PSYCHODYNAMIC PSYCHOTHERAPY
for Personality Disorders

A CLINICAL HANDBOOK

Edited by

John F. Clarkin, Ph.D.

Peter Fonagy, Ph.D., F.B.A.

Glen O. Gabbard, M.D.

The Shedler-Westen Assessment Procedure

Making Personality Diagnosis Clinically Meaningful

Jonathan Shedler, Ph.D.
Drew Westen, Ph.D.

One of the greatest challenges facing psychiatry and psychology is the growing schism between science and practice. The schism is especially pronounced in conceptualizing and assessing personality. For most clinical practitioners, personality diagnosis is a task requiring

---

This chapter is adapted, with permission, from previously published material: Shedler J, Westen D: "Personality Diagnosis With the Shedler-Westen Assessment Procedure (SWAP): Bridging the Gulf Between Science and Practice," in *Psychodynamic Diagnostic Manual (PDM).* Edited by PDM Task Force. Silver Spring, MD, Alliance of Psychoanalytic Organizations, 2006, pp. 17–69; Shedler J, Westen D: "The Shedler-Westen Assessment Procedure (SWAP): Making Personality Diagnosis Clinically Meaningful." *Journal of Personality Assessment* 89:41–55, 2007.

judgment and expertise. Expert clinicians consider a wide range of psychological data, attending not only to *what* patients say but also to *how* they say it, and drawing complexly determined inferences from patients' accounts of their lives and relationships, from their manner of interacting with the clinician, and from their own emotional reactions to the patient (Westen and Arkowitz-Westen 1998).

For example, clinicians tend *not* to assess lack of empathy, a diagnostic criterion for narcissistic personality disorder, by administering self-report questionnaires or asking patients direct questions (Westen 1997). Not only are narcissistic patients unlikely to report their own lack of empathy, they may well describe themselves as caring people and wonderful friends. An initial sign of lack of empathy on the part of the patient is often a subtle sense on the part of the clinician of being interchangeable or replaceable—of being treated as a sounding board rather than as a fellow human being (for empirical evidence, see Betan et al. 2005; for clinical discussions, see Kernberg 1975; McWilliams 1994). The clinician might go on to consider whether she consistently feels this way with this particular patient and whether such feelings are characteristic for her in her role as therapist. She might then become aware that the patient tends to describe others more in terms of the functions they serve or the needs they fulfill than in terms of who they are as people. She might further consider whether and how these issues dovetail with the facts the patient has provided about his life, with the problems that led him to treatment, with information gleaned from family members or other collateral contacts, and so on. This type of thinking, reasoning, and inference lies at the heart of psychodynamic approaches to understanding people.

It is just such clinical judgment and inference that many researchers eschew. As successive editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) have minimized the role of clinical inference, investigators have increasingly treated personality diagnosis as a technical task of tabulating signs and symptoms, with relatively little consideration for how the signs and symptoms fit together, the psychological functions they serve, their meanings, the developmental trajectory that gave rise to them, or the present-day factors that serve to maintain them. Indeed, the diagnostic "gold standard" in personality disorder (PD) research is the structured interview. Such assessment methods are designed to achieve interrater reliability by minimizing the role of clinical judgment and substituting standardized questions and decision rules. Indeed, the interviews are typically administered by research assistants or trainees, not by experienced clinicians.

DSM and structured assessment procedures evolved as they did for good reason. Prior to DSM-III (American Psychiatric Association 1980), psychiatric diagnosis was unsystematic, overly subjective, and of questionable scientific merit. It sometimes revealed more about the clinician's background and theoretical predilections than it did about the patient's personality dispositions. Structured assessment methods evolved in the service of science and in reaction against the unsystematic diagnostic methods of the past. In the evolution of personality diagnosis from a largely subjective, clinical enterprise to a largely technical, research-driven enterprise, much has been gained and much has been lost. The solution to the science–practice schism cannot be to turn back the clock and abandon the scientific advances of the past decades. Nor can it be to disregard the cumulative insights of generations of clinical observers. The solution, rather, may be a marriage of the best aspects of clinical observation and empirical rigor.

This chapter describes the Shedler-Westen Assessment Procedure (SWAP), an approach to personality assessment designed to *harness* clinical judgment and inference rather than eliminate it, and to combine the best features of the clinical and empirical traditions. It provides a means of assessing personality that is both clinically relevant and empirically rigorous.

In this chapter we 1) review problems with the DSM diagnostic system for personality disorders, 2) discuss the challenges of using clinical observation and inference in research, 3) describe the development of the SWAP as a method for systematizing clinical observation and insight, 4) illustrate its use for diagnosis and clinical case conceptualization, 5) review evidence for reliability and validity, and 6) discuss recommendations for revising Axis II for DSM-5.

Why Revise Axis II?

The approach to PD diagnosis codified by DSM now finds little favor with either clinicians or researchers. There is consensus that DSM Axis II requires reconfiguration (Skodol and Bender 2009). Problems with Axis II include the following (see also Clark 1992; Grove and Tellegen 1991; Jackson and Livesley 1995; Livesley 1995; Livesley and Jackson 1992; Westen and Shedler 1999a, 2000; Widiger and Frances 1985):

1. The diagnostic categories do not rest on a sound empirical foundation and often disagree with findings from cluster and factor analyses (Blais and Norman 1997; Clark 1992; Harkness 1992; Livesley and Jackson 1992; Morey 1988).

2. Axis II commits arbitrarily to a categorical diagnostic system. For example, it may be more useful to conceptualize borderline pathology on a continuum from none through moderate to severe, rather than as present or absent. This same consideration applies to individual diagnostic criteria. For example, just how little empathy constitutes "lack of empathy"?

3. Axis II lacks the capacity to weight criteria that differ in diagnostic importance (Davis et al. 1993).

4. Comorbidity between PD diagnoses is unacceptably high. Patients who meet criteria for any PD often meet criteria for four to six PDs (Blais and Norman 1997; Grilo et al. 2002; Oldham et al. 1992; Pilkonis et al. 1995; Watson and Sinha 1998). This suggests lack of discriminant validity of the diagnostic constructs, the assessment methods, or both.

5. In attempting to reduce comorbidity, DSM work groups have gerrymandered diagnostic categories and criteria, sometimes in ways faithful neither to clinical observation nor to empirical data. For example, they excluded lack of empathy and grandiosity from the diagnostic criteria for antisocial PD to minimize comorbidity with narcissistic PD, even though the traits apply to *both* PDs (Westen and Shedler 1999a, 1999b; Widiger and Corbitt 1995).

6. Efforts to define PDs more precisely have led to narrower criterion sets over time, progressively eroding the distinction between personality *disorders* (multifaceted syndromes encompassing cognition, affectivity, motivation, interpersonal functioning, and so on) and simple personality *traits*. The diagnostic criteria for paranoid PD, for example, are essentially redundant indicators of one trait, chronic suspiciousness. The diagnostic criteria no longer describe the multifaceted personality syndrome recognized by most experienced clinicians (Millon 1990; Millon and Davis 1997).

7. Axis II does not consider personality strengths that might rule out PD diagnoses for some patients. For example, differentiating between a patient with narcissistic PD and a much healthier person with narcissistic personality dynamics may not be a matter of counting symptoms, but of noting whether the patient has such positive qualities as the capacity to love and sustain meaningful relationships characterized by mutual caring and understanding.

8. Axis II does not encompass the spectrum of personality pathology that clinicians see in practice. Among patients receiving treatment for personality pathology, fewer than 40% can be diagnosed on Axis II (Westen and Arkowitz-Westen 1998).

9. Axis II diagnoses are not as clinically useful as they might be. For example, knowing whether a patient meets criteria for avoidant PD or dependent PD tells us little about the function of the person's symptoms, the personality processes to target for treatment, or how to treat them.

10. The algorithm used for diagnostic decisions (symptom counting) diverges from the methods clinicians use—or could plausibly be expected to use—in real-world practice. Cognitive research suggests that clinicians do *not* make diagnoses by tabulating symptoms. Rather, they gauge the overall "match" between a patient and a cognitive template or prototype of the disorder (i.e., they consider the features of a disorder as a configuration or gestalt), or they apply causal theories that make sense of the interrelations between symptoms (Blashfield 1985; Cantor and Genero 1986; Kim and Ahn 2002; Westen et al. 2002).

11. PD assessment instruments do not meet standards for reliability and validity normally expected in psychological research. Questionnaires and structured interviews show relatively weak convergence with one another and with the LEAD (longitudinal evaluation using all available data) standard (Perry 1992; Pilkonis et al. 1995; Skodol et al. 1991; Spitzer 1983; Westen 1997). They also show poor test-retest reliability at intervals greater than 6 weeks (First et al. 1995; Zimmerman 1994). Poor test-retest reliability is especially problematic given that PDs are by definition enduring and stable over time.[1]

Most of the proposed solutions to these problems share the assumption that progress lies in further minimizing the role of the clinician, either by developing increasingly behavioral and less inferential diagnostic criteria or by bypassing the clinician altogether through the use of

---

[1]Poor test-retest reliability has led some researchers to suggest that PDs are less stable than previously believed. Such an interpretation of the data seems inconsistent with the observations of virtually all clinical theorists. A more viable hypothesis may be that the assessment instruments do not capture core features of personality that are salient to clinicians who treat patients with PDs and know them well. Specifically, the instruments may overemphasize transient behavioral symptoms (e.g., self-cutting and suicidality in borderline patients, which may emerge only when an attachment relationship is threatened) and underemphasize underlying personality processes that endure over time (such as affect dysregulation and feelings of emptiness and self-loathing in borderline patients) (cf. Zanarini et al. 2000).

self-report instruments. These attempted solutions may, however, be part of the problem. By eliminating clinical observation and inference, we may inadvertently be eliminating crucial psychological phenomena from consideration (Cousineau and Shedler 2006; Shedler et al. 1993). An alternative to eliminating clinical inference is to harness it for scientific use.

The Challenge of Clinical Data

The problem with clinical observation and inference is not that it is inherently unreliable, as some researchers have assumed (for a discussion and literature review, see Westen and Weinberger 2004). The problem is that it tends to come in a form that is difficult to study systematically. Rulers measure in inches and scales measure in pounds, but what metric do psychotherapists share? Imagine three clinicians, all psychodynamically oriented, reviewing the same case material. One might speak of conflict and compromise formation, another of projected and introjected self and object representations, and the third, perhaps, of self defects and fragmentation. It is not readily apparent whether the hypothetical clinicians can or cannot make the same observations. There are three possibilities: 1) they may be observing the same thing but using different language and metaphor systems to describe it; 2) they may be attending to different aspects of the clinical material, as in the parable of the elephant and the blind men; and 3) they may not be able to make the same observations at all. To determine whether clinicians can make the same observations and inferences, we must ensure that they speak the same language and attend to the same spectrum of clinical phenomena.

A Standard Vocabulary for Case Description

The SWAP is an assessment instrument designed to provide clinicians of all theoretical orientations with a standard vocabulary for case description (Shedler and Westen 1998, 2004a, 2004b; Westen and Shedler 1999a, 1999b). The "vocabulary" consists of 200 statements, each of which may describe a given patient very well, somewhat, or not at all. The clinician describes a patient by ranking or ordering the statements into eight categories, from those that are most descriptive (assigned a value of 7) to those that are not descriptive (assigned a value of 0). Thus, the SWAP yields a score ranging from 0 to 7 for each of 200 personality-descriptive variables. (The SWAP instrument is available online at www.SWAPassessment.org.)

The "standard vocabulary" of the SWAP allows clinicians to provide in-depth psychological descriptions of patients in a systematic and quantifiable form and ensures that all clinicians attend to the same spectrum of clinical phenomena (cf. Block 1961/1978). SWAP statements are written in a manner close to the data (e.g., "Tends to get into power struggles" or "Is capable of sustaining meaningful relationships characterized by genuine intimacy and caring"), and statements that require inference about internal processes are written in clear, unambiguous language (e.g., "Tends to see own unacceptable feelings or impulses in other people instead of in him/herself"). Writing items in this jargon-free manner minimizes unreliable interpretive leaps and makes the item set useful to clinicians of all theoretical perspectives.

The SWAP is based on the Q-Sort method, which requires clinicians to assign each score a specified number of times (i.e., there is a "fixed distribution" of scores). The SWAP distribution is asymmetric, with many items receiving scores of 0 (not descriptive) and progressively fewer items receiving higher scores. The use of a fixed distribution has psychometric advantages and eliminates much of the measurement error or "noise" inherent in standard rating scales.[2] The method maximizes the opportunity to observe statistical relations where they exist but does not, as some incorrectly believe, artifactually inflate reliability or validity coefficients. Block (1961/1978) described the psychometric rationale for the Q-Sort method in detail; his psychometric conclusions remain unchallenged, and we refer the interested reader to his classic text.

The SWAP item set was drawn from a wide range of sources, including the clinical literature on PDs written over the past 50 years (e.g., Kernberg 1975, 1984; Kohut 1971; Linehan 1993); Axis II diagnostic criteria included in DSM-III through DSM-IV (American Psychiatric Association 1994); selected DSM Axis I items that could reflect aspects of personality (e.g., depression and anxiety); research on coping, defense, and affect-regulatory mechanisms (e.g., Perry and Cooper 1987; Shedler

---

[2] One way it does so is by ensuring that raters are "calibrated" with one another. Consider the situation with rating scales, in which raters can use any value as often as they wish. Inevitably, certain raters will tend toward extreme values (e.g., values of 0 and 7 on a 0–7 scale), and others will tend toward middle values (e.g., values of 4 and 5). Thus, the scores reflect not only the characteristics of the patients but also the calibration of the raters. The Q-Sort method, with its fixed distribution, eliminates this kind of measurement error, because all clinicians must assign each score the same number of times. If use of a standard item set gives clinicians a common vocabulary, use of a fixed distribution can be said to give them a "common grammar" (Block 1961/1978).

et al. 1993; Vaillant 1992; Westen et al. 1997); research on interpersonal pathology in patients with PDs (Westen 1991; Westen et al. 1990); research on personality traits in nonclinical populations (e.g., Block 1971; John 1990; McCrae and Costa 1990); research on PDs conducted since the development of Axis II (see Livesley 1995); pilot interviews in which observers watched videotaped interviews of patients with PDs and, using earlier versions of the item set, described the patients; and the clinical experience of the authors.

Most important, the SWAP-200 (the first major edition of the SWAP item set) was the product of a 7-year iterative item revision process that incorporated the feedback of hundreds of clinician-consultants who used earlier versions of the instrument (Shedler and Westen 1998) to describe their patients. We asked each clinician-consultant one crucial question: "Were you able to describe the things you consider psychologically important about your patient?" We added, rewrote, and revised items based on this feedback, then asked new clinician-consultants to describe new patients. We repeated this process over many iterations until most clinicians could answer "yes" most of the time. A new, revised version of the SWAP item set, the SWAP-II, incorporates the additional feedback of more than 2,000 clinicians of all theoretical orientations (Westen and Shedler 2007a). The iterative item revision process was designed to ensure the comprehensiveness and clinical relevance of the SWAP item set.

Because the SWAP is jargon free and clinically comprehensive, it has the potential to serve as a language for describing personality pathology that can be used by any skilled clinical observer. Our studies demonstrate that experienced clinicians of all theoretical orientations understand the items and score them reliably. In one study, a nationwide sample of 797 experienced psychologists and psychiatrists of diverse theoretical orientations, who had an average of 18 years' practice experience post training, used the SWAP-200 to describe patients with personality pathology (Westen and Shedler 1999a). These experienced clinicians provided similar SWAP-200 descriptions of patients with specific PDs regardless of their theoretical commitments, and fully 72.7% agreed with the statement "I was able to express most of the things I consider important about this patient" (the highest rating category). In a subsequent sample of 1,201 psychologists and psychiatrists who used the SWAP-II, 84% "agreed" or "strongly agreed" with the statement "The SWAP-II allowed me to express the things I consider important about my patient's personality" (fewer than 5% disagreed). Again, the ratings were unrelated to clinicians' theoretical orientation. Virtually

identical findings were obtained in a national sample of 950 clinicians who used the adolescent version of the instrument, the SWAP-II-A. We are unaware of other personality item sets that have been evaluated in this manner for *clinical* relevance and comprehensiveness.

Clinicians using the SWAP for the first time can complete the scoring procedure in 30–45 minutes. Clinicians familiar with the SWAP may be able to complete the procedure in 20 minutes or less. The SWAP can be scored after six or more clinical contact hours with a patient (the lower limit we specify in our research protocols). Additionally, we have developed a systematic interview, the Clinical Diagnostic Interview (Westen 2002; Westen and Weinberger 2004), that can be administered in approximately 2½ hours and yields sufficient patient information to score the SWAP reliably and validly. The interview can be used in either clinical or research settings and is designed to mirror but systematize the kind of interviewing approach used by experienced clinicians of all theoretical orientations to assess personality (Westen 1997).

Psychodynamics Without Jargon

Some investigators have assumed that clinical concepts, especially psychodynamic constructs, are too vague, theoretical, or hypothetical to study empirically. The following SWAP-II items illustrate how the instrument operationalizes some psychodynamic concepts (focusing, for purposes of illustration, on defenses). Note that the constructs—rinsed of theoretical jargon—are relevant to a wide range of clinicians, irrespective of theoretical commitments. Traditional psychoanalytic terms for the concepts (which are not part of the SWAP items) are indicated in brackets:

SWAP item #	SWAP item
116	Tends to see own unacceptable feelings or impulses in other people instead of in him/herself. [projection]
144	Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential. [intellectualization]
78	Tends to express anger in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.). [passive aggression]

(continues)

SWAP item #	SWAP item
14	Tends to blame own failures or shortcomings on other people or circumstances; attributes his/her difficulties to external factors rather than accepting responsibility for own conduct or choices. [externalization]
45	Is prone to idealizing people; may see admired others as perfect, larger than life, all wise, etc. [idealization]
165	Tends to distort unacceptable wishes or feelings by transforming them into their opposite (e.g., may express excessive concern while showing signs of unacknowledged hostility, disgust about sexual matters while showing signs of unacknowledged excitement, etc.). [reaction formation]
9	When upset, has trouble perceiving both positive and negative qualities in the same person at the same time (e.g., may see others in black or white terms, shift suddenly from seeing someone as caring to seeing him/her as malevolent and intentionally hurtful, etc.). [splitting]

Capturing Clinical Nuance

Just as researchers tend to be skeptical regarding the scientific useful-ness of clinical observation, many clinicians express skepticism that a structured assessment instrument can do justice to the richness and complexity of clinical case description. However, SWAP statements can be combined in patterns to capture a wide range of subtle clinical phe-nomena and convey meanings that transcend the content of the individ-ual items.

