

DIMENSIONS OF PERSONALITY AND PERSONALITY PATHOLOGY: FACTOR STRUCTURE OF THE SHEDLER–WESTEN ASSESSMENT PROCEDURE-II (SWAP-II)

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Researchers have proposed replacing the current system for diagnosing personality disorders with a dimensional trait model. Proposed trait models have been derived primarily from data provided by untrained lay informants (often via self-report questionnaires) using item sets derived from lay conceptions of personality. An alternative is to derive personality trait dimensions from data provided by clinically expert informants using an instrument that includes personality features salient to clinicians who treat personality dysfunction. The authors report the factor structure of the latest edition of the Shedler–Westen Assessment Procedure (SWAP-II) using a normative clinical sample of 1,201 North American patients assessed by experienced psychologists and psychiatrists. Factor analysis identified 14 clinically and empirically coherent factors. The findings highlight dimensions of personality and personality pathology that have not emerged in personality item sets designed for lay personality description.

Dimensional personality diagnosis has substantial advantages over categorical diagnosis, at least for research purposes (Krueger, Watson, & Barlow, 2005; Westen, Gabbard, & Blagov, 2006; Widiger & Samuel, 2005). Some investigators equate the term “dimensional” with trait models derived via factor analysis. However, trait models represent only one of several alternative approaches to dimensional personality diagnosis.

One approach to dimensional diagnosis is simply to dimensionalize existing *DSM-IV* personality disorders. This can be accomplished by sum-

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ming the number of diagnostic criteria met for each disorder (instead of imposing an arbitrary cut-point; Oldham & Skodol, 2000). It can also be accomplished via a prototype matching procedure, whereby diagnosticians gauge the similarity or “fit” between a patient’s clinical presentation and a paragraph-length narrative description of each disorder (Rottman, Ahn, Sanislow, & Kim, 2009; Spitzer, First, Shedler, Westen, & Skodol, 2008; Westen & Shedler, 2000; Westen, Shedler, & Bradley, 2006). Elsewhere, we have proposed a dimensional approach to personality diagnosis based on *empirically derived* personality prototypes (Westen & Shedler, 1999a, 1999b; Westen, Shedler, Bradley, & DeFife, 2012). This diagnostic system preserves a syndromal approach to personality, consistent with all editions of *DSM* to date; however, both the diagnostic groupings and the descriptions of the diagnoses are derived empirically and reflect naturally occurring groupings in the clinical population.

The classification systems just described are person-centered and syndromal. That is, they focus on personality *syndromes*, or multifaceted constellations of interrelated personality features. A very different approach to dimensional diagnosis is variable-centered, focusing on discrete trait dimensions (rather than multidimensional syndromes) derived via factor analysis (e.g., Krueger & Markon, 2011; Krueger, Watson, & Barlow, 2005; Widiger, Simonsen, Krueger, Livesley, & Verheul, 2005). For several years, trait psychologists have advocated moving away from the syndromal approach of *DSM-IV* to a diagnostic system based on the five factor model (FFM) (e.g., Widiger, Costa, & McCrae, 2002). Investigators have also proposed that both normal and pathological personality can be understood in terms of a trait model comprising four superordinate factors, variously described as (1) negative affectivity or neuroticism, (2) introversion or low positive affectivity, (3) antagonism or low agreeableness, and (4) impulsivity or low conscientiousness (Livesley, Jang, & Vernon, 1998; Watson, Clark, & Harkness, 1994; Widiger & Simonsen, 2005).

The FFM and derivative models proposed as taxonomic alternatives to the syndromal diagnoses of *DSM-IV* (Widiger & Trull, 2007) have a number of advantages, perhaps most importantly that FFM factors tend to replicate across multiple methods and informants and reliably capture important aspects of normal personