Guide to SWAP-200 Interpretation

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NOTE: THIS IS A DRAFT DOCUMENT

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Introduction

The Shedler-Westen Assessment Procedure (SWAP) is based on the premise, now well established empirically, that the psychological difficulties that bring people to treatment are most often rooted in personality—that is, they are woven into the fabric of the person's life and reflected in characteristic patterns of thinking, feeling, behaving, coping, and relating to others. Lasting treatment gains are achieved when therapy addresses not only presenting symptoms but also the personality patterns that fuel them. An understanding of underlying personality patterns can clarify the meaning and function of symptoms and provide a roadmap for conducting effective therapy.

Two Assessment Traditions

The term *personality assessment* is used in different ways. For clinical practitioners, personality assessment often means *clinical case formulation*: understanding the complex interplay of psychological processes that make a person unique. Clinical case formulation is concerned with both the surface and depth of personality—both what the person can tell about himself and what he cannot tell. It necessarily relies on clinical observation and inference, most often in the context of an ongoing therapy relationship (e.g., How are the person's wishes and fears manifested in interactions with the therapist?). The strength of the clinical assessment tradition lies in the depth, richness, and complexity of clinical formulations.

For empirical researchers, personality assessment often means *psychometric measurement*: using structured questionnaires or inventories to measure a predetermined set of psychological characteristics relative to population norms. Statistical methods are used to develop scales and maximize reliability, validity, and predictive accuracy (e.g., Does a scale designed to measure *neuroticism* predict depressive episodes, peer ratings, or genetic variations linked to the neurotransmitter serotonin?). The strength of the empirical assessment tradition lies in its objectivity and scientific rigor.

The SWAP-200 is a unique assessment tool that bridges these assessment traditions and combines the best features of each. It is an instrument completed by *clinicians*, not patients. It relies on clinicians to do what they do best: provide psychologically rich descriptions of the individual patients they know and treat. It relies on psychometric and statistical methods to do what they do best: combine information in optimal ways to maximize reliability, validity, and predictive accuracy. The result is an assessment instrument that illuminates both the surface and depth of personality, that is both *scientifically valid* and *clinically relevant*.

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When to Use the SWAP-200

The SWAP-200 can be used by any trained mental health professional. Because the instrument is completed by the clinician and not the patient, assessment with the SWAP-200 does not require the patient's participation. However, the clinician must know the patient well enough to score the SWAP-200 items. If the patient is being seen in psychotherapy, the clinician can score the SWAP-200 after a minimum of six sessions. If the patient is being seen for assessment only (e.g., for forensic evaluation or for research purposes), the SWAP-200 can be completed on the basis of an in-depth clinical interview. We have developed a systematic *Clinical Diagnostic Interview* (CDI) for this purpose that can be administered in approximately 2½ hours (clinical, forensic, and research versions are available). If the clinician has access to additional sources of information about the patient (e.g., patient records, collateral contacts, other psychological tests), the clinician should draw on them freely. The SWAP-200 provides a means of synthesizing and describing systematically *everything* the clinician knows about a patient.

Clinicians using the SWAP-200 for the first time may require up to 45 minutes to score the items. Clinicians who have used the instrument several times and are familiar with the item set may be able to complete the scoring process in as little as 20 minutes.

The SWAP-200 can be used to assess the personality functioning of a broad range of patients, from psychologically healthy, high functioning individuals (who have personalities, not personality *disorders*) to patients with severe character pathology and specific personality disorder diagnoses. It is not designed for assessing patients who have organic brain syndromes or psychotic disorders (although it will detect subclinical thought disturbance and transient psychotic episodes, e.g., in patients with severe borderline personality disorder).

Understanding Prototype Matching

There are many ways to select and combine test items to construct diagnostic scales. The SWAP-200 employs several methods, but one method is unique to the SWAP and merits special discussion. This method is diagnosis by *prototype matching*.

The SWAP-200 is a set of 200 items or statements that allow a knowledgeable clinician to describe a person's psychological functioning in rich detail. This detailed psychological portrait exists in quantitative form, as a configuration or profile of scores across 200 variables.

A *diagnostic prototype* is a SWAP-200 description of a recognized personality disorder or syndrome. It is not a description of an individual person, but rather a

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richly detailed description of a disorder or syndrome in its “ideal” or pure form. Through our research, we have developed SWAP-200 diagnostic prototypes for a wide range of personality disorders and syndromes. For example, we have developed diagnostic prototypes for the personality disorders included in DSM-IV (e.g., paranoid personality disorder, narcissistic personality disorder). We have also developed diagnostic prototypes for additional personality syndromes identified through our research (e.g., high functioning depressive personality).

Diagnosis by prototype matching involves gauging the similarity or “match” between a patient’s SWAP-200 description and a diagnostic prototype. The better the match, the more applicable the diagnosis. The degree of “match” is expressed as a single numeric score. We are currently using standardized scores (T-scores) to express the degree of match.

The SWAP-200 software computes and graphs a range of standardized scores. The resulting graphs (score profiles) resemble MMPI profiles. A clinician can derive a great deal of psychological information by “reading” these profiles.

Prototype matching is central to SWAP-200 personality assessment. This approach to diagnosis has considerable advantages over other diagnostic methods, both clinically and empirically. Among other advantages, it incorporates a tremendous amount of diagnostic information, far more than other diagnostic methods. Descriptions of patients and diagnostic syndromes are unusually psychologically rich and nuanced. At the same time, it summarizes this information and communicates it simply and efficiently, in a clear, user-friendly form.

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Interpreting Test Results

The SWAP-200 scoring software currently generates three personality score profiles. This document is a guide to interpreting these score profiles. Future versions of the SWAP-200 software will automate the interpretation process and provide computer generated interpretive reports.

All scores described in this Guide are standardized scores (T-scores) based on norms established in a clinical sample of patients with DSM-IV Axis II diagnoses (Westen & Shedler, 1999a).

The three personality score profiles are as follows:

1. *DSM-IV Personality Disorders (PD T-Scores).* This profile provides a score for each DSM-IV personality disorder and can be used to derive a formal DSM-IV axis II diagnosis. The profile includes a *Psychological Health Index* that assesses personality strengths.

2. *SWAP Personality Syndromes (Q-Factor T-Scores).* This profile provides scores for an alternative set of personality syndromes that were identified empirically. This alternative diagnostic system addresses limitations of the DSM-IV diagnostic system and is designed to capture more faithfully the personality patterns and syndromes seen in clinical practice.

3. *Factor T-Scores*. This profile provides scores for twelve personality factors (trait dimensions) identified via factor analysis of the SWAP-200 item set. The factor scores supplement the diagnostic picture by highlighting specific areas of psychological functioning.

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DSM-IV Personality Disorders (PD T-Scores)

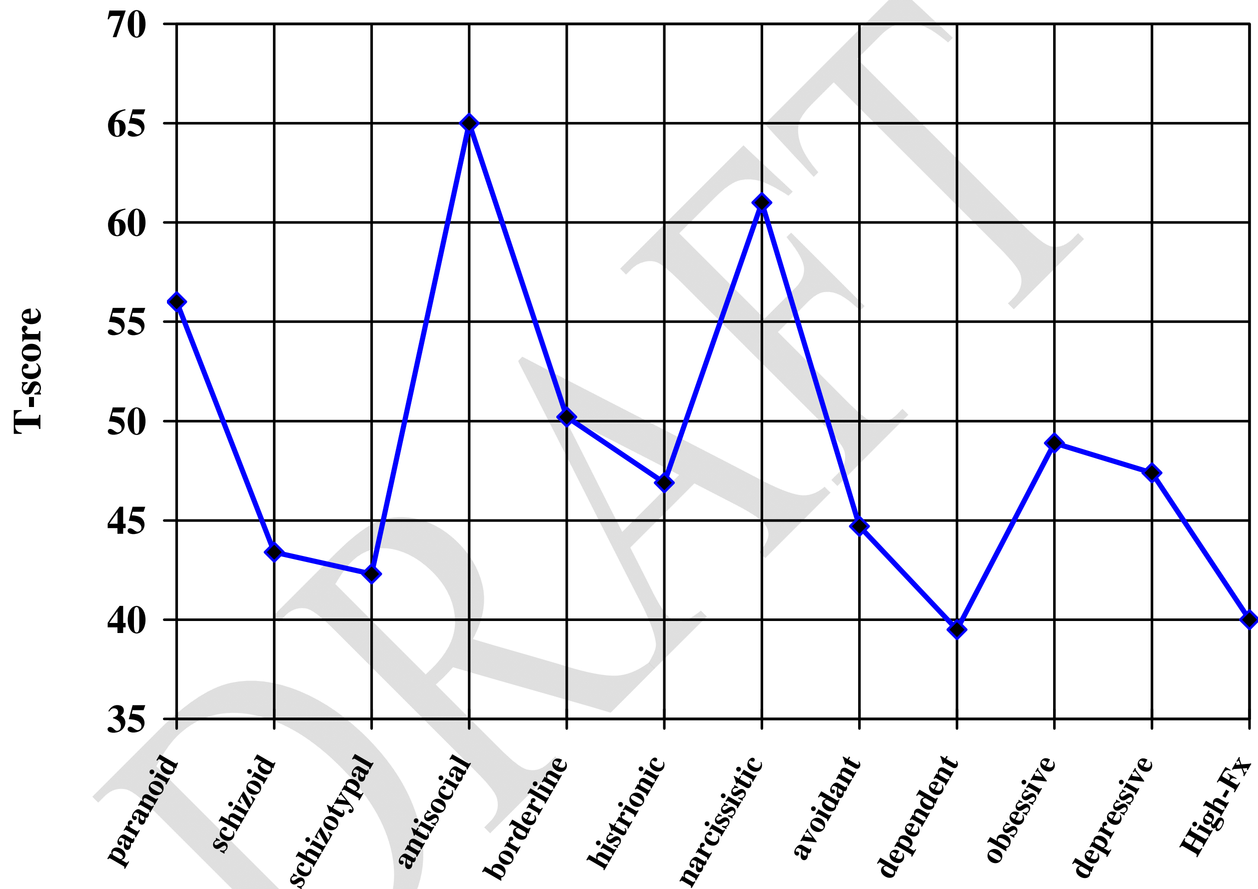
Personality Disorder (PD) scores indicate the degree of resemblance or “match” between your patient and diagnostic prototypes representing each DSM-IV axis II disorder in its “ideal” or pure form (see the section, “Understanding Prototype Matching” on page 4). The diagnostic prototypes reflect the consensual understanding of experienced clinical practitioners and are richer and more detailed than the diagnostic criteria included in DSM-IV. This score profile covers the ten PDs included in DSM-IV plus depressive PD (included in the DSM-IV appendix).

A strong match with a PD prototype (T $\geq$ 60) indicates that *the patient would be given the PD diagnosis by a consensus of knowledgeable clinicians*. A moderate

match (T $\geq$ 55) means that the patient has “features” of the disorder but is sub-threshold for diagnosis. If two or more scales have scores above T=60, the highest score provides the primary axis II diagnosis.

Figure 1

DSM-IV Personality Disorder Profile



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For the sample patient graphed in Figure 1, the formal DSM-IV axis II Diagnosis is as follows:

—**Antisocial Personality Disorder (T=65)**
—**Narcissistic Personality Disorder (T=61)**
—**Paranoid features (T=56)**

For descriptions of the DSM-IV diagnostic prototypes and their development, see Shedler & Westen, 2004a.

Psychological Health Index

Because of the importance of assessing psychological strengths (e.g., ego strengths) as well as limitations, the score profile includes a *Psychological Health Index* (labeled "High-Fx" on the profile graph). This index measures the resemblance or match between your patient and a prototype representing optimal psychological health. The index serves as a global measure of personality functioning, analogous to the *Global Assessment of Functioning* (GAF) scale in DSM-IV.

A score of T=50 on the *Psychological Health Index* indicates an average level of functioning *relative to a sample of patients with DSM-IV Axis II diagnoses*. The low score (T=40) for the sample patient in Figure 1 indicates relatively severe personality pathology, a standard deviation below the mean in a reference sample of patients with personality disorders.

Scores above T=60 indicate significant psychological resources and capacities, such as the capacity to sustain meaningful relationships, to use talents and abilities effectively and productively, to recognize alternative perspectives, to respond to others' needs and feelings, to find meaning and fulfillment in life's activities, and so on. To facilitate interpretation of high scores, the most important (highest ranked) items contributing to the *Psychological Health Index* are reproduced in Appendix 1.

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SWAP Personality Syndromes (Q-Factor T-Scores)

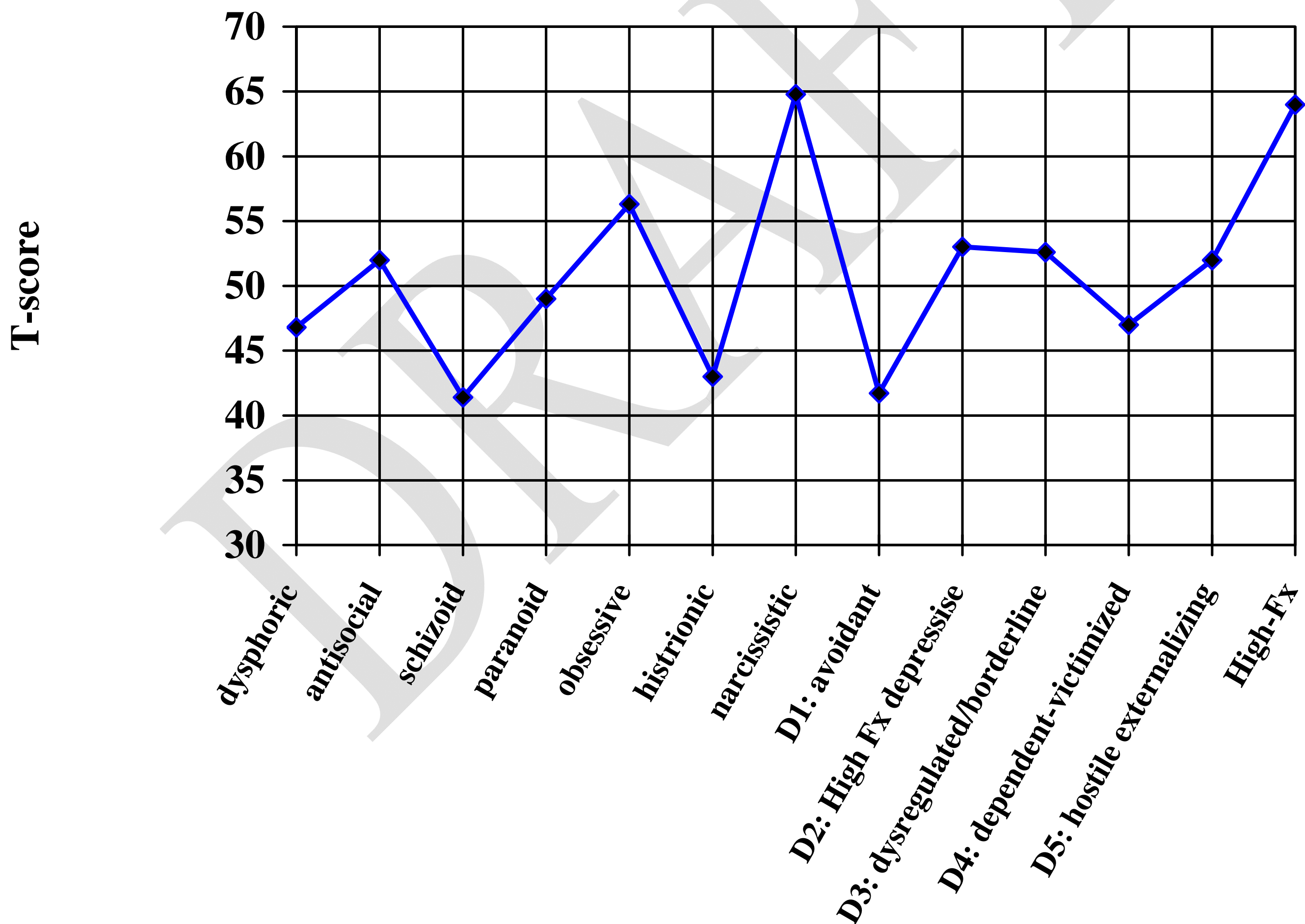
The DSM-IV PD score profile described above maintains "backward compatibility" with DSM-IV for purposes of formal diagnosis, billing and coding, and so on. However, research shows that the DSM-IV diagnostic categories are not optimal for classifying and describing the personality syndromes seen in clinical practice.

The SWAP Personality Syndromes (Q-Factor T-Score) profile shows the degree of resemblance or match between your patient and an alternative set of personality syndromes that were identified empirically (via the method of Q-factor analysis). These personality syndromes overlap DSM-IV diagnostic categories but differ in important ways. They are designed to more faithfully capture the personality syndromes seen in clinical practice and to facilitate clinical case formulation and treatment planning.

Scores indicate the degree of resemblance or "match" between your patient and diagnostic prototypes representing each personality syndrome in its "ideal" or pure form (see the section, "Understanding Prototype Matching" on page 4). Diagnosis is dimensional rather than categorical, so personality syndromes are diagnosed on a continuum from less to more severe. Where categorical diagnosis is desired, T-scores $\geq$ 60 indicate that a diagnosis applies and T-scores $\geq$ of 55 indicate the presence of clinically significant "features." If more than one scale has a T-score above 60, the highest score provides the primary personality diagnosis. The *Psychological Health Index* (High-Fx) is included in the score profile as well.