Consider, for example, the SWAP-II item "Tends to be sexually se-ductive or provocative." If a patient receives a high score on this item along with high scores on the items "Has an exaggerated sense of self-importance (e.g., feels special, superior, grand, or envied)" and "Seems to treat others primarily as an audience to witness own importance, bril-liance, beauty, etc.," the portrait that begins to emerge is one of a nar-cissistically organized individual who seeks sexual attention to bolster a sense of being special and uniquely desirable. If the same patient also re-ceives high scores on the items "Tends to feel s/he is not his/her true self with others; may feel false or fraudulent" and "Tends to feel s/he is inadequate, inferior, or a failure," then a more complex psychological portrait begins to emerge. The SWAP items in combination indicate that feelings of grandiosity and inadequacy coexist in the same person, and suggest the hypothesis that grandiosity may serve the function of mask-ing painful feelings of inadequacy. Indeed, this duality may lie at the

very heart of narcissistic PD for many patients (for empirical evidence, see Russ et al. 2008). The ability to describe and quantify psychological conflict and contradiction is a key feature of the SWAP, one that distinguishes it from other dimensional models (which assume that a person can be high or low on a trait, but not both).

If the SWAP-II item describing sexual seductiveness is instead combined with the items "Tends to fear s/he will be rejected or abandoned," "Appears to fear being alone; may go to great lengths to avoid being alone," and "Tends to be ingratiating or submissive (e.g., consents to things s/he does not want to do, in the hope of getting support or approval)," the portrait that begins to emerge is one of a dependent individual who relies on sexuality as a desperate means of maintaining attachments in the face of feared abandonment.

If the SWAP-II item describing sexual seductiveness is combined with the items "Tends to act impulsively (e.g., acts without forethought or concern for consequences)," "Takes advantage of others; has little investment in moral values (e.g., puts own needs first, uses or exploits people with little regard for their feelings or welfare, etc.)," and "Experiences little or no remorse for harm or injury caused to others," the portrait that begins to emerge is one of an antisocial individual who exploits others sexually and whose primary concern is gratifying immediate needs.

If the item describing sexual seductiveness is combined with the items "Has a deep sense of inner badness; sees self as damaged, evil, or rotten to the core" and "Appears to want to 'punish' self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification," we could plausibly infer that sexuality plays a role in a larger pattern of self-devaluation and self-abasement (such a person might well become the victim of the antisocial individual described above).

These brief examples illustrate how SWAP items can be combined to communicate subtle clinical concepts, and how the same item can convey different meanings depending on the items that surround and contextualize it. We will further illustrate this in a later section with a clinical case example.

Treatment Implications

DSM diagnostic criteria are largely descriptive, providing little guidance for clinicians trying to understand the meaning and function of the symptoms or how to intervene. For example, DSM tells us that borderline patients are characterized by "a pattern of unstable and intense

interpersonal relationships." The statement may be descriptively accurate, but *why* does the patient have unstable relationships and how can the clinician help? Because the SWAP addresses underlying personality processes that give rise to these characteristics, it suggests some answers.

Consider the following personality process (item 9 in the SWAP-II):

> When upset, has trouble perceiving both positive and negative qualities in the same person at the same time (e.g., may see others in black or white terms, shift suddenly from seeing someone as caring to seeing him/her as malevolent and intentionally hurtful, etc.).

The item describes the phenomenon known to psychodynamic clinicians as *splitting* and to cognitive-behavioral clinicians as *dichotomous thinking.* If the patient's perceptions of others gyrate between contradictory extremes, it follows that his relationships will be unstable. This implies a specific treatment strategy: the therapist will intervene effectively if he can help the patient recognize the extremes of thinking and perceive others in a more balanced light. For example, the therapist may observe, "When you are angry with your partner, it is hard to keep in mind that there is anything you like about him. When you are feeling close, it seems hard for you to recognize that he has flaws." Such interventions are designed to develop the patient's capacity to integrate contradictory perceptions and perceive self and others in more complex, modulated, and balanced ways. A recent clinical trial has demonstrated the efficacy of a treatment for borderline PD based on just this type of intervention (Clarkin et al. 2007; Levy et al. 2006).

DSM also tells us that borderline patients may have "transient, stress-related paranoid ideation" but leaves us in the dark about why this occurs or how to intervene. Suppose the patient has high scores on the following SWAP-II items: "Is prone to intense anger, out of proportion to the situation at hand" (item 185) and "Tends to see own unacceptable feelings or impulses in other people instead of in him/herself" (item 116). The items, considered in combination, suggest a hypothesis about the meaning and function of paranoid ideation: the patient may become paranoid (i.e., see the world as dangerous and hostile) because, in times of intense agitation, he sees his own hostility wherever he looks. (Empirically, these items *do* emerge in combination for paranoid patients; see section "Toward DSM-5: An Improved Classification of Personality Disorders" later in this chapter). The treatment implications are clear: the therapist must help the patient to recognize his own aggression and develop more adaptive ways of regulating it.

SWAP Dimensional Diagnosis

The SWAP scoring algorithms generate a dimensional score for each PD included in DSM-IV (as well as for factor-analytically derived traits, and for an alternative set of diagnostic syndromes that we identified empirically; see section "Toward DSM-5: An Improved Classification of Personality Disorders"). Additionally, the SWAP generates richly detailed narrative case descriptions relevant to clinical case conceptualization and treatment planning.

Dimensional PD scores measure the similarity or "match" between a patient and *prototype* SWAP descriptions representing each personality syndrome in its typical or "ideal" form (e.g., a prototypical patient with paranoid PD). Dimensional PD scores can be expressed as T-scores and graphed to create a PD score profile resembling a Minnesota Multiphasic Personality Inventory profile, as shown in Figure 4–1 (see p. 138). Thus, each personality syndrome is assessed on a continuum rather than diagnosed categorically as present or absent. Low PD scores indicate that the patient does not resemble or match the PD prototype, and high scores indicate that the patient matches it well, with intermediate scores indicating varying degrees of resemblance (for descriptions of the PD prototypes and scale construction methods, see Shedler and Westen 2004b; Westen and Shedler 1999a, 1999b).

Note that this dimensional approach preserves a *syndromal* understanding of personality styles and disorders. That is, it treats personality as a *configuration of functionally interrelated psychological processes* encompassing affectivity, cognition, motivation, interpersonal functioning, coping strategies and defenses, and so on. By *functionally related,* we mean that the personality processes are interdependent and have causal relations to one another. (For example, in the example of paranoid ideation given above, intense anger and the propensity to project unacceptable feelings onto others are functionally related.) The approach does not deconstruct personality configurations into separate trait dimensions such as those derived from factor analysis of questionnaire data (the approach taken by, e.g., the Five Factor Model).

A syndromal approach is consistent with research showing that clinicians view psychopathology in terms of functionally interrelated psychological processes (just as human judgment about category membership more generally relies on implicit causal theories linking component parts into coherent gestalts [Kim and Ahn 2002]). It is also consistent with empirical and conceptual recognitions that personality syndromes fall on continua from relatively healthy through severely disturbed (e.g., from neurotic through borderline). For example, a rela-

tively healthy person with an obsessional personality style might be precise, orderly, logical, more comfortable with ideas than feelings, a bit more concerned than most with issues of authority and control, and somewhat rigid in certain areas of thought and behavior. Such a person may excel in fields where such attributes are adaptive, such as finance, engineering, or, perhaps, the development of dimensional diagnostic systems. Toward the more disturbed end of the obsessional spectrum, we find individuals who are rigidly dogmatic, oblivious to affect, and preoccupied with control, and who misapply logic in ways that lead them to miss the forest for the trees.

Although we are emphasizing here the utility of a syndromal approach, we do not discount the utility of trait approaches derived from conventional factor analysis. Indeed, factor analysis of the SWAP has identified clinically and empirically coherent trait dimensions (Shedler and Westen 2004a; Westen et al. 2005; D. Westen, N. Waller, J. Shedler, and P. Blagov, unpublished manuscript, Emory University, 2010), some of which map readily onto trait dimensions included in other dimensional trait models (Widiger and Simonsen 2005) and some of which do not (e.g., thought disorder, sexual conflict). Both syndromal and trait approaches have advantages for different assessment purposes. A combined approach may well prove most informative—for example, by describing patients syndromally, then adding trait dimensions that are not redundant with the syndromes (e.g., hostility, thought disorder) to create fine-grained psychological portraits.
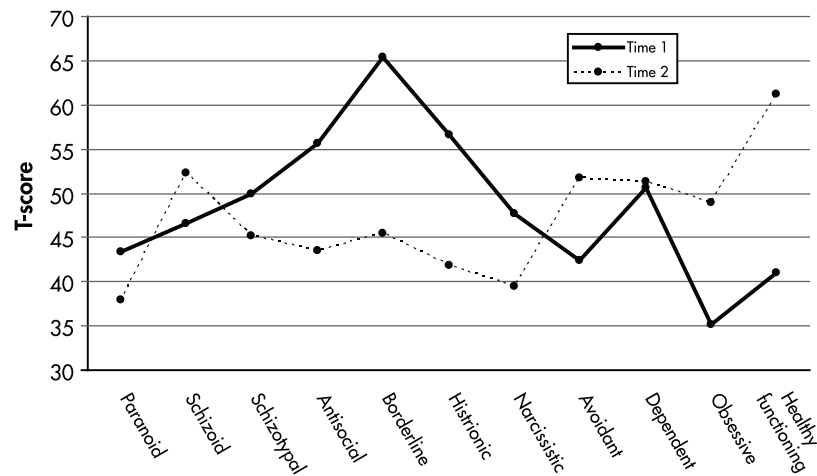

FIGURE 4–1.   Personality disorder score profile for "Melanie".

Case Illustration[3]

BACKGROUND

Melanie is a 30-year-old white woman with presenting complaints of substance abuse and inability to extricate herself from an emotionally and physically abusive relationship. Assessment with the Structured Clinical Interview for DSM-IV (SCID and SCID-II) yielded an Axis I diagnosis of substance abuse and an Axis II diagnosis of borderline PD with histrionic traits, with a Global Assessment of Functioning (GAF) score of 45.

