliation; and (c) who reports being easily exploitable and describes himself/herself as easy to take advantage of by others. High scores on the Non-Assertive Scale can be taken to represent patients who: (a) report significant lack of self-confidence and self-esteem; (b) see themselves as unassertive and report having difficulty being the center of attention; and (c) report problems being assertive with others. Finally, a high score on the Self-Sacrificing Scale could be indicative of a patient who: (a) describes him or herself as too eager to please, to serve, and to give in to others; (b) reports finding it difficult to set limits on others or express anger towards others; and (c) find themselves empathizing too readily with others while putting others' needs in front of their own. Raw IIP scores were used in all analyses.

Therapists used the SWAP-200 to describe their patients after the therapeutic assessment and the first 2 therapy sessions (approximately 5–6 contact hours). This was the case for all but 5 cases; for these limited exceptions, ratings were based on either the therapeutic assessment only or the therapeutic assessment and the first therapy session. As such, while therapists completed the IIP and SWAP-200 at different times in the assessment process, when completing the SWAP-200 therapists may not be considered blind to the patients' IIP scores.

To complete the SWAP-200 the rater arranges a set of 200 personality descriptions into 8 different categories ranging from 0 (irrelevant or inapplicable to this patient), to 7 (highly descriptive of the patient). The Q-Sort has a fixed distribution that protects against measurement error and heteroscedasticity. Correlation coefficients are then calculated to assess the match between the characteristics of the particular patient and the 10 empirically derived, aggregate descriptions (Clinical Prototypes and composite descriptions). Several studies support the reliability and validity of the SWAP-200 in the diagnosis of PDs. For example, Shedler and Westen (1998), in a study using an earlier version of the SWAP-200, and Shedler and Westen (1999a) demonstrated strong evidence for convergent and discriminant validity.

RESULTS

The DPD composite description demonstrated statistically significant correlations of small magnitude with DSM-IV DPD diagnosis ($r = 0.26$; $p = 0.02$), with the IIP AS Scale ($r = 0.23$; $p = 0.03$), and with 2 of the AS Octant Scales: Overly Accommodating ($r = 0.24$; $p = 0.03$) and Self-Sacrificing ($r = 0.24$; $p = 0.03$) (as shown in Table 3). In other words, the greater patients' SWAP-200 profiles resembled the DPD composite description, the more likely these patients would be rated by clinician observers as having DPD and the more likely the patients were to self-report a characteristic relational style that was Affiliative/Submissive, Overly-

TABLE 3. Relationship of SWAP Dependent Personality Disorder Scales With DSM-IV Dependent Personality Disorder and IIP Circumplex Scales (*N* = 85)

	SWAP DPD Clinical Prototype	SWAP DPD Composite Description
DSM-IV dependent dx	<i>r</i> = 0.31 <i>p</i> = 0.004	<i>r</i> = 0.26 <i>p</i> = 0.02
Affiliative/Submissive	<i>r</i> = 0.37 <i>p</i> < 0.0001	<i>r</i> = 0.23 <i>p</i> = 0.03
Nonassertive	<i>r</i> = 0.34 <i>p</i> = 0.001	<i>r</i> = 0.11 <i>p</i> = 0.30
Overly-accommodating	<i>r</i> = 0.39 <i>p</i> < 0.0001	<i>r</i> = 0.24 <i>p</i> = 0.03
Self-sacrificing	<i>r</i> = 0.20 <i>p</i> = 0.07	<i>r</i> = 0.24 <i>p</i> = 0.03

Accommodating, and Self-Sacrificing. The correlation between the DPD composite description and the AS Octant Scale Non-Assertive was small in magnitude and not significant (*r* = 0.11; *p* = 0.30).

The DPD Clinical Prototype was significantly correlated with DSM-IV DPD diagnosis (*r* = 0.31; *p* = 0.004). This suggests that the more patients resembled the prototypical-dependent personality, the more likely clinician observers were to diagnose them as having DPD. The DPD Clinical Prototype also correlated moderately with the IIP AS Scale (*r* = 0.37; *p* < 0.0001) and 2 of the AS Octant Scales: Non-Assertive (*r* = 0.34; *p* = 0.001) and Overly-Accommodating (*r* = 0.39; *p* < 0.0001) suggesting that the more strongly patients resembled the prototypical dependent personality, the more they described themselves as having a relational style that was characteristically Affiliative/Submissive, Nonassertive, and Overly-Accommodating.