Figure 2

Q-Factor T-Scores



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For the sample patient in Figure 2, the categorical diagnosis is as follows:

—**Narcissistic personality (T=65)**
—**Obsessional features (T=56)**

The high score on the *Psychological Health Index* (T=64) indicates that the patient possesses significant psychological capacities and resources. His level of functioning is considerably higher than that of the average patient who receives an Axis II personality disorder diagnosis.

For information about the SWAP personality syndromes and the research behind them, see Westen & Shedler, 1999b.

Descriptions of SWAP Personality Syndromes

This section provides prototype descriptions of the SWAP personality syndromes (Q-factors) in their "ideal" or pure form. Since no patient is a perfect representative of a diagnostic syndrome, no prototype will describe your patient exactly. However, considering a prototype description as a whole or "gestalt," you should recognize similarity or fit between your patient and the prototype in proportion to the T-Score elevation.

Where available, we have supplemented the prototype descriptions with information about the kinds of emotional reactions the patient is likely to elicit in the treating clinician (common countertransference responses) and brief comments concerning treatment implications. Computer generated interpretive reports (under development) will provide more comprehensive clinical case formulations and treatment recommendations.

Dysphoric (Depressive) Personality

Comments: Despite its omission from DSM-IV, dysphoric or depressive personality is the most common personality syndrome seen in clinical practice. Dysphoric patients may present with an axis I diagnosis (e.g., major depression, dysthymic disorder) but symptoms are rooted in enduring personality patterns. This diagnostic grouping has several clinically distinct subtypes that are described later in this section (avoidant, high functioning, dependent-victimized, emotionally dysregulated, and hostile-oppositional).

Detailed description: Patients who match this prototype tend to be unhappy, depressed, or despondent, and to find little pleasure, satisfaction, or enjoyment in life's activities. They tend to feel inadequate, inferior, or a failure; are insufficiently

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concerned with meeting their own needs; and seem not to feel entitled to get or ask for things they deserve. They tend to be passive and unassertive. They appear to want to "punish" themselves by creating situations that lead to unhappiness or actively avoiding opportunities for pleasure and gratification. They are also self-critical, tending to set unrealistically high standards for themselves, showing little tolerance for their own human defects, and blaming themselves or feeling responsible for bad things that happen. They tend to feel guilty, ashamed, or embarrassed; to feel listless, fatigued, and lacking energy; and to feel empty or bored. They tend to be anxious, and to feel helpless, powerless, or at the mercy of forces outside their control. In addition to pervasive dysphoria, individuals who fit this prototype tend to be needy or dependent, requiring excessive reassurance or approval. They tend to fear that they will be rejected or abandoned by those who are emotionally significant and may be ingratiating or submissive in the hope of gaining support or approval.

Treatment Considerations: Although acute axis I symptoms may prompt the patient to seek treatment, underlying personality patterns must be addressed to achieve lasting treatment gains. The therapist should identify and explore self-defeating patterns in the patient's thinking, behavior, and relationships, including the relationship with the therapist, and help the patient gain insight into the ways in which he discounts or repudiates his own emotional needs or inhibits his capacity to fulfill them. Underlying feelings of guilt, shame, anger, or unworthiness may emerge as the patient gains greater access to inner experience. Increased self-acceptance can develop over time as the patient internalizes the therapist's more benign and accepting attitudes toward his thoughts, feelings, and impulses.

Antisocial-Psychopathic Personality

Comments: The DSM-IV diagnosis of antisocial personality disorder emphasizes overt behavior and criminality. In contrast, this prototype places greater emphasis on internal psychological processes and motives.

Detailed description: 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 they cause 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

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pleasure or satisfaction by being sadistic or aggressive toward others. They tend to blame others for their own failures or shortcomings and believe their problems are caused by external factors. They have little psychological insight into their own motives and behavior. 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."

Treatment Considerations: Antisocial-psychopathic patients are motivated by a desire for power and by pleasure in "getting one over" on others, including the therapist. They may give the impression of working in therapy if they perceive some immediate personal advantage to doing so (e.g., inducing the therapist to intercede on their behalf, or to get out of legal trouble) but have little genuine interest in self-examination. They are likely to perceive the therapist's sympathetic attention or compassion as weakness. Therapeutic leverage, to the extent there is any, comes from a position of power and dominance that most therapists are reluctant to assume (and that would be counterproductive with other patients). Prognosis is poor.

Schizoid-Schizotypal Personality

Comments: SWAP research does not support the DSM-IV distinction between schizoid and schizotypal personality disorders. The empirical data indicate a single personality syndrome.

Detailed description: Patients who match this prototype lack close friendships and relationships. They appear to have little need for human company or contact and to be indifferent to the presence of others. They lack social skills and often appear socially awkward or inappropriate. They tend to be shy or reserved in social situations; to avoid social situations because of fear of embarrassment or humiliation; and to feel like an outcast or outsider. Their appearance or manner may seem odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or "off"). They appear to have a limited or constricted range of emotions. They tend to be inhibited or constricted; to be passive and unassertive; to have difficulty acknowledging or expressing anger; to have difficulty experiencing strong pleasurable emotions (e.g., excitement, joy, pride); and they tend to elicit boredom in others. They have difficulty making sense of other people's behavior and often misunderstand, misinterpret, or are confused by others' actions and reactions. They appear unable to describe important others in a way that conveys a sense of who they are as people, and their descriptions of others come across as two-dimensional and lacking in richness. They have little psychological insight into their own motives and behavior. They tend to think in concrete terms and interpret things in overly literal ways, and have limited ability to appreciate metaphor, analogy, or nuance. Their reasoning processes or perceptual experiences seem may seem odd and idiosyncratic (e.g., they may make seemingly arbitrary inferences, or see hidden

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messages or special meanings in ordinary events), and their perception of reality can become grossly impaired under stress.

Treatment Considerations: Although DSM-IV describes schizoid patients as indifferent to social relationships and emotionally detached, some individuals who match this prototype crave social contact but avoid it because they are exquisitely sensitive to the pain of interpersonal engagement. They easily feel in danger of being engulfed, enmeshed, controlled, intruded upon, or traumatized, dangers they associate with becoming involved with others. The therapist should respect the patient's interpersonal vulnerabilities and proceed slowly and patiently. Over time, the patient may gradually allow the therapist greater access to his or her inner world and reveal a capacity for attachment that was not initially evident.

Where disturbance in thinking and reasoning is prominent, the patient may be suffering from a subclinical schizophrenic spectrum disorder rather that a personality disorder. The Thought Disorder factor score (see section on "Factor T-Scores," below) can help clarify the extent of thought disturbance, as can additional psychological testing. A thorough history may reveal a biological relative with a psychotic disorder.

Paranoid Personality

Comment: This diagnostic prototype overlaps the DSM-IV construct of Paranoid Personality Disorder but emphasizes traits and personality dynamics that are not recognized by DSM-IV.

Detailed description: Patients who match this prototype tend to hold grudges and may dwell on insults or slights for long periods. They are quick to assume that others wish to harm them or take advantage, and tend to perceive malevolent intentions in others' words and actions. They tend to feel misunderstood, mistreated, or victimized. People who match this prototype also tend to express intense and inappropriate anger, out of proportion to the situation at hand; to be critical of others; to be angry or hostile; to get into power struggles; to be oppositional, contrary, or quick to disagree; and to react to criticism with feelings of rage or humiliation. They tend to see certain others as "all bad" and lose the capacity to perceive any positive qualities the person may have. They tend to blame others for their own failures or shortcomings and to believe their problems are caused by external factors. They are likely to see their own unacceptable feelings or impulses in other people instead of in themselves. Individuals who match this prototype may become irrational when strong emotions are stirred up. They may "catastrophize," seeing problems as disastrous, unsolvable, etc. They tend to be self-righteous or moralistic, and often elicit dislike or animosity in others.

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Common therapist reactions to paranoid patients: Therapists treating paranoid patients report that the patients stir up very strong feelings in them. They report feeling criticized by the patient; feeling unappreciated; feeling dismissed or devalued; feeling mistreated or abused; feeling like they are "walking on eggshells," afraid the patient will explode, fall apart, or walk out if they say the wrong thing; feeling overwhelmed by the patient's strong emotions; feeling frightened; feeling annoyed, angry, or even enraged; feeling anxious or depressed; feeling used or manipulated; having trouble relating to the patient's feelings; disliking the patient; wishing they had never taken on the patient; dreading sessions; feeling resentful working with the patient; feeling repulsed by the patient; feeling frustrated in sessions; and feeling that they have to work to stop themselves from responding to the patient in aggressive or critical ways.