Melanie's early family environment was marked by neglect and parental strife. A recurring family scenario is illustrative: the mother would scream at her husband, telling him he was a failure and that she was going to leave him; she would then slam the door and lock herself in her room, leaving Melanie frightened and in tears. Both parents would then ignore Melanie, often forgetting to feed her. By adolescence, Melanie was often skipping school, spending her days sleeping or wandering the streets. At age 18, she left home and began a "life on the streets," entering a series of impulsive and chaotic sexual relationships, abusing street drugs, and engaging in petty theft. In her mid-twenties, Melanie moved in with her boyfriend, a small-time drug dealer. Melanie periodically prostituted herself to obtain money or drugs for her boyfriend, who sometimes beat her when she did not bring home enough.

Melanie began psychoanalytic psychotherapy at a frequency of three sessions per week. The first 10 sessions were tape-recorded and transcribed. Two clinicians (blind to all other data) reviewed the transcripts and scored the SWAP-200 on the basis of the information contained in the transcripts. The SWAP-200 scores were then averaged across the two clinical judges to enhance reliability and obtain a single SWAP-200 description. After 2 years of psychotherapy, 10 consecutive psychotherapy sessions were again recorded and transcribed, and the SWAP assessment procedure was repeated.

PERSONALITY DISORDER DIAGNOSIS

The solid line in Figure 4–1 shows Melanie's PD scores at the beginning of treatment for the 10 PDs included in DSM-IV. A "healthy functioning"

---

[3]The material in this section is adapted from Lingiardi et al. 2006. Please see the original publication for a more complete description of the case, treatment methods, and findings.

index (rightmost data points) is graphed as well to reflect clinicians' consensual understanding of healthy personality functioning (Westen and Shedler 1999a). For ease of interpretation, the PD scores have been converted to T-scores based on norms established in a psychiatric sample of patients with Axis II diagnoses (Westen and Shedler 1999a).

Although the SWAP assesses PDs dimensionally and treats personality syndromes as continua, we have also established cutoff scores for "backward compatibility" with the categorical approach of DSM-IV. We have suggested T=60 as a threshold for making a categorical Axis II diagnosis, and T=55 as a threshold for diagnosing "features."[4]

Melanie's PD profile shows a marked elevation for borderline PD (T=65.4, approximately 1.5 standard deviations above the sample mean), with secondary elevations for histrionic PD (T=56.6) and antisocial PD (T=55.7). With application of the recommended cutoff scores, Melanie's DSM-IV Axis II diagnosis is borderline PD with histrionic and antisocial features. Also noteworthy is the T-score of 41 for the healthy functioning index, nearly a standard deviation below the mean in a reference sample of patients with Axis II diagnoses. The low score indicates significant impairment in functioning and parallels the low GAF score assigned at intake.

Narrative Case Description

We can generate a narrative case description by listing the SWAP items with the highest scores in the patient's SWAP description (e.g., items with scores of 5, 6, and 7). The narrative description below is based on the top 30 most descriptive SWAP-200 items. We have grouped together conceptually related items. To aid the flow of the text, we have made some minor grammatical changes and added some summary statements and connecting text (italicized). However, the SWAP-200 items are reproduced essentially verbatim.

Melanie experiences severe depression and dysphoria. She tends to feel unhappy, depressed, or despondent, appears to find little or no pleasure or satisfaction in life's activities, feels life is without meaning, and tends to feel like an outcast or outsider. She tends to feel guilty, and to feel inadequate, inferior, or like a failure. Her behavior is often self-defeating and

---

[4]The relatively low thresholds reflect the fact that the reference sample consisted of patients with PD diagnoses. Thus, a T-score of 50 indicates average functioning among patients with PD diagnoses, and a T-score of 60 represents an elevation of one standard deviation relative to other patients with PD diagnoses.

self-destructive. She appears inhibited about pursuing goals or successes, is insufficiently concerned with meeting her own needs, and seems not to feel entitled to get or ask for things she deserves. She appears to want to "punish" herself by creating situations that lead to unhappiness, or actively avoiding opportunities for pleasure and gratification. *Specific self-destructive tendencies include* getting drawn into and remaining in relationships in which she is emotionally or physically abused, abusing illicit drugs, and acting impulsively and without regard for consequences. She shows little concern for consequences in general.

Melanie shows many personality traits associated specifically with borderline PD. Her relationships are unstable, chaotic, and rapidly changing. She has little empathy and seems unable to understand or respond to others' needs and feelings unless they coincide with her own. Moreover, she tends to confuse her own thoughts, feelings, and personality traits with those of others, and she often acts in such a way as to elicit her own feelings in other people (for example, provoking anger when she herself is angry, or inducing anxiety in others when she herself is anxious).[5]

Melanie expresses contradictory feelings without being disturbed by the inconsistency, and she seems to have little need to reconcile or resolve contradictory ideas. She is prone to see certain others as "all bad," losing the capacity to perceive any positive qualities they may have. She lacks a stable image of who she is or would like to become (e.g., her attitudes, values, goals, and feelings about self are unstable and changing) and she tends to feel empty. *Affect regulation is poor:* She tends to become irrational when strong emotions are stirred up and shows a noticeable decline from her customary level of functioning. She also seems unable to soothe or comfort herself when distressed and requires the involvement of another person to help her regulate affect. Both her living arrangements and her work life tend to be chaotic and unstable.

Finally, Melanie's attitudes toward men and sexuality are problematic and conflictual. She tends to be hostile toward members of the opposite sex (whether consciously or unconsciously) and she associates sexual activity with danger (e.g., injury or punishment). She appears afraid of commitment to a long-term love relationship, instead choosing partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), or other factors.

The narrative provides a detailed psychological portrait of a severely troubled patient with borderline personality pathology. It captures psychodynamic processes characteristic of borderline personality

---

[5]Psychoanalytically informed readers will recognize these SWAP items as capturing aspects of borderline personality organization as conceptualized by Kernberg (1984) and his associates (see Chapter 1 of this volume).

(e.g., splitting, identity diffusion, projective identification) in plain, jargon-free language (cf. Schafer 1976). The description helps illustrate the difference between *descriptive psychiatry* (aimed at establishing a diagnosis) and *clinical case formulation* (aimed at understanding an individual person). In this instance, however, all findings are derived from the same quantitative assessment data.

Assessing Change in Psychotherapy

The case of Melanie has a happy ending. After 2 years of psychodynamic psychotherapy, the SWAP revealed significant personality changes. The dotted line in Figure 4–1 shows Melanie's PD scores after 2 years of treatment. Her scores on the borderline, histrionic, and antisocial dimensions had dropped below T=50, and she no longer warranted a DSM-IV PD diagnosis. Her score on the healthy functioning index had increased by two standard deviations, from 41.0 to 61.2. These personality changes paralleled concrete changes in Melanie's life circumstances, such as ending her drug abuse, getting and keeping a good job, ending her involvement with her abusive boyfriend, and no longer engaging in theft, promiscuous sex, or prostitution.

To assess change in an idiographic, more fine-grained manner, we created a change score for each SWAP item by subtracting the item score at Time 1 from the score at Time 2. The narrative description of change, below, comprises the SWAP items with change scores >4. Again, we have made some minor grammatical changes and added connecting text to aid the flow of the text (italicized), but the SWAP-200 items are reproduced essentially verbatim.

> *Melanie has developed strengths and inner resources that were not evident at the Time 1 assessment.* She has come to terms with painful experiences from the past, finding meaning in, and growing from, these experiences; she has become more articulate and better able to express herself in words; she has a newfound ability to appreciate and respond to humor; she is more capable of recognizing alternative viewpoints, even in matters that stir up strong feelings; she is more empathic and sensitive to others' needs and feelings; and she is more likeable.
>
> *There is marked improvement in many areas associated specifically with borderline psychopathology.* With respect to affect regulation, Melanie is less prone to become irrational when strong emotions are stirred up, is more likely to express affect appropriate in quality and intensity to the situation at hand, and is better able to soothe or comfort herself when distressed. She is less prone to confuse her own thoughts and feelings with those of others, less manipulative, and less likely to devalue others

and see them as "all bad." She has come to terms with negative feelings toward her parents.

Melanie is also less impulsive, more conscientious and responsible, and more aware of the consequences of her actions. Her living arrangements are more stable, as is her work life. Melanie's use of illicit drugs has decreased significantly, and she is no longer drawn to abusive relationships.

As the more severe aspects of borderline personality pathology have receded, other conflicts and symptoms have moved to the fore. For example, Melanie appears to have developed somewhat obsessional defenses against painful affect. She adheres more rigidly to daily routines and becomes anxious or uncomfortable when they are altered. She is more prone to think in an abstract and intellectualized manner and tries to see herself as more logical and rational, less influenced by emotion.

Despite her wish to act more logically and rationally, Melanie seems engaged in an active struggle to control her affect and impulses. She tends to oscillate between undercontrol and overcontrol of needs and wishes, either expressing them impulsively or disavowing them entirely. She has more difficulty allowing herself to experience strong pleasurable emotions (e.g., excitement, joy). She is more prone to repress, "forget," or otherwise distort distressing events.

Finally, there are changes in Melanie's relationships and orientation toward sexuality. Whereas before she presented in a histrionic manner (i.e., with exaggerated feminine traits), she is now more disparaging of traditionally feminine traits, instead emphasizing independence and achievement. Whereas previously she engaged in multiple chaotic sexual relationships, she now seems conflicted about her intimacy needs. She craves intimacy but tends to reject it when offered. She has more difficulty directing both sexual and tender feelings toward the same person, seeing men as either respectable and virtuous or sexy and exciting, but not both. She is more likely to hold grudges.