DISCUSSION

The results of the present study have both diagnostic and clinical relevance for working with patients suffering from DPD. The significant, positive correlations between the SWAP DPD Clinical Prototype and the IIP Affiliative-Submissive (AS) Quadrant and Overly Accommodating Octant scales suggest that the more a patient resembles the prototypic DPD patient, the more likely she is to describe herself as experiencing problems in her relationships stemming from being Overly Accommodating and Affiliative/Submissive. Hence, we find that clinicians who hear their patients reporting relational episodes with significant others and the therapist in which their patients exhibit overly accommodating and AS behaviors are more likely to assess these patients as matching the theoretically based prototype of DPD using the SWAP-200. An additional significant correlation involving the DPD Clinical Prototype was the relationship with the Non-Assertive AS Octant scale; this provides converging evidence that patients who report problematic interpersonal episodes resulting from nonassertiveness are more likely to be seen as matching the prototypic SWAP-200 DPD patient personality profile. Likewise, a moderate relationship was found between the DPD Clinical Prototype and the clinician-rated, DSM-IV diagnosis of DPD, suggesting that the more an individual patient's personality profile matched what is considered to be the prototypic SWAP-200 DPD patient, the more likely an external rater (unaware of that patient's SWAP profile) diagnosed that patient as having DPD according to DSM-IV criteria. This finding may reflect the moderate confluence of DSM criteria for DPD and clinicians' SWAP-200 prototype ratings of DPD.

Consistent with recent findings regarding the interpersonal dynamics of dependency and DPD, the statistically significant correlation of the SWAP-200 DPD composite description with the IIP Affiliative/Submissive (AS) quadrant scale suggests that the more a patient resembles an aggregated personality profile of actual patients, the more likely that patient will have reported experiencing problems in her relationships due to an over-reliance on AS behaviors with others (see Bornstein, 2005, for a review of studies documenting submissive and affiliative self-presentation styles in dependent patients). Likewise, the significant correlations found between the DPD composite description and the IIP Overly Accommodating and Self-Sacrificing octant scales suggest that the more a patient reports experiencing interpersonal problems stemming from being overly accommodating and self-sacrificing, the more that patient's SWAP-200 profile resembles the aggregated personality description of actual patients. Turning our attention back to the DPD Clinical Prototype, the significant correlations found between the DPD composite description and DPD Clinical Prototype with overly accommodating behaviors (IIP: Overly Accommodating Scale) suggest that both theoretical and clinical understandings of DPD should include this criterion as an essential feature of the disorder.

Thus, the present study adds to the understanding of specific DSM-IV criteria for DPD in several ways. The convergent validity of the SWAP-200 DPD Clinical Prototype and IIP Non-Assertive Scale may be viewed as consistent with DSM-IV criteria 2 (Needs others to assume responsibility for most major areas of his or her life), 3 (Has difficulty expressing disagreement with others because of fear of loss of support or approval), and 4 (Has difficulty initiating projects or doing things on his or her own). Likewise, the significant correlations between the SWAP-200 DPD composite description and IIP Self-Sacrificing Scale provide some support for the contribution of DSM-IV criterion 5 (Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant).

Lastly, both the DPD composite description and Clinical Prototype demonstrated statistically significant correlations with clinician-rated DSM-IV diagnoses of DPD: The more a patient resembled either the SWAP-200 hypothetical, prototypic DPD patient or aggregate personality descriptions of actual patient profiles for DPD, the more likely the patient was to be diagnosed categorically (presence or absence) as having DPD by an independent clinical rater. Because these correlations range from small to medium in size as indicated by the guidelines of Cohen (1988, i.e. *r* > 0.30), they suggest a modicum of overlap, though not a redundancy in underlying constructs.

Examining the coefficient of determination (*r*²), which indicates the amount of variance explained, makes this point even clearer: The DSM-IV criteria for DPD accounted for only 7% and 10% of the variance explained by the SWAP-200 DPD composite description and Clinical Prototype, respectively. This makes sense after one examines the most heavily loaded items for the SWAP-200 composite description and Clinical Prototype as compared with DSM-IV characterization of DPD. For example, DSM-IV criterion 7 (Urgently seeks another relationship as a source of care and support when a close relationship ends) was a description not found to load highly on either the DPD composite description or Clinical Prototype. Additionally, both the SWAP DPD Clinical Prototype and composite description describe the dependent patient as needing others to help soothe and regulate affect. Although DSM criterion 6 includes fear of being unable to take care of oneself, it does not include any mention of a possible difficulty in self-regulation of affect. Such findings suggest that the SWAP-200 describes a broader dependent personality syndrome recognized theoretically (DPD Clinical Prototype) and clinically (DPD composite description) by

most experienced clinicians, that may help extend and enhance current DSM-IV diagnostic criteria for DPD.