Treatment considerations: The therapist's own strong reactions give some hint of the fear and anger the patient chronically experiences and seeks to manage through externalization and projection. The therapist can help the patient reality test by encouraging him to explore his assumptions and conclusions about interactions with the therapist and with others, and by sharing his own alternative perspectives and reasoning processes. The therapist may also invite the patient to participate in finding solutions to the ongoing dilemma inherent in the therapy relationship: that the patient has come to therapy for help, yet often responds to the therapist in ways that make it difficult to provide help. An overly friendly or sympathetic stance may arouse the patient's suspicions and intensify paranoia. A neutral, matter-of-fact stance is generally more helpful. Effective treatment must ultimately address the patient's underlying aggression and help him develop more effective ways of expressing and regulating it. Patients who have the capacity to maintain meaningful attachments are likely to benefit from psychotherapy. In the absence of a genuine capacity for empathy and attachment, prognosis is poor.

Obsessional Personality

Comments: Obsessional patients generally fall toward the healthier end of the personality spectrum, and the psychological characteristics described in the diagnostic prototype are often accompanied by significant ego strengths. Except in extreme cases, obsessional personality does not reach the severity of pathology typically associated with an Axis II personality "disorder" and may be better conceptualized as a personality pattern or style. Contrary to common assumptions, obsessional personality is largely unrelated to axis I obsessive-compulsive disorder, which appears to be a distinct syndrome with a separate etiology.

Detailed description: Patients who match this prototype are excessively devoted to work and productivity, to the detriment of leisure and relationships. They tend to see themselves as logical and rational, uninfluenced by emotion; prefer to

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operate as if emotions were irrelevant or inconsequential; tend to think in abstract and intellectualized terms, even in matters of personal import; and appear to have a limited or constricted range of emotions. They tend to be inhibited or constricted; to have difficulty allowing themselves to acknowledge or express wishes and impulses; to have difficulty allowing themselves to experience strong pleasurable emotions (e.g., excitement, joy, pride); and to have difficulty acknowledging or expressing anger. They tend to deny or disavow their own need for caring, comfort, closeness, etc., or to consider such needs unacceptable. Additionally, they tend to be controlling; competitive with others (whether consciously or unconsciously); critical of others; conflicted about authority (e.g., they may feel they must submit, rebel against, win over, defeat, etc.); prone to get into power struggles; and self-righteous or moralistic. They are also self-critical, tending to set unrealistically high standards for themselves, showing little tolerance for their own human defects, and expecting themselves to be "perfect." They may adhere rigidly to daily routines and become anxious or uncomfortable when they are altered.

Treatment considerations: Obsessional personality is organized around a need to defend against unacceptable affect, especially fear and rage. For this reason, obsessional patients prefer to think rather than feel. Reliance on intellectualization, adherence to routine, and preoccupation with work and productivity serve to ward off threatening affect, but underlying fear and aggression tend to “leak out” in the form of critical attitudes, controlling behavior, power struggles, and so on. Obsessional patients will benefit from an interpretive approach aimed at helping them recognize and understand their efforts, often unconscious, to ward off painful affect, and the cost of these defenses vis-à-vis relationships and capacity for enjoyment. The therapist should be alert to the patient’s tendency to intellectualize, especially the tendency to treat the therapist’s comments as abstract theories to ponder. For example, if the patient says the therapist’s comments “make sense,” the therapist might ask whether the comments just “make sense,” or whether the patient actually recognizes something in himself and feels it to be personally true. In this way, the therapist may gently draw the patient’s attention to affective experience.

Histrionic Personality

Comments: Patients who match this prototype rely on sexuality to gain attention and notice. They tend to be attention seeking, flamboyant, and seductive, and to express emotion in dramatic, even theatrical ways. Sexualization and attention seeking serve to ward off underlying fears of abandonment and powerlessness.

Detailed description: Patients who match this prototype tend to be overly needy or dependent, requiring excessive reassurance or approval. They tend to be overly sexually seductive or provocative, whether consciously or unconsciously (e.g., they may be inappropriately flirtatious, preoccupied with sexual conquest,

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or prone to “lead people on”); to use their physical attractiveness to an excessive degree to gain attention or notice; and to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc. They seek to be the center of attention; fantasize about finding ideal, perfect love; and are suggestible or easily influenced. Their perceptions seem glib, global, and impressionistic; they have difficulty focusing on specific details. Individuals who match this prototype tend to become attached quickly or intensely, and to develop feelings, expectations, etc. that are not warranted by the history or context of the relationship. They tend to fear they will be rejected or abandoned by those who are emotionally significant; yet they become attached to, or romantically interested in, people who are emotionally unavailable. Patients who match this prototype express emotion in exaggerated and theatrical ways, and tend to become irrational when strong emotions are stirred up. They may have difficulty soothing or comforting themselves when distressed, and require involvement of another person to help regulate affect. Their emotions tend to spiral out of control, and to change rapidly and unpredictably. They tend to be anxious, and to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.).

*Common therapist reactions to histrionic patients***:** Therapists treating histrionic patients report thinking or fantasizing about ending the treatment (especially therapists treating male histrionic patients); feeling resentful working with the patient; feeling angry with the patient; feeling pushed to set very firm limits; having trouble relating to the patient’s feelings; feeling frightened by the patient; losing their temper with the patient; feeling that they have to stop themselves from saying or doing something aggressive or critical; more than with most patients, feeling that they’ve been pulled into things that they didn't realize until after the session was over; feeling dismissed or devalued; at times disliking the patient; not trusting what the patient is telling them; feeling annoyed in sessions; feeling repulsed by the patient; feeling used or manipulated; and feeling that they are being mean or cruel to the patient.

Treatment considerations: Clinical experience suggests that heterosexual histrionic patients perceive the opposite gender as powerful, exciting, and potentially dangerous, and their own gender as relatively weak, needy, and powerless. Sexual attention seeking can be understood as an effort, generally unconscious, to avoid feared rejection and abandonment, and to gain power over the opposite gender through sexuality and seductiveness. Healthier patients with histrionic styles may be charming and engaging, but sicker patients (such as those described by the prototype) tend to paradoxically elicit the very dismissiveness they fear, as therapists (and others) become exasperated with continuing drama, the feeling of being manipulated, and the patient’s seemingly willful naïveté and apparent lack of interest in self examination. Histrionic patients benefit from an insight oriented approach emphasizing patient, self-paced exploration of underlying needs, feelings, wishes, fears, and defenses. A didactic or authoritarian stance may inadvertently reinforce feelings of deficiency and

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powerlessness. Sicker histrionic patients (e.g., those prone to impulsive acting out and frank manipulation, or those with borderline features) may require more explicit limit setting, attention to boundary issues, and confrontation of destructive acting out that may occur inside or outside of therapy sessions.

Narcissistic Personality

Comments: This diagnostic prototype overlaps the DSM-IV construct of Narcissistic Personality Disorder but emphasizes traits and personality dynamics that are not currently recognized by DSM-IV.

Detailed description: Patients who match this prototype have fantasies of unlimited success, power, beauty, talent, brilliance, etc. They appear to feel privileged and entitled, and expect preferential treatment. They have an exaggerated sense of self-importance, and believe they can only be appreciated by, or should only associate with, people who are high-status, superior, or otherwise “special.” Individuals who match this prototype seek to be the center of attention, and seem to treat others primarily as an audience to witness their own importance, brilliance, beauty, etc. They tend to be arrogant, haughty, or dismissive; to be competitive with others (whether consciously or unconsciously); to feel envious; and to think others are envious of them. They expect themselves to be “perfect” (e.g., in appearance, achievements, performance, etc.). They are likely to fantasize about finding ideal, perfect love. They tend to lack close friendships and relationships; to feel life has no meaning; and to feel like they are not their true selves with others, so that they may feel false or fraudulent.

Common therapist reactions to narcissistic patients: Narcissistic patients stir up strong feelings in therapists, which can fluctuate between anger and boredom. Therapists treating narcissistic patients report feeling unappreciated; criticized; dismissed or devalued, used or manipulated; and mistreated or abused by the patient. They report feeling like they are “walking on eggshells,” afraid the patient will explode, fall apart, or walk out if they say the wrong thing. They report disliking the patient at times; feeling resentful working with the patient; feeling annoyed; feeling angry; feeling enraged; losing their temper; having to stop themselves from saying or doing something aggressive or critical; feeling like they are being mean or cruel to the patient; and with opposite sex patients, feeling sexual tension in the room. Additionally, therapists treating narcissistic patients report feeling bored in sessions; watching the clock more than with other patients; and struggling to keep their minds from wandering. They report talking more about the patient with their spouse or significant other than about other patients; feeling hopeless working with the patient; dreading sessions; dreading phone messages; fantasizing about ending the treatment; and wishing they had never taken him on as a patient.

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Treatment considerations: For most narcissistic patients, grandiosity and self-importance serve a defensive function, serving to ward off painful feelings of inadequacy, smallness, anxiety, and loneliness. The narcissistic patient wants to feel important and privileged, and when defenses are operating effectively, he does. When defenses fail, there is a powerful undercurrent of negative affect and feelings of inadequacy, often accompanied by rage. Narcissistic patients may alternately idealize and devalue others, including the therapist. When they idealize someone with whom they are connected, they feel special or important by virtue of association. When they devalue someone, they feel superior.