Reliability and Validity

Psychological and psychiatric researchers often assume that clinical observation and judgment are unreliable; a well-established research literature documents the limitations of "clinical judgment." Unfortunately, studies of "clinical judgment" have too often asked clinicians to make predictions about things that fall outside their legitimate area of expertise (and just as unfortunately, some clinicians have been all too willing to offer such prognostications). More problematically, the studies have typically conflated clinicians' ability to make accurate observations and inferences (which they do well) with their ability to combine and weight variables to derive optimal predictions (a task *necessarily* performed

better by statistical methods such as regression equations). In fact, a substantial literature documents the reliability and validity of clinical observation and inference *when it is quantified and utilized appropriately* (Westen and Weinberger 2004).

The SWAP differs from other assessment approaches in that it harnesses clinical judgment, using psychometric methods developed specifically for this purpose, and then applies statistical and actuarial methods to the resulting data. In short, it relies on clinicians to do what they do best—namely, making specific behavioral observations and inferences about individual patients they treat and know well. It relies on statistical algorithms to do what they do best—namely, combining data optimally to derive reliable and valid diagnostic scales and indices.

Interrater reliability of SWAP-200 PD scale scores and other diagnostic scales is above 0.80 for all scales in all studies to date and is often above 0.90 (Marin-Avellan et al. 2005; Westen and Muderrisoglu 2003, 2006; Westen and Shedler 2007a). It is noteworthy that high reliability coefficients have been reported by independent investigators unaffiliated with our own laboratory. The reliability coefficients compare favorably with those typically reported for structured interviews that avoid clinical inference and "stick to the facts" (e.g., DSM-IV criteria). Additionally, the SWAP diagnostic scales correlate highly with a wide range of external criterion measures in both adult and adolescent samples, including genetic history variables such as psychosis in first- and second-degree relatives, substance abuse in first- and second-degree relatives, developmental history variables such as childhood physical and sexual abuse, life events including psychiatric hospitalizations and suicide attempts, violent criminal behavior, and ratings of adaptive functioning (Marin-Avellan et al. 2005; Shedler and Westen 2004a; Westen and Muderrisoglu 2003; Westen and Shedler 1999a, 2007b; Westen and Weinberger 2004; Westen et al. 2003).

Toward DSM-5: An Improved Classification of Personality Disorders[6]

It is an empirical question whether DSM-IV includes the optimal diagnostic categories and criteria. It is also an empirical question whether a diagnostic system based on personality *types* or *syndromes* is consistent with the available data (as opposed to being a mere convenience that

---

[6]The material presented here is adapted from Westen and Shedler (1999b).

facilitates clinical communication). To address these questions, we examined SWAP-200 personality descriptions provided by the treating psychologist or psychiatrist from a national sample of patients (N=496) diagnosed with Axis II disorders (Westen and Shedler 1999b). We used the technique of Q-factor analysis (or simply Q-analysis) to answer the following questions:

1. Are there clear, empirically identifiable diagnostic groupings among PD patients treated in the community? That is, are there groupings of patients who share common psychological features that distinguish them from other patients?
2. Do the current DSM-IV diagnostic categories adequately "fit" the data? That is, are there empirically identifiable personality syndromes that are not included in DSM-IV, or vice versa?
3. What are the most defining psychological features (diagnostic criteria) for each personality syndrome?

Q-analysis is computationally equivalent to the familiar technique of factor analysis. The difference is that factor analysis identifies groupings of similar *variables* (i.e., columns in a data matrix) that are assumed to be markers of a common underlying factor. In contrast, Q-analysis identifies groupings of similar *people* (i.e., cases or rows in a data matrix) who are assumed to represent a common diagnostic syndrome or type. The former approach is *variable-centered;* the latter is *person-centered* (for a description of computational methods, see Westen and Shedler 1999b). Q-analysis has been used by biologists conducting taxonomic research to aid in classifying species and has been used successfully in research on normal personality (Block 1971).[7]

The Q-analysis analysis demonstrated that there are empirically distinguishable personality syndromes among patients treated in the community, and that a syndromal or person-centered approach is consistent with the data. Note that the personality syndromes are best understood dimensionally, not as mutually exclusive categories (see section "SWAP Dimensional Diagnosis" earlier in this chapter). This is an important clarification, because some researchers mistakenly conflate "dimensional" with *trait* (variable-centered) models, and conflate "categorical" approaches with *syndromal* (person-centered) models. In fact, these issues are separate and independent (Westen et al. 2006a). The dimensional/categorical distinction refers to whether people are assumed to fall into discrete categories or to vary along a continuum; the syndromal/trait distinction refers to whether the unit of diagnosis is a constellation of interrelated personality characteristics or separate characteristics.

The analysis identified 11 conceptually coherent diagnostic groupings or personality syndromes, many of which resembled DSM-IV diagnostic categories and some of which did not. We created a *prototype personality description* for each empirically identified diagnostic syndrome by listing the SWAP items in descending order by Q-factor score. The SWAP-200 items with the highest Q-factor scores indicate the central or defining psychological features for each diagnostic group (i.e., the diagnostic "criteria"). This represents a purely empirical approach to identifying optimal diagnostic categories and criteria.

We will use the examples of paranoid PD and depressive PD to illustrate this approach to identifying PD syndromes and criteria (for descriptions of all 11 empirically identified diagnostic groupings, see Shedler and Westen 2004b; Westen and Shedler 1999b). Table 4–1 lists the SWAP-200 items most defining of patients in the paranoid personality diagnostic grouping, along with their associated factor scores (indicating their diagnostic importance). A number of findings are noteworthy. First, the empirical identification of this diagnostic grouping validates the inclusion of paranoid PD as a diagnostic category in DSM-IV. Second, the items are clinically richer than the DSM-IV diagnostic criteria, addressing inner experience and intrapsychic processes as well as behavior. Third, the description differs in important ways from the description provided by DSM-IV and offers crucial insights into the meaning and function of paranoid symptoms.

---

[7]A discussion of person-centered versus variable-centered assessment is beyond the scope of this chapter and merits a chapter in its own right. We believe the distinction underlies much misunderstanding between clinicians and researchers, because clinicians tend to think in person-centered terms and researchers tend to think in variable-centered terms. The choice of a person- or variable-centered approach, which can profoundly affect how we think about psychological issues, is often not even recognized as a choice. Instead, one or the other approach is accepted by convention and without consideration of what is at stake. (The fact that statistical data analysis programs are designed to operate on variables rather than cases may have shaped academic psychology in ways we can barely fathom.) It is not that one approach is "right" and one is "wrong," but rather that they serve different purposes and draw our attention to different matters. Good assessment systems are like good maps, in that they must accurately depict the territory. But sometimes one wants a road map, sometimes a map of elevations, and sometimes a political map. A motorist navigating the interstate will have little interest in a map of elevations, no matter how many studies document its validity.

TABLE 4–1. SWAP-200 prototype description of patients in the paranoid personality disorder diagnostic category

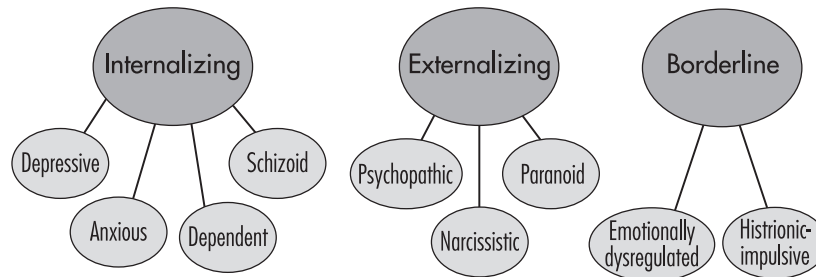| Item	Factor score
Tends to hold grudges; may dwell on insults or slights for long periods.	3.61
Tends to feel misunderstood, mistreated, or victimized.	3.23
Is quick to assume that others wish to harm or take advantage of him/her; tends to perceive malevolent intentions in others' words and actions.	3.08
Tends to express intense and inappropriate anger, out of proportion to the situation at hand.	2.77
Tends to be critical of others.	2.59
Tends to get into power struggles.	2.43
Tends to be angry or hostile (whether consciously or unconsciously).	2.40
Tends to see certain others as "all bad," and loses the capacity to perceive any positive qualities the person may have.	2.38
Tends to be self-righteous or moralistic.	2.25
Tends to react to criticism with feelings of rage or humiliation.	2.19
Tends to blame others for own failures or shortcomings; tends to believe his/her problems are caused by external factors.	2.15
Tends to be oppositional, contrary, or quick to disagree.	2.08
Tends to see own unacceptable feelings or impulses in other people instead of in him/herself.	2.08
Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning.	1.94
Tends to "catastrophize"; is prone to see problems as disastrous, unsolvable, etc.	1.82
Tends to elicit dislike or animosity in others.	1.78
Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc.	1.73
Has difficulty making sense of other people's behavior; often misunderstands, misinterprets, or is confused by others' actions and reactions.	1.53
Tends to be controlling.	1.49
Tends to elicit extreme reactions or stir up strong feelings in others.	1.44
Tends to avoid confiding in others for fear of betrayal; expects things s/he says or does will be used against him/her.	1.41
Reasoning processes or perceptual experiences seem odd and idiosyncratic (e.g., may make seemingly arbitrary inferences; may see hidden messages or special meanings in ordinary events).	1.39
Perception of reality can become grossly impaired under stress (e.g., may become delusional).	1.37

For example, the item list (Table 4–1) emphasizes paranoid patients' cognitive confusion in ways that DSM-IV does not (e.g., "tends to become irrational when strong emotions are stirred up"; "has difficulty making sense of other people's behavior"; "reasoning processes or perceptual experiences seem odd and idiosyncratic"). It also emphasizes paranoid patients' anger and aggression in ways that DSM-IV does not (e.g., "tends to hold grudges"; "tends to be angry or hostile"; "tends to express intense and inappropriate anger"), as well as their tendency to rely on projection as a defense ("tends to see own unacceptable feelings or impulses in other people instead of in him- or herself"). The findings are consistent with psychoanalytic thought, which recognizes projection as a central dynamic in paranoid patients. (Stated differently, the paranoid patient perceives the world as hostile because he sees his own hostility everywhere he looks.) The personality description has clear implications for treatment, unlike the description in DSM-IV. It tells us that a clinician treating a patient with paranoid PD will need to assist the patient with reality testing, for example, by examining his reasoning processes and helping him consider alternative constructions and interpretations of events. It also tells us that the clinician will be dealing with intense anger and aggression and that successful treatment will have to address the patient's aggression and help him to find more adaptive ways of regulating it.