Our results concerning the relationship between the DPD Clinical Prototype and DSM DPD can be compared with prior research for reasons of contextualization. Shedler and Westen (1999b) found a significant correlation ($r = 0.49$) between DSM DPD diagnosis and the extent to which a patient's SWAP-200 description matched DPD diagnostic prototype (Clinical Prototype). The difference in the strength of the 2 studies' findings could be attributable to the method of assessment concerning DSM DPD: Shedler and Westen (1999b) used a 7-point scale assessing the extent to which a subject met criteria for DSM DPD diagnosis, while in the present study a categorical basis was used. It is of note that both methods of assessment produced significant results consistent with a priori predictions.

The discrepancies of nonsignificant and significant findings between the DPD composite description and Clinical Prototype with IIP Octant scales are also worth examining. A significant correlation was found between the IIP Non-Assertive Scale and the DPD Clinical Prototype ($r = 0.34, p < 0.001$), but not with the DPD composite description ($r = 0.11, p < 0.30$). This result supports recent findings with regard to the level of nonassertiveness or passivity exhibited in DPD. As top-down, theoretically derived conceptualizations of DPD (i.e., the SWAP DPD Clinical Prototype) continue to describe dependent patients as globally nonassertive, empirical evidence argues against such conclusions: both Bornstein (1995) and Pincus and Wilson (2001) have demonstrated the exhibition of assertion, even aggression, by the dependent patient when emotionally significant relationships are threatened.

Overall, the present study is generally supportive of the validity of the SWAP-200 DPD Clinical Prototype and DPD composite description aggregate PD descriptions. One limitation of note is the mild to moderate range of pathology in the present sample, although these pathology levels are consistent with those observed in many university-based community outpatient samples. Clearly further research is needed before applying the findings to more severe patient populations. In addition, because IIP-64 data are based on patient self-reports, the degree to which these patient-generated descriptions reflect actual behavior exhibited in vivo remains unaddressed (discussions of this issue are mentioned in Bornstein, 2003; 2005).

Another potential objection to the validity of the findings could be the nonblindness of some SWAP-200 raters to the results of subjects' IIP T-scores. Although at first glance this methodological limitation may be concerning, we believe its impact on the results is negligible for several reasons. First, the IIP produces 8 T-scores reflecting the degree to which a particular subject's self-report of interpersonal psychological distress matches each of the 8 factors, also referred to by the IIP authors as "problem areas." Thus, the IIP is a unidirectional measure in that it only assesses the degree to which a subject is distressed by their interpersonal patterns. Unlike the SWAP-200, the IIP does not assess adaptive interpersonal behaviors, adaptive use of coping strategies, or adaptive cognitive styles that could contraindicate a high T-score on one of the 8 IIP scales. Additionally, if the IIP T-scores significantly impacted the SWAP descriptions, we would anticipate a much larger correlation between the SWAP composite description and Clinical Prototype with the IIP scales when compared with the blind, independently rated DSM DPD diagnoses. Yet, this was not the case. Lastly, the SWAP-200 is scored by the clinician on average 2 to 3 weeks after any likely exposure to the IIP results. It would seem unlikely that after such a time, these clinician-raters could remember the distribution of a subject's 8 IIP scores to the extent that it would significantly impact their ratings on the SWAP-200 and across the

sorting of 200 individual items, especially for the psychologically adaptive SWAP-200 items.

Another potential objection revolves around the method of assessment for DSM DPD diagnosis. The current model for classifying PDs in Axis II is polythetic (Beckner, 1959; Davis et al., 1993), in that all cases that surpass the designated threshold for number of criteria met for a specific disorder, regardless of the specific criteria, are considered representative of the disorder. Using this system, a diagnosis of DPD may be given to any one of 56 combinations of DPD criteria that surpass the threshold. In other words, there are many different "ways of having DPD." Because data from the present study were drawn from a larger, ongoing project, constraints were placed on the choice of measures (e.g., clinician raters had assessed DSM DPD on a categorical, presence or absence basis). It is possible that because the SWAP-200 items do not share all the criteria with DSM DPD, the differing combinations of criteria existent within our diagnoses of DPD may have influenced further the correlations between these 2 variables. Future research may consider examining the relationships between individual DSM DPD criteria and SWAP DPD Clinical Prototype and composite description items. This may help to increase the external validity of specific DSM DPD criteria. These methodological limitations notwithstanding, the multimethod approach used in this study, combined with the ecologically valid sampling procedure, demonstrates general support of the SWAP-200 DPD Composite Description and DPD Clinical Prototype using a naturalistic patient population.

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