Effective treatment may require a careful balancing act, with a judicious blend of empathy and confrontation. Narcissistic patients benefit from empathic understanding of their underlying pain, insecurity, and vulnerability (including open and honest acknowledgement of the therapist's own inevitable empathic failures in the therapy relationship), and with the therapist's help, may develop greater capacity to tolerate these feelings without resorting to grandiosity and devaluation. On the other hand, the patient may benefit from confrontation of narcissistic defenses (e.g., against shame, envy, and normal dependency) and exploration of the considerable cost of these defenses. Narcissistic patients may be most receptive to psychotherapy in mid-life or later, when fantasies of limitless beauty, fame, wealth, or power have been disappointed and they are forced to confront life's realistic limits. Where narcissism is accompanied by sadistic aggression and psychopathy (the syndrome of "malignant narcissism"), prognosis is poor.

Avoidant Personality

Comments: Patients who match this prototype attempt to manage chronic dysphoric affect through avoidance and withdrawal. This syndrome is a clinically important subtype of the dysphoric or depressive personality syndrome.

Detailed description: Patients who match this prototype tend to be shy or reserved in social situations, and tend to avoid social situations because of fear of embarrassment or humiliation. They lack social skills, and lack close friendships and relationships. They tend to feel like an outcast or outsider, and to feel as if they do not truly belong. More generally, they tend to feel inadequate, inferior, or a failure; to feel ashamed or embarrassed; to be anxious; and to be self-critical, setting unrealistically high standards for themselves. They tend to blame themselves or feel responsible for bad things that happen, and to find little or no pleasure, satisfaction, or enjoyment in life's activities. Individuals who match this prototype tend to be inhibited or constricted, having difficulty allowing themselves to acknowledge or express their wishes and impulses. They display a limited or constricted range of emotions. They tend to have difficulty allowing themselves to experience strong pleasurable emotions (e.g., excitement, joy, pride); to be passive and unassertive; to have difficulty acknowledging or

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expressing anger; and to be inhibited about pursuing goals or successes, sometimes leading to aspirations or achievements below their potential. They may seem to know less about the ways of the world than might be expected, given their intelligence, background, etc.

Treatment Considerations: Avoidant personality is a subtype of Dysphoric (Depressive) personality and similar treatment considerations apply. However, the therapy should specifically address the patient's avoidance. Patients with avoidant personality may be verbally as well as behaviorally avoidant, and may steer clear of difficult topics or change the subject when disturbing thoughts or feelings arise. The patient may require extra help and encouragement from the therapist to experience, name, and express emotions. When the patient responds to situations (both inside and outside of therapy sessions) with fearful avoidance, the therapist should challenge the patient's expectations and beliefs ("And what would happen then?"). When a secure working alliance has been established, the patient should be urged to face feared situations and experiences, ideally in progressive and manageable steps.

High Functioning Depressive Personality

Comments: This is a distinct personality syndrome observable in a large percentage of patients treated in the community. It does not reach the severity of pathology typically associated with an Axis II personality "disorder" and may be better regarded as a personality pattern or style. Patients who match this prototype possess many personality strengths and capacities in combination with dysphoric, self-denigrating personality dynamics. This syndrome is a clinically important subtype of the dysphoric or depressive personality syndrome.

Detailed description: Patients who match this prototype have many psychological strengths. They tend to be articulate; empathic; capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring; able to form close and lasting friendships; and able to find meaning and fulfillment in guiding, mentoring, or nurturing others. Further, they tend to be psychologically insightful, able to understand themselves and others in subtle and sophisticated ways; to be creative; to appreciate and respond to humor; and to be able to hear information that is emotionally threatening (i.e., that challenges cherished beliefs, perceptions, and self-perceptions) and use and benefit from it. Their strengths and weaknesses, however, tend to spring from the same wells: They may be conscientious and responsible to a fault; they have moral and ethical standards and strive to live up to them, often at the cost of their happiness or self-esteem; they enjoy challenges and are able to use their talents, abilities, and energy effectively and productively, but often put tremendous pressure on themselves; and they tend to seek out or create interpersonal relationships in which they are in the role of caring for, rescuing, or protecting the other. They tend to blame themselves or feel responsible for bad things that happen; to feel

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guilty; to feel unhappy, depressed, or despondent; and to feel listless, fatigued, or lacking in energy. They tend to be self-critical, setting unrealistically high standards for themselves and being intolerant of their own human defects. They tend to fear that they will be rejected or abandoned by those who are emotionally significant.

Common therapist reactions to high-functioning depressive patients:
Therapists treating patients who match this prototype tend to feel hopeful about the gains the patient is making or will likely make in treatment; tend to like the patient a good deal; regard the patient as one of their favorites; feel that if s/he were not a patient, they could imagine being friends; look forward to sessions; feel pleased or satisfied after sessions; find it exciting to work with the patient; and feel that they understand the patient. They also tend to report that the patient makes them feel good about themselves and the therapy work.

Treatment considerations: Generally, high functioning depressive patients derive benefit from treatment and are seen as “good” patients. The flip side is that the therapist may feel good because the patient is recreating a pattern of subordinating his needs to those of others (in this case, those of the therapist), squelching negative feelings toward the therapist, or in other ways attending to the therapist’s perceived needs rather than his own, as the patient tends to do in relationships more generally. The therapist would do well to point out these patterns as they arise and to help the patient understand their relation to depression. More specifically, it is vital when treating such patients to elicit their negative feelings, especially their hostility and criticism, because they typically idealize the therapist, try to be good patients, and tend to interpret the therapist’s noncritical acceptance as evidence that the therapist has not yet noticed how bad they really are. It is also important to help depressive patients see how they persist in believing that their badness is the cause of the difficulties and losses they experience.

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Borderline (Emotionally Dysregulated) Personality

Comments: This diagnostic prototype overlaps the DSM-IV construct of Borderline Personality Disorder. Patients who match this prototype suffer from deficits in the capacity for affect regulation. They experience intense and volatile affect, profound states of desperation and despair, and are prone to self-harm.

Detailed description: Patients who match this prototype struggle with emotions that spiral out of control, leading to extremes of anxiety, sadness, rage, etc. They are unable to soothe or comfort themselves when distressed and may require involvement of another person to help regulate their emotions. They struggle with genuine wishes to kill themselves; tend to make repeated suicidal threats or gestures, either as a “cry for help” or as an effort to manipulate others; and tend to engage in self-mutilating behavior (e.g., self-cutting, self-burning, etc.).

Individuals who match this prototype tend to feel unhappy, depressed, or despondent; to feel life has no meaning; to be preoccupied with death and dying; to feel empty; and to find little or no pleasure, satisfaction, or enjoyment in life's activities. They are likely to "catastrophize," seeing problems as disastrous or unsolvable. They tend to become irrational when strong emotions are stirred up and may show a noticeable decline from their customary level of functioning. Their emotions tend to change rapidly and unpredictably. They tend to be angry or hostile (whether consciously or unconsciously), and to feel misunderstood, mistreated, or victimized. Patients who match this prototype tend to feel like an outcast or outsider; to feel inadequate, inferior, or a failure; and to be overly needy or dependent. They may repeatedly re-experience or re-live a past traumatic event (e.g., having intrusive memories or recurring dreams of the event, or becoming startled or terrified by present events that resemble or symbolize the past event).

Treatment Considerations: Borderline patients benefit from psychotherapy but are among the most challenging patients to treat, predictably testing the limits of therapists' capacities. They require intensive, long-term treatments, active management of a range of acute axis I symptoms, and management of destructive and self-destructive behaviors. All effective treatments for borderline personality emphasize active limit setting, attention to boundary issues, and management of behavior that is potentially destructive to the therapy and the therapy relationship. A number of therapies have shown empirical efficacy for borderline personality, including variants of psychodynamic psychotherapy (*Transference-Focused Psychotherapy* and *Mentalization-Based Therapy*) and variants of cognitive behavioral therapy (*Dialectical Behavior Therapy* and *Schema-Focused Therapy*).

Dependent-Victimized Personality

Comments: Patients who match this prototype are characterized by extreme dependency which leads them to subordinate their own needs to those of others, and leaves them vulnerable to relationships in which they are exploited or ill-used. This syndrome is a clinically important subtype of the dysphoric or depressive personality syndrome.