The findings cannot be explained away as artifacts of clinicians' theoretical beliefs or expectations. They emerged repeatedly when we stratified the sample by the theoretical orientation of the reporting clinicians, and the personality characteristics described above were ranked just as highly by cognitive-behavioral therapists as by psychoanalysts. The SWAP-200 provides a common language for all clinicians, and the PD prototypes reflect only those personality traits that clinicians of all orientations observe consistently and reliably.

Table 4–2 lists the SWAP-200 items most defining of another personality syndrome, one absent from DSM-IV, which we have labeled "depressive (or dysphoric) personality." Despite its omission from DSM-IV, our data indicate that it is the most prevalent personality syndrome seen in the community (Westen and Shedler 1999b). Its absence from DSM-IV appears to be a significant omission. Note that the SWAP description encompasses the *multiple domains of functioning* described in DSM-IV as defining of a PD, including cognition (e.g., tends to blame self; tends to be self-critical), affectivity (e.g., tends to feel unhappy, depressed, despondent; tends to feel ashamed or embarrassed), interpersonal relations (tends to fear s/he will be rejected or abandoned; tends to be overly needy or dependent), and impulse regulation (e.g., has difficulty

TABLE 4–2. SWAP-200 prototype description of patients in the depressive (dysphoric) personality disorder diagnostic category

Item	Factor score
Tends to feel s/he is inadequate, inferior, or a failure.	3.63
Tends to feel unhappy, depressed, or despondent.	3.11
Tends to feel ashamed or embarrassed.	2.76
Tends to blame self or feel responsible for bad things that happen.	2.71
Tends to feel guilty.	2.67
Tends to fear s/he will be rejected or abandoned by those who are emotionally significant.	2.66
Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.	2.52
Tends to be overly needy or dependent; requires excessive reassurance or approval.	2.30
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).	2.12
Tends to be passive and unassertive.	2.12
Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects.	2.02
Tends to feel like an outcast or outsider; feels as if s/he does not truly belong.	1.94
Tends to be anxious.	1.91
Tends feel listless, fatigued, or lacking in energy.	1.79
Tends to feel empty or bored.	1.77
Appears to want to "punish" self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification.	1.71
Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities.	1.71
Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves.	1.70
Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect.	1.60
Lacks a stable image of who s/he is or would like to become (e.g., attitudes, values, goals, and feelings about self may be unstable and changing).	1.55
Tends to feel life has no meaning.	1.49
Tends to avoid social situations because of fear of embarrassment or humiliation.	1.43
Has difficulty acknowledging or expressing anger.	1.34

FIGURE 4–2.   Hierarchical structure of personality syndromes.

acknowledging or expressing anger). The depressive (or dysphoric) personality syndrome appears to have its origin in late childhood or early adolescence (Westen et al. 2005) and appears to be stable and enduring over time. In short, it is a *personality disorder* by every definition of the term (cf. Huprich 2003, 2005; Huprich and Frisch 2004; McDermut et al. 2003; Ryder et al. 2001).

Analysis of SWAP-II data from our most recent subject samples (*N*=1,201 adult patients studied with the SWAP-II, and *N*=950 adolescent patients with the SWAP-II-A) revealed a hierarchical structure of PD syndromes, as illustrated in Figure 4–2 (Westen and Shedler 2007a). At the superordinate level are three broad diagnostic groupings (Q-factors) that can be described as *internalizing*, *externalizing*, and *borderline*. The results map onto the internalizing and externalizing spectra identified in research on Axis I syndromes (Krueger 2002) and may provide a basis for an integrated understanding of Axis I and Axis II pathology. The borderline personality constellation contains elements of both internalizing and externalizing pathology and is characterized by emotional instability that is not evident in either stable internalizers or externalizers. The hierarchical structure of PD syndromes will be described in greater detail in future publications.

Dimensional Diagnosis: The Prototype Matching Approach

For research purposes, for situations in which maximum psychometric precision is required (e.g., forensic assessment), or for clarifying challenging diagnostic dilemmas, clinicians can, using the SWAP, describe patients and obtain dimensional diagnosis scores such as those graphed in Figure 4–1. (Investigators will soon be able to enter SWAP data and

Patients who match this prototype tend to be deceitful, to lie and mislead people. They take advantage of others, have minimal investment in moral values, and appear to experience no remorse for harm or injury caused to others. They tend to manipulate others' emotions to get what they want; to be unconcerned with the consequences of their actions, appearing to feel immune or invulnerable; and to show reckless disregard for the rights, property, or safety of others. They have little empathy and seem unable to understand or respond to others' needs and feelings unless they coincide with their own. Individuals who match this prototype tend to act impulsively, without regard for consequences; to be unreliable and irresponsible (e.g., failing to meet work obligations or honor financial commitments); to engage in unlawful or criminal behavior; and to abuse alcohol. They tend to be angry or hostile; to get into power struggles; and to gain pleasure or satisfaction by being sadistic or aggressive toward others. Patients who match this prototype tend to blame others for their own failures or shortcomings and to believe their problems are caused by external factors. They have little psychological insight into their own motives, behavior, etc. They may repeatedly convince others of their commitment to change but then revert to previous maladaptive behavior, often convincing others that "this time is really different."

Please form an overall impression of the type of person described, then rate the extent to which your patient matches or resembles this prototype.

5	Very good match (patient ***exemplifies*** this disorder; prototypical case)	**Diagnosis**
4	Good match (patient ***has*** this disorder; diagnosis applies)	
3	Moderate match (patient has ***significant features*** of this disorder)	**Features**
2	Slight match (patient has minor features of this disorder)	
1	No match (description does not apply)	

FIGURE 4–3. Antisocial-psychopathic personality disorder prototype.

receive diagnostic reports via the Internet; for information, visit www .SWAPassessment.org.) When routine use of the SWAP-200 would be impractical, we advocate a "prototype matching" approach to personality diagnosis, and we have proposed this approach for DSM-5.

Figure 4–3 illustrates the prototype matching approach. The figure shows the prototype description for one personality syndrome, identified empirically through Q-analysis, which we have labeled *antisocial-psychopathic personality* (Westen and Shedler 1999b). The description is made up of the SWAP-200 statements that are most empirically defining of the syndrome. The SWAP items are reproduced essentially verbatim but have been arranged in paragraph (rather than list) form.

The clinician's task is to consider the prototype description as a whole—that is, as a configuration or gestalt—and to rate the overall similarity or match between the prototype and the patient being assessed. The resulting diagnosis is dimensional (a 1–5 rating), but the scale can be dichotomized for convenience when a present/absent classification is desired to facilitate clinical communication (with a rating of 4 indicating "caseness"). Thus, the approach offers the advantages of dimensional diagnosis while maintaining "backward compatibility" with the categorical approach of DSM-IV.

Our research indicates that the prototype matching method has advantages over the current DSM-IV approach to personality diagnosis. In a series of studies of Cluster B disorders (antisocial, borderline, histrionic, and narcissistic), we compared prototype matching and DSM-IV diagnosis with respect to validity, diagnostic comorbidity, and clinical utility (Westen et al. 2006b). Clinicians diagnosed patients using the prototype matching method (as illustrated in Figure 4–3) and the DSM-IV diagnostic system. We compared the prototype matching method to both categorical DSM-IV diagnoses and "dimensionalized" DSM-IV diagnoses obtained by summing the number of criteria met per disorder (a method commonly used in PD research).

The prototype matching method substantially reduced diagnostic comorbidity relative to both DSM-IV diagnostic methods. For example, the median correlation between the four Cluster B disorders was 0.47 for dimensionalized DSM-IV diagnoses and 0.14 for prototype diagnoses based on empirically identified diagnostic groupings (as described in the preceding section). At the same time, the prototype diagnoses appeared to have higher validity, yielding higher correlations with ratings of adaptive functioning and developmental history variables known to be associated with antisocial PD and borderline PD. The advantages of the prototype matching approach were not only statistically significant but also clinically meaningful: prototype diagnoses predicted treatment outcomes better than either categorical or dimensionalized DSM-IV diagnoses, for both psychotherapy and antidepressant medication.

Finally, we examined clinical utility by asking clinicians to compare the prototype matching method to the DSM-IV diagnostic system with respect to ease of use, usefulness for communicating with other clinicians, ability to capture the important information about the patient, and so on. The clinicians strongly preferred prototype diagnosis to DSM-IV diagnosis on every dimension assessed, despite the fact that they had no prior experience with either the prototype matching method or the empirically derived prototype personality descriptions.

Spitzer et al. (2008) also found that clinicians prefer prototype matching both to DSM-IV diagnosis and to dimensional trait models such as the Five Factor Model, and rate the prototype method as more clinically relevant and useful.