Detailed description: Patients who match this prototype tend to get drawn into or remain in relationships in which they are emotionally or physically abused. They tend to be ingratiating or submissive; to be overly needy or dependent; to be suggestible or easily influenced; to have trouble making decisions, often vacillating when faced with choices; and to be unable to soothe or comfort themselves when distressed, requiring involvement of another person to help regulate their emotions. They tend to become attached quickly or intensely; developing feelings, expectations, etc. that are not warranted by the history or context of the relationship. They fear being alone, and fear that they will be

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rejected or abandoned by those who are emotionally significant. They are likely to become attached to, or romantically interested in, people who are emotionally unavailable; to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.; to idealize certain others in unrealistic ways, seeing them as "all good," to the exclusion of commonplace human defects; and to fantasize about finding ideal, perfect love. Patients who match this prototype tend to be passive and unassertive; to have difficulty acknowledging or expressing anger; and to express aggression in passive and indirect ways (e.g., they may make mistakes, procrastinate, forget, become sulky, etc.). They lack a stable image of who they are or would like to become (e.g., their attitudes, values, goals, and feelings about themselves may be unstable and changing). They may repeatedly convince others of their commitment to change, but then revert to previous maladaptive behavior.

*Common therapist reactions to Dependent Patients***:** Therapists treating Dependent patients report feeling pushed to set very firm limits with the patient; not trusting what the patient tells them; when checking phone messages, feeling anxiety or dread about receiving a message from the patient; thinking or fantasizing about ending treatment; worrying about the patient after sessions more than other patients; having their mind wander to things other than what the patient is talking about; feeling confused in sessions with the patient; thinking the patient might do better with another therapist or in a different kind of therapy; returning the patient's phone calls less promptly than usual; wishing they had never taken him on as a patient; feeling sad in sessions with the patient; feeling annoyed in sessions; feeling like their hands have been tied or that they have been put in an impossible bind; and feeling used or manipulated by the patient.

Treatment considerations: Dependent-victimized patients seem to repetitively place themselves in harm's way. They appear to operate on the belief that attachment requires suffering and may cling to relationships that, in the eyes of virtually everyone else, are destructive. In severe cases, existence outside of the relationship, however abusive, may seem unimaginable. While Dependent-victimized patients may present as helpless, an underlying (passive) aggression is often evident in the tenacity with which they defeat the therapist's interventions and resist efforts to help. The therapist's frustration and annoyance may provide a window into the kind of reactions the patient elicits from others (who are generally less inclined than the therapist to inhibit sadistic and punitive impulses). When a secure working alliance is established, the patient should be confronted with his own contributions to recurring difficulties, and the therapist should be prepared for the patient's resulting anxiety or anger. It can be helpful to make explicit the ways in which the patient places the therapist (and himself) in untenable binds and invite the patient to explore solutions for getting out of them, instead of the therapist undertaking the generally futile task of trying to find solution on the patient's behalf.

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Hostile-Externalizing Personality

Comments: Hostile/Externalizing patients represent a subtype of depressive or dysphoric personality characterized by anger, hostility, and externalization of blame. Because hostile/externalizing patients blame their difficulties on external factors, they tend to be angry, critical, oppositional, and conflicted about authority. When these traits emerge in therapy, they present considerable treatment challenges.

Detailed description: Patients who match this diagnostic prototype tend to get into power struggles. They tend to be angry or hostile (whether consciously or unconsciously); to blame others for their own failures or shortcomings; and to believe their problems are caused by external factors. They tend to be oppositional, contrary, or quick to disagree. They tend to be critical of others; controlling; and hostile toward members of the opposite sex (whether consciously or unconsciously). They tend to express aggression in passive and indirect ways (e.g., by making mistakes, procrastinating, forgetting things, become sulky, etc.), and they tend to see their own unacceptable feelings or impulses in other people instead of in themselves. Individuals who match this prototype tend to be conflicted about authority (e.g., feel they must submit, rebel against, win over, defeat, etc.), and to react to criticism with feelings of rage or humiliation. They tend to feel misunderstood, mistreated, or victimized; to feel helpless, powerless, or at the mercy of forces outside their control; and to assume that others wish to harm or take advantage of them. They are likely to hold grudges, dwelling on insults or slights for long periods. They often appear inhibited about pursuing goals or successes, so that their aspirations or achievements may be below their potential

Common therapist reactions to hostile-externalizing patients: Therapists treating hostile/externalizing patients report having trouble relating to the feelings the patient expresses; not feeling engaged in sessions with the patient; feeling annoyed with the patient; feeling dismissed or devalued; feeling unappreciated; feeling criticized; feeling used or manipulated; at times disliking the patient; and at times dreading sessions. The therapist may feel a “pull” toward becoming controlling in turn.

Treatment implications: Hostile-externalizing patients present treatment challenges because they blame others for their difficulties and see their problems as externally caused. They may misuse therapy appointments as complaint sessions, recounting dissatisfactions and grievances with others instead of examining their own contributions to repetitive dissatisfying interactions. The patient should be helped to recognize how his interpersonal style drives others away or leads them to respond in hostile or controlling ways, and how this creates a vicious cycle that leaves the patient feeling still more angry, depressed, or alienated. The therapist can empathize with the patient’s unhappiness while

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also confronting the externalization ("If you are certain that your difficulties are caused by other people, I'm sympathetic to your situation, but there is little I can do as a therapist to help. On the other hand, if you think there is something *you* are contributing to these unhappy interactions, we can work to understand that so you don't have to keep reliving the same kind of painful experience."). Underlying feelings of pain, loneliness, and inadequacy will emerge as the patient relinquishes externalizing defenses and increasingly attends to inner experience.

Factor T-Scores

The diagnostic approach described in the previous sections is *person-centered*. Diagnostic constructs are *types of people* (e.g., people with narcissistic personality disorder, people with high functioning depressive personality) and scale scores measure the extent to which a patient resembles or matches the personality type.

An alternative assessment approach is *variable-centered*. Diagnostic constructs are personality *traits*, often identified via the statistical method of factor analysis. Scale scores measure the patient on each trait relative to population norms. Person-centered (type) and variable centered (trait) approaches serve different purposes and provide different kinds of information.

Factor analysis of the SWAP-200 item set yields twelve conceptually interpretable trait dimensions or factors. Some of the factors converge on recognized personality disorders (e.g., Psychopathy, Narcissism). Other factors highlight important psychological characteristics that are not synonymous with a specific personality disorder (e.g., Hostility, Thought Disorder, Sexual Conflict). The factor scores supplement the diagnostic picture provided by the other score profiles and provide additional information relevant to case formulation and treatment planning. All scores are T-Scores based on norms established in a reference sample of patients with DSM-IV personality disorder diagnoses.

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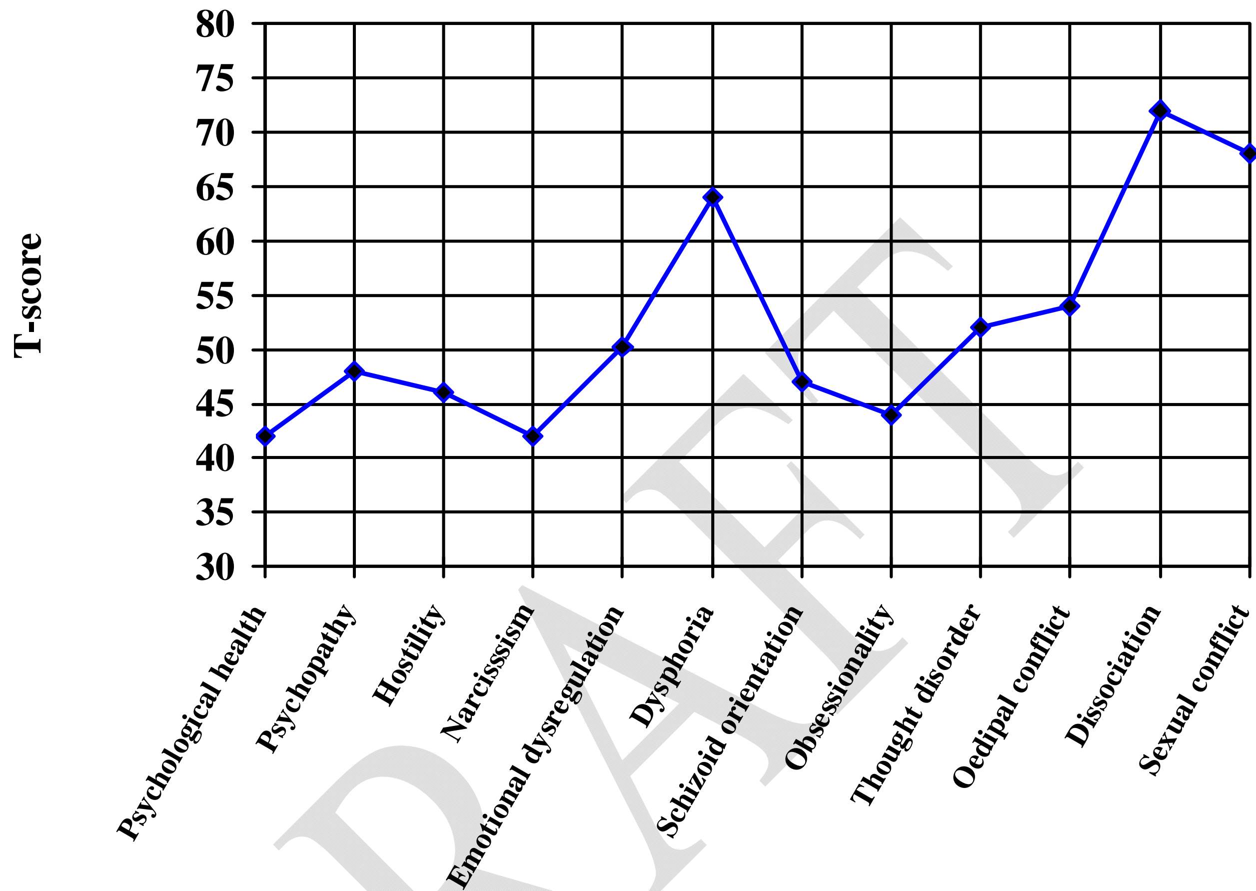
Figure 3

Factor T-Scores



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The sample patient graphed in Figure 3 shows profile elevations on Dissociation (T=72), Sexual Conflict (T=68), and Dysphoria (T=64). High scores on the Dissociation factor indicate pronounced discontinuities in mental life, generally due to an inability to integrate painful or traumatic experience. Some patients with high scores on this factor experience dissociative episodes (e.g., altered states of consciousness, depersonalization, derealization). High scores on the Sexual Conflict factor indicate disturbed attitudes toward sexuality, for example, associating sex with danger and experiencing sexuality as shameful or disgusting. The sample patient's combined high scores on Dissociation and Sexual Conflict are consistent with a history of sexual abuse and trauma. The high score on Dysphoria indicates that the patient experiences considerable emotional distress and is chronically susceptible to painful affect.

To facilitate interpretation of the Factor T-Scores, a brief summary description of each factor is provided below. The summary descriptions do not necessarily

capture the complexities and nuances of the factors. For more comprehensive descriptions, please consult the complete listing of items and factor loading in Appendix 1.

For additional information about the SWAP-200 factors and their derivation, see Shedler & Westen, 2004b.

Summary Descriptions of SWAP-200 Factors

Psychological Health measures the positive presence of psychological resources and capacities (e.g., ego strengths). It encompasses the capacity to love, to use one's talents and abilities effectively and creatively, to pursue long-term goals, to respond to others' needs and feelings, and to hear and make constructive use of challenging information.

Psychopathy assesses attitudes and behaviors associated with antisocial personality disorder and psychopathy. High scores are associated with increased likelihood of unlawful behavior, disregard for the rights of others, lack of remorse, deceitfulness, irresponsibility, exploitation of others, impulsivity, thrill seeking behavior, and a tendency to abuse substances.

Hostility measures chronic anger, hostility, suspiciousness, and mistrust.

Narcissism assesses self-importance, grandiosity, arrogance, entitlement, fantasies of unlimited success, and a tendency to treat others as an audience.

Emotional Dysregulation refers to a deficiency in the capacity to modulate and regulate affect, so that affect tends to spiral out of control, change rapidly and unpredictably, get expressed in extreme form, and overwhelm rational thought.

Dysphoria measures chronic feelings of depression, inadequacy, meaningless, emptiness, and shame.

Schizoid Orientation assesses a pervasive impoverishment in both relationships and mental life. Individuals who score high on this factor lack close relationships, appear indifferent to human company or contact, think in concrete, overly literal ways, and have a limited or constricted range of affect.

Obsessionality assesses excessive concern with rules and procedures, preoccupation with detail, rigid adherence to routine, concerns about dirt and cleanliness, a cognitive style characterized by intellectualization, and a tendency to experience intrusive obsessional thoughts.

Thought Disorder (or schizotypy) assesses peculiarities in thinking and reasoning and deficits in reality testing. Higher scores on this factor are

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associated with increased likelihood of having a biological relative with a psychotic disorder.

Oedipal Conflict indicates a tendency to choose sexual or romantic partners who are emotionally unavailable or inappropriate, to be overly sexually seductive or provocative, and to become embroiled in romantic or sexual “triangles” that involve a third party competitor.

Dissociation refers to disconnected thoughts, feelings, and memories, gaps in memory, and a tendency to enter altered, dissociated states. Such discontinuities in mental life are generally related to a history of trauma or abuse.

Sexual Conflict indicates disturbed attitudes toward sexuality. Sexual activity is consciously or unconsciously associated with danger (e.g., injury, punishment), sexuality is associated with guilt, shame, or disgust, and there may be a specific sexual dysfunction.

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Annotated Bibliography

Shedler, J. & Westen, D., (2007). The Shedler-Westen Assessment Procedure (SWAP): Making personality diagnosis clinically meaningful. *Journal of Personality Assessment*, 89, 41-55.

An overview of the SWAP-200 instrument and research program. The best starting point for practitioners and researchers new to the SWAP.

Lingiardi, V., Shedler, J., Gazillo, F. (2006). Assessing personality change in psychotherapy with the SWAP-200: a case study. *Journal of Personality Assessment,* 86, 23-32.

A case study of a patient with borderline personality disorder assessed with the SWAP-200 at the start of treatment and after two years of psychotherapy. This is the most therapy-relevant SWAP article, demonstrating the use of the SWAP for initial assessment and for tracking personality change in intensive psychotherapy.

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

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

These papers, published as a two-part series, are the seminal articles on the SWAP-200. They describe the rationale, development, and validity of the instrument. Part 1 describes the normative sample and the development and validation of SWAP personality disorder (PD) scores. Part 2 describes the research behind the SWAP diagnostic syndromes (Q factors).

Shedler, J., & Westen, D. (2004a). Refining personality disorder diagnoses: Integrating science and practice. *American Journal of Psychiatry, 161*, 1-16.

This paper provides detailed SWAP-200 descriptions of DSM-IV personality disorders as conceptualized by clinical practitioners and observed in clinical practice. It discusses the limitations of the Axis II diagnostic system and offers recommendations for the next revision of the DSM.

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

This paper describes the SWAP-200 factors and the methods used to derive them.

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Westen, D. & Shedler, J. (2007). Personality diagnosis with the Shedler-Westen Assessment Procedure (SWAP): Integrating clinical and statistical measurement and prediction. *Journal of Abnormal Psychology*, 116, 810-822.

This paper addresses technical psychometric and methodological issues and presents preliminary findings for the SWAP-II (the successor to the SWAP-200). Primarily for technically oriented readers.

Spitzer, R.L., First, M.B., Shedler, J., Westen, D., & Skodal, M.D. (2008). Clinical Utility of Five Dimensional Systems for Personality Diagnosis: A "Consumer Preference" Study. *Journal of Nervous and Mental Disease*, 196, 356-374.

This article examines the clinical utility of the SWAP diagnostic system (SWAP personality syndromes) relative to the DSM-IV diagnostic system and other dimensional models of personality.

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

Russ, E., Bradley, R., Shedler, J., & Westen, D. (2008). Refining the construct of narcissistic personality disorder: Diagnostic criteria and subtypes. *American Journal of Psychiatry*, 165, 1473-1481.

Westen, D., & Harnden-Fischer, J. (2001). Classifying eating disorders by personality profiles: Bridging the chasm between Axis I and Axis II. *American Journal of Psychiatry*, 158, 547-562.

A selection of SWAP articles focusing on specific syndromes and disorders.

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Appendix 1: Psychological Health Index (highest ranked items)

Item	Score
Appreciates and responds to humor.	6.41
Is empathic; is sensitive and responsive to other peoples' needs and feelings.	6.24
Tends to be conscientious and responsible.	6.24
Is able to use his/her talents, abilities, and energy effectively and productively.	6.18
Is able to form close and lasting friendships characterized by mutual support and sharing of experiences.	6.12
Tends to express affect appropriate in quality and intensity to the situation at hand.	6.06
Generally finds contentment and happiness in life's activities.	6.00
Is creative; is able to see things or approach problems in novel ways.	6.00
Has moral and ethical standards and strives to live up to them.	5.94
Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring.	5.88
Is able to assert him/herself effectively and appropriately when necessary.	5.82
Finds meaning in belonging and contributing to a larger community (e.g., organization, church, neighborhood, etc.).	5.76
Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.	5.76
Is articulate; can express self well in words.	5.71
Enjoys challenges; takes pleasure in accomplishing things.	5.65
Is capable of hearing information that is emotionally threatening (i.e., that challenges cherished beliefs, perceptions, and self-perceptions) and can use and benefit from it.	5.65
Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others.	5.59
Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.	5.41
Appears to have come to terms with painful experiences from the past; has found meaning in, and grown from such experiences.	5.35
Tends to elicit liking in others.	5.29
Appears comfortable and at ease in social situations.	5.24
Tends to be energetic and outgoing.	5.18
Has an active and satisfying sex life.	4.76

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Appendix 2: SWAP-200 Factor Structure