Whether or not items from the SWAP are directly incorporated into future editions of DSM, SWAP research leads to two clear recommendations for revision of the manual. First, existing DSM-IV diagnostic criteria are too narrow, emphasizing behavioral signs and symptoms to the relative exclusion of inner experience and underlying psychological processes. Such underlying psychological processes (e.g., motives, conflicts, defenses, self and object representations) are centrally defining features of personality syndromes and crucial to their understanding (Shedler and Westen 2004b). SWAP research also makes clear that clinicians can assess underlying psychological processes far more reliably than many investigators had previously believed. Second, prototype matching has advantages over the present symptom-counting approach to diagnosis. It combines the advantages of a syndromal or configural approach to personality assessment with the advantages of dimensional diagnosis. Moreover, clinical practitioners have consistently shown a strong preference for prototype matching approaches over the present DSM-IV diagnostic system and over dimensional trait models such as the Five Factor Model (Rottman et al. 2009; Spitzer et al. 2008; Westen et al. 2006b).

Conclusion: Integrating Science and Practice

A clinically useful diagnostic system should encompass the spectrum of personality pathology seen in clinical practice and have meaningful implications for treatment. An empirically sound diagnostic system should facilitate reliable and valid diagnoses: independent clinicians should be able to arrive at the same diagnosis, the diagnoses should be relatively distinct from one another, and each diagnosis should be associated with unique and theoretically meaningful correlates, antecedents, and sequelae (Livesley and Jackson 1992; Millon 1991; Robins and Guze 1970).

One obstacle to achieving this ideal has been an unfortunate schism in the mental health professions between science and practice. Too often, research has been conducted in isolation from the crucial data of clinical observation. The results often strike clinicians as naive and of dubious clinical relevance. Ultimately, the most empirically elegant diagnostic system will have little impact if clinicians do not find it helpful for understanding their patients (First et al. 2004; Shedler and Westen 2005). On the other hand, clinical theory has too often developed with-

out sufficient regard for questions of falsifiability and empirical credibility. The results have often struck researchers as scientifically naive.

The Shedler-Westen Assessment Procedure represents an effort to bridge the schism between science and practice by quantifying clinical observation and expertise, making clinical constructs accessible to empirical study. It relies on clinicians to do what they do best—namely, making observations and inferences about the individual patients they know and treat. It relies on quantitative methods to do what they do best—namely, aggregating observations to reveal relationships and commonalities, and combining data to yield optimal predictions (Sawyer 1966). It provides a "language" for clinical case description that is at once psychometrically sound and clinically rich enough to describe the complexities of real patients. There remains a sizeable schism between science and practice. Perhaps the SWAP will provide a language all parties can speak.

Key Clinical Concepts

- ◆ The diagnostic system provided by Axis II of DSM-IV has significant limitations for understanding personality, from both clinical and empirical perspectives. An important clinical limitation is that the DSM-IV Axis II system does not address the meaning and function of personality processes and therefore offers little guidance with respect to treatment.
- ◆ Meaningful assessment of personality requires clinical judgment and inferences about underlying psychological processes. The Shedler-Westen Assessment Procedure (SWAP) is a personality assessment instrument that harnesses clinical judgment, allowing clinicians to describe their observations and inferences systematically and reliably.
- ◆ The standard vocabulary of the SWAP captures complex intrapsychic processes (e.g., splitting, identity diffusion, and projective identification in borderline patients) in jargon-free English. Combinations of items express clinical case formulations that imply specific treatment strategies and interventions (e.g., integrating contradictory peceptions of self and others in borderline patients).
- ◆ The SWAP approach integrates descriptive psychiatric diagnosis and clinical case formulation. It preserves a syndromal approach to personality diagnosis (i.e., recognizing functional relations among multiple areas of functioning) while allowing dimensional diagnosis. Despite (or because of) its

reliance on clinical inference, the SWAP shows high reliability and validity.

◆ SWAP research has empirically identified 11 personality syndromes or groupings that provide an alternative to DSM-IV diagnostic categories. The syndromes are defined by items or criteria that address inner experience and intrapsychic processes (e.g., projection of aggression in paranoid patients) as well as overt behaviors. They also include diagnostic syndromes, such as depressive personality, that are prevalent in the community but absent from DSM.

◆ A "prototype matching" approach to diagnosis is a practical alternative to the current DSM diagnostic system and addresses many of its limitations. The resulting diagnoses are both empirically based and clinically meaningful. Clinicians judged this diagnostic system to be preferable to the existing DSM diagnostic system and also preferable to alternative dimensional trait models.

Suggested Readings

Psychodynamic Case Formulation

PDM Task Force (ed): Personality patterns and disorders: P Axis, in Psychodynamic Diagnostic Manual (PDM). Silver Spring, MD, Alliance of Psychoanalytic Organizations, 2006, pp 17–69. [A concise overview of contemporary psychoanalytic thought on personality styles and disorders, with jargon-free descriptions of the major personality syndromes and references to relevant empirical research.]

McWilliams N: Psychoanalytic Diagnosis: Understanding Personality Structure in the Clinical Process. New York, Guilford, 1994. [A more in-depth discussion of the personality syndromes recognized by psychoanalytic practitioners. A contemporary classic.]

Peebles-Kleiger MJ: Beginnings: The Art and Science of Planning Psychotherapy. Hillsdale, NJ, Analytic Press, 2002. [An elegant introduction to case formulation and treatment planning, useful to practitioners of all theoretical orientations.]

The Shedler-Westen Assessment Procedure (SWAP)

Westen D, Shedler J: Revising and assessing Axis II, part 1: developing a clinically and empirically valid assessment method. Am J Psychiatry 156:258–272, 1999a

Westen D, Shedler J: Revising and assessing Axis II, part 2: toward an empirically based and clinically useful classification of personality disorders. Am J Psychiatry 156:273–285, 1999b. [These are the seminal publications on the SWAP, describing its development and rationale.]

Lingiardi V, Shedler J, Gazillo F: Assessing personality change in psychotherapy with the SWAP-200: a case study. J Pers Assess 86:23–32, 2006. [A more thorough discussion of the case of Melanie, described briefly in this chapter. The paper illustrates the use of the SWAP as a method for assessing personality change (i.e., intrapsychic change) in psychotherapy.]

Shedler J: A new language for psychoanalytic research. Psychologist-Psychoanalyst 20:30–37, 2000. [On the relevance of SWAP research for psychoanalytic theory, practice, and training.]

Shedler J, Westen D: Refining personality disorder diagnosis: integrating science and practice. Am J Psychiatry 161:1350–1365, 2004. [Descriptions of the major personality syndromes as they are conceptualized by experienced clinicians and observed in clinical practice, with recommendations for revision of DSM.]

Spitzer RL, First MB, Shedler J, et al: Clinical utility of five dimensional systems for personality diagnosis: a "consumer preference" study. J Nerv Ment Dis 196:356–374, 2008

Westen D, Shedler J, Bradley R: A prototype approach to personality diagnosis. Am J Psychiatry 163:846–856, 2006. [Discussion of the "prototype matching" approach to personality diagnosis.]

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition. Washington, DC, American Psychiatric Association, 1980

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Association, 1994

Betan E, Heim AK, Conklin CZ, et al: Countertransference phenomena and personality pathology in clinical practice: an empirical investigation. Am J Psychiatry 162:890–898, 2005

Blais M, Norman D: A psychometric evaluation of the DSM-IV personality disorder criteria. J Pers Disord 11:168–176, 1997

Blashfield R: Exemplar prototypes of personality disorder diagnoses. Compr Psychiatry 26:11–21, 1985

Block J: Lives Through Time. Berkeley, CA, Bancroft, 1971

Block J: The Q-Sort Method in Personality Assessment and Psychiatric Research (1961). Palo Alto, CA, Consulting Psychologists Press, 1978

Cantor N, Genero N: Psychiatric diagnosis and natural categorization: a close analogy, in Contemporary Directions in Psychopathology: Toward the DSM-IV. Edited by Klerman GL. New York, Guilford, 1986, pp 233–256

Clark L: Resolving taxonomic issues in personality disorders: the value of larger scale analyses of symptom data. J Pers Disord 6:360–376, 1992

Clarkin JF, Levy KN, Lenzenweger MF, et al: Evaluating three treatments for borderline personality disorder: a multiwave study. Am J Psychiatry 164:922–928, 2007

Cousineau TM, Shedler J: Predicting physical health: implicit mental health measures versus self report scales. J Nerv Ment Dis 194:427–432, 2006

Davis R, Blashfield R, McElroy R: Weighting criteria in the diagnosis of a personality disorder: a demonstration. J Abnorm Psychol 102:319–322, 1993

First M, Spitzer R, Gibbon M, et al: The Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II). Part II: multi-site test-retest reliability study. J Pers Disord 9:92–104, 1995

First MB, Pincus HA, Levine JB, et al: Clinical utility as a criterion for revising psychiatric diagnoses. Am J Psychiatry 161:946–954, 2004

Grilo CM, Sanislow CA, McGlashan TH: Co-occurrence of DSM-IV personality disorders with borderline personality disorder. J Nerv Ment Dis 190:552–553, 2002

Grove WM, Tellegen A: Problems in the classification of personality disorders. J Pers Disord 5:31–41, 1991

Harkness A: Fundamental topics in the personality disorders: candidate trait dimensions from lower regions of the hierarchy. J Consult Clin Psychol 4:251–259, 1992

Huprich SK: Depressive personality and its relationship to depressed mood, interpersonal loss, negative parental perceptions, and perfectionism. J Nerv Ment Dis 191:1–7, 2003

Huprich SK: Differentiating avoidant and depressive personalities. J Pers Disord 19:659–673, 2005

Huprich SK, Frisch MB: Depressive personality and its relationship to quality of life, hope, and optimism. J Pers Assess 83:22–28, 2004

Jackson DN, Livesley WJ: Possible contributions from personality assessment to the classification of personality disorders, in The DSM-IV Personality Disorders. Edited by Livesley WJ. New York, Guilford, 1995, pp 459–481

John O: The "big five" factor taxonomy: dimensions of personality in the natural language and in questionnaires, in Handbook of Personality: Theory and Research. Edited by Pervin L. New York, Guilford, 1990, pp 66–100

Kernberg O: Borderline Conditions and Pathological Narcissism. New York, Jason Aronson, 1975

Kernberg O: Severe Personality Disorders. New Haven, CT, Yale University Press, 1984

Kim NS, Ahn W: Clinical psychologists' theory-based representations of mental disorders predict their diagnostic reasoning and memory. J Exp Psychol 131:451–476, 2002

Kohut H: The Analysis of the Self. New York, International Universities Press, 1971

Krueger RF: The structure of common mental disorders. Arch Gen Psychiatry 59:570–571, 2002

Levy KN, Kelly KM, Meehan KB, et al: Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. J Consult Clin Psychol 74:1027–1040, 2006

Linehan MM: Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York, Guilford, 1993

Lingiardi V, Shedler J, Gazillo F: Assessing personality change in psychotherapy with the SWAP-200: a case study. J Pers Assess 86:23–32, 2006

Livesley WJ (ed): The DSM-IV Personality Disorders. New York, Guilford, 1995

Livesley WJ, Jackson DN: Guidelines for developing, evaluating, and revising the classification of personality disorders. J Nerv Ment Dis 180:609–618, 1992

Marin-Avellan L, McGauley G, Campbell C, et al: Using the SWAP-200 in a personality-disordered forensic population: is it valid, reliable and useful? J Crim Behav Ment Health 15:28–45, 2005

McCrae R, Costa P: Personality in Adulthood. New York, Guilford, 1990

McDermut W, Zimmerman M, Chelminski I: The construct validity of depressive personality disorder. J Abnorm Psychol 112:49–60, 2003

McWilliams N: Psychoanalytic Diagnosis: Understanding Personality Structure in the Clinical Process. New York, Guilford, 1994

Millon T: Toward a New Psychology. New York, Wiley, 1990

Millon T: Classification in psychopathology: rationale, alternatives and standards. J Abnorm Psychol 100:245–261, 1991

Millon T, Davis RD: The place of assessment in clinical science, in The Millon Inventories: Clinical and Personality Assessment. Edited by Millon T. New York, Guilford, 1997, pp 3–20

Morey LC: Personality disorders in DSM-III and DSM-III-R: convergence, coverage, and internal consistency. Am J Psychiatry 145:573–577, 1988

Oldham J, Skodol A, Kellman HD, et al: Diagnosis of DSM-III-R personality disorders by two semistructured interviews: patterns of comorbidity. Am J Psychiatry 149:213–220, 1992

Perry JC: Problems and considerations in the valid assessment of personality disorders. Am J Psychiatry 149:1645–1653, 1992

Perry JC, Cooper SH: Empirical studies of psychological defense mechanisms, in Psychiatry. Edited by Cavenar J, Michels R. Philadelphia, PA, JB Lippincott, 1987, pp 1–19

Pilkonis PA, Heape CL, Proietti JM, et al: The reliability and validity of two structured diagnostic interviews for personality disorders. Arch Gen Psychiatry 52:1025–1033, 1995

Robins E, Guze S: The establishment of diagnostic validity in psychiatric illness: its application to schizophrenia. Am J Psychiatry 126:983–987, 1970

Rottman BM, Ahn WK, Sanislow CA: Can clinicians recognize DSM-IV personality disorders from five-factor model descriptions of patient cases? Am J Psychiatry 166:427–433, 2009

Russ E, Bradley R, Shedler J, et al: Refining the construct of narcissistic personality disorder: diagnostic criteria and subtypes. Am J Psychiatry 165:1473–1481, 2008

Ryder AG, Bagby RM, Dion KL: Chronic low-grade depression in a nonclinical sample: depressive personality or dysthymia? J Pers Disord 15:84–93, 2001

Sawyer J: Measurement and prediction, clinical and statistical. Psychol Bull 66:178–200, 1966

Schafer R: A New Language for Psychoanalysis. New Haven, CT, Yale University Press, 1976

Shedler J, Westen D: Refining the measurement of Axis II: a Q-sort procedure for assessing personality pathology. Assessment 5:333–353, 1998

Shedler J, Westen D: Dimensions of personality pathology: an alternative to the five-factor model. Am J Psychiatry 161:1743–1754, 2004a

Shedler J, Westen D: Refining personality disorder diagnosis: integrating science and practice. Am J Psychiatry 161:1350–1365, 2004b

Shedler J, Westen D: A simplistic view of the five-factor model: Drs. Shedler and Westen reply (letter). Am J Psychiatry 162:1551, 2005

Shedler J, Westen D: Personality diagnosis with the Shedler-Westen Assessment Procedure (SWAP): bridging the gulf between science and practice, in Psychodynamic Diagnostic Manual (PDM). Edited by PDM Task Force. Silver Spring, MD, Alliance of Psychoanalytic Organizations, 2006, pp 476–513

Shedler J, Westen D: The Shedler-Westen Assessment Procedure (SWAP): making personality diagnosis clinically meaningful. J Pers Assess 89:41–55, 2007

Shedler J, Mayman M, Manis M: The illusion of mental health. Am Psychol 48:1117–1131, 1993

Skodol A, Bender D: The future of personality disorders in DSM-V? Am J Psychiatry 164:4:1–2, 2009

Skodol A, Oldham J, Rosnick L, et al: Diagnosis of DSM-III-R personality disorders: a comparison of two structured interviews. Int J Methods Psychiatr Res 1:13–26, 1991

Spitzer RL: Psychiatric diagnosis: are clinicians still necessary? Compr Psychiatry 24:399–411, 1983

Spitzer RL, First MB, Shedler J, et al: Clinical utility of five dimensional systems for personality diagnosis: a "consumer preference" study. J Nerv Ment Dis 196:356–374, 2008

Vaillant GE (ed): Ego Mechanisms of Defense: A Guide for Clinicians and Researchers. Washington, DC, American Psychiatric Press, 1992

Watson D, Sinha BK: Comorbidity of DSM-IV personality disorders in a nonclinical sample. J Clin Psychol 54:773–780, 1998

Westen D: Social cognition and object relations. Psychol Bull 109:429–455, 1991

Westen D: Divergences between clinical and research methods for assessing personality disorders: implications for research and the evolution of Axis II. Am J Psychiatry 154:895–903, 1997

Westen D: Clinical Diagnostic Interview. 2002. Available at: http://www
.psychsystems.net/lab. Accessed October 3, 2009.

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

Westen D, Muderrisoglu S: Reliability and validity of personality disorder as-
sessment using a systematic clinical interview: evaluating an alternative to
structured interviews. J Pers Disord 17:350–368, 2003

Westen D, Muderrisoglu S: Clinical assessment of pathological personality
traits. Am J Psychiatry 163:1285–1287, 2006

Westen D, Shedler J: Revising and assessing Axis II, part 1: developing a clini-
cally and empirically valid assessment method. Am J Psychiatry 156:258–
272, 1999a

Westen D, Shedler J: Revising and assessing Axis II, part 2: toward an empiri-
cally based and clinically useful classification of personality disorders. Am
J Psychiatry 156:273–285, 1999b

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

Westen D, Shedler J: Personality diagnosis with the Shedler-Westen Assessment
Procedure (SWAP): integrating clinical and statistical measurement and
prediction. J Abnorm Psychol 116:810–822, 2007a

Westen D, Shedler J: The Shedler-Westen Assessment Procedure (SWAP): mak-
ing personality diagnosis clinically meaningful. J Pers Assess 89:42–55,
2007b

Westen D, Weinberger J: When clinical description becomes statistical predic-
tion. Am Psychol 59:595–613, 2004

Westen D, Lohr N, Silk K, et al: Object relations and social cognition in border-
lines, major depressives, and normals: a TAT analysis. J Consult Clin Psy-
chol 2:355–364, 1990

Westen D, Muderrisoglu S, Fowler C, et al: Affect regulation and affective expe-
rience: individual differences, group differences, and measurement using a
Q-sort procedure. J Consult Clin Psychol 65:429–439, 1997

Westen D, Heim AK, Morrison K, et al: Classifying and diagnosing psychopa-
thology: a prototype matching approach, in Rethinking the DSM: Psycho-
logical Perspectives. Edited by Beutler LE, Malik M. Washington, DC,
American Psychological Association, 2002, pp 221–250

Westen D, Shedler J, Durrett C, et al: Personality diagnosis in adolescence: DSM-
IV Axis II diagnoses and an empirically derived alternative. Am J Psychia-
try 160:952–966, 2003

Westen D, Dutra L, Shedler J: Assessing adolescent personality pathology. Br J
Psychiatry 186:227–238, 2005

Westen D, Gabbard G, Blagov P: Back to the future: personality structure as a
context for psychopathology, in Personality and Psychopathology. Edited
by Krueger RF, Tackett JL. New York, Guilford, 2006a, pp 335–384

Westen D, Shedler J, Bradley R: A prototype approach to personality diagnosis.
Am J Psychiatry 163:846–856, 2006b

Widiger TA, Corbitt EM: Antisocial personality disorder, in The DSM-IV Personality Disorders. Edited by Livesley WJ. New York, Guilford, 1995, pp 103–126

Widiger T, Frances A: The DSM-III personality disorders: perspectives from psychology. Arch Gen Psychiatry 42:615–623, 1985

Widiger TA, Simonsen ES: Alternative dimensional models of personality disorders: finding common ground. J Pers Disord 19:110–130, 2005

Zanarini MC, Skodol AE, Bender D, et al: The Collaborative Longitudinal Personality Disorders Study: reliability of Axis I and II diagnoses. J Pers Disord 14:291–299, 2000

Zimmerman M: Diagnosing personality disorders: a review of issues and research methods. Arch Gen Psychiatry 51:225–245, 1994