Factor	Loading
Factor 1: Psychological health	
Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring	0.75
Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions	0.75
Is capable of hearing information that is emotionally threatening (i.e., that challenges cherished beliefs, perceptions, and self-perceptions) and can use and benefit from it	0.73
Is creative, is able to see things or approach problems in novel ways	0.73
Is able to use his or her talents, abilities, and energy effectively and productively	0.72
Enjoys challenges, takes pleasure in accomplishing things	0.72
Is empathic, is sensitive and responsive to other peoples' needs and feelings	0.71
Is able to assert himself or herself effectively and appropriately when necessary	0.71
Appreciates and responds to humor	0.71
Tends to elicit liking in others	0.67
Is articulate, can express self well in words	0.67
Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others	0.66
Finds meaning in belonging and contributing to a larger community (e.g., organization, church, neighborhood, etc.)	0.65
Appears comfortable and at ease in social situations	0.64
Tends to be energetic and outgoing	0.64
Has an active and satisfying sex life	0.62
Has moral and ethical standards and strives to live up to them	0.58
Tends to be conscientious and responsible	0.56
Factor 2: Psychopathy	
Tends to engage in unlawful or criminal behavior	0.80
Tends to show reckless disregard for the rights, property, or safety of others	0.79
Tends to be deceitful, tends to lie or mislead	0.74
Appears to experience no remorse for harm or injury caused to others	0.69
Tends to be unreliable and irresponsible (e.g., may fail to meet work obligations or honor financial commitments)	0.68
Takes advantage of others, is out for number one, has minimal investment in moral values	0.67
Tends to be unconcerned with the consequences of his or her actions, appears to feel immune or invulnerable	0.67
Tends to act impulsively, without regard for consequences	0.67
Tends to abuse illicit drugs	0.67
Tends to abuse alcohol	0.61
Tends to seek thrills, novelty, adventure, etc.	0.58
Seeks to dominate an important other (e.g., spouse, lover, family member) through violence or intimidation	0.54
Repeatedly convinces others of his or her commitment to change but then reverts to previous maladaptive behavior; tends to convince others that "this time is really different"	0.53
Tends to break things or become physically assaultive when angry	0.52
Factor 3: Hostility	
Tends to be critical of others	0.64
Tends to be angry or hostile (whether consciously or unconsciously)	0.62
Is quick to assume that others wish to harm or take advantage of him or her, tends to perceive malevolent intentions in others' words and actions	0.61
Tends to hold grudges, may dwell on insults or slights for long periods	0.61
Tends to express intense and inappropriate anger that is out of proportion to the situation at hand	0.60
Tends to be oppositional, contrary, or quick to disagree	0.59
Tends to get into power struggles	0.56
Tends to elicit dislike or animosity in others	0.52
Tends to feel misunderstood, mistreated, or victimized	0.50
Factor 4: Narcissism	
Seems to treat others primarily as an audience to witness own importance, brilliance, beauty, etc.	0.75
Appears to feel privileged and entitled, expects preferential treatment	0.69
Has fantasies of unlimited success, power, beauty, talent, brilliance, etc.	0.68
Seeks to be the center of attention	0.65
Has an exaggerated sense of self-importance	0.63
Tends to be arrogant, haughty, or dismissive	0.57
Tends to believe he or she can only be appreciated by, or should only associate with, people who are high-status, superior, or otherwise "special."	0.55
Tends to think others are envious of himself or herself	0.50

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Factor 5: Emotional dysregulation	
Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc.	0.68
Emotions tend to change rapidly and unpredictably	0.68
Expresses emotion in exaggerated and theatrical ways	0.66
Is unable to soothe or comfort self when distressed, requires involvement of another person to help regulate affect	0.56
Tends to become irrational when strong emotions are stirred up, may show a noticeable decline from customary level of functioning	0.51
Tends to be overly needy or dependent, requires excessive reassurance or approval	0.48
Tends to “catastrophize”; is prone to see problems as disastrous, unsolvable, etc.	0.45
Factor 6: Dysphoria	
Tends to feel he or she is inadequate, inferior, or a failure	0.60
Tends to feel life has no meaning	0.58
Tends to feel empty or bored	0.55
Tends to feel unhappy, depressed, or despondent	0.54
Appears to find little or no pleasure, satisfaction, or enjoyment in life’s activities	0.52
Tends to avoid social situations because of fear of embarrassment or humiliation	0.51
Tends to feel ashamed or embarrassed	0.50
Tends to feel like an outcast or outsider, feels as if he or she does not truly belong	0.49
Tends to feel listless, fatigued, or lacking in energy	0.48
Factor 7: schizoid orientation	
Appears to have little need for human company or contact, is genuinely indifferent to the presence of others	0.58
Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance	0.57
Appears unable to describe important others in a way that conveys a sense of who they are as people; descriptions of others come across as two-dimensional and lacking in richness	0.52
Has little or no interest in having sexual experiences with another person	0.46
Tends to elicit boredom in others (e.g., may talk incessantly, without feeling, or about inconsequential matters)	0.46
Lacks close friendships and relationships	0.45
Appears to have a limited or constricted range of emotions	0.43
Has little empathy, seems unable to understand or respond to others’ needs and feelings unless they coincide with his or her own	0.40
Factor 8: Obsessionality	
Tends to be overly concerned with rules, procedures, order, organization, schedules, etc.	0.72
Tends to become absorbed in details, often to the point that he or she misses what is significant in the situation	0.70
Tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered	0.62
Tends to be preoccupied with concerns about dirt, cleanliness, contamination, etc. (e.g., drinking from another person’s glass, sitting on public toilet seats, etc.)	0.54
Is troubled by recurrent obsessional thoughts that he or she experiences as senseless and intrusive	0.52
Tends to be stingy and withholding (whether of money, ideas, emotions, etc.)	0.44
Tends to think in abstract and intellectualized terms, even in matters of personal import	0.44
Has difficulty discarding things even when they are worn out or worthless; tends to hoard, collect, or hold on to things	0.43
Is excessively devoted to work and productivity to the detriment of leisure and relationships	0.42
Factor 9: Thought disorder (schizotypy)	
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)	0.70
Tends to be superstitious or believe in magical or supernatural phenomena (e.g., astrology, tarot cards, crystals, estrasensory perception, “auras,” etc.)	0.60
Perception of reality can become grossly impaired under stress (e.g., may become delusional)	0.49
Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc., seem somehow strange or “off”)	0.49
Speech tends to be circumstantial, vague, rambling, digressive, etc.	0.45
Is extremely identified with a social or political “cause” to a degree that seems excessive or fanatical	0.41
Feels some important other has a special, almost magical ability to understand his or her innermost thoughts and feelings (e.g., may imagine rapport is so perfect that ordinary efforts at communication are superfluous)	0.40
Tends to confuse own thoughts, feelings, or personality traits with those of others (e.g., may use the same words to describe the self and another person, believe the two share identical thoughts and feelings, or treat the person as an “extension” of himself or herself, etc.)	0.37

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Factor 10: Oedipal conflict (histrionic sexualization)	
Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.	0.63
Tends to become attached to, or romantically interested in, people who are emotionally unavailable	0.60
Tends to become involved in romantic or sexual "triangles" (e.g., is most interested in partners who are already attached, sought by someone else, etc.)	0.59
Tends to be overly sexually seductive or provocative, whether consciously or unconsciously (e.g., may be inappropriately flirtatious, preoccupied with sexual conquest, prone to "lead people on," etc.)	0.54
Fantasizes about finding ideal, perfect love	0.44
Tends to be sexually possessive or jealous, tends to be preoccupied with concerns about real or imagined infidelity	0.38
Factor 11: Dissociation	
Tends to describe experiences in generalities, is unwilling or unable to offer specific details	0.59
Verbal statements seem incongruous with accompanying affect or incongruous with accompanying nonverbal messages	0.57
Appears to experience the past as a series of disjointed or disconnected events; has difficulty giving a coherent account of his or her life story	0.53
Tends to repress or "forget" distressing events or distort memories of distressing events beyond recognition	0.52
Tends to enter altered, dissociated state of consciousness when distressed (e.g., the self or the world feels strange, unfamiliar, or unreal)	0.38
Expresses contradictory feelings or beliefs without being disturbed by the inconsistency, has little need to reconcile or resolve contradictory ideas	0.37
Factor 12: Sexual conflict	
Appears to associate sexual activity with danger (e.g., injury, punishment, contamination, etc.), whether consciously or unconsciously	0.70
Tends to feel guilty or ashamed about his or her sexual interests or activities (whether consciously or unconsciously)	0.58
Tends to see sexual experiences as somehow revolting or disgusting	0.54
Experiences a specific sexual dysfunction during sexual intercourse or attempts at intercourse (e.g., inhibited orgasm or vaginismus in women, impotence or premature ejaculation in men)	0.48
When romantically or sexually attracted, tends to lose interest if other person reciprocates	0.36
Has difficulty directing both tender feelings and sexual feelings toward the same person (e.g., sees people as respectable and virtuous or sexy and exciting but not both)	0.35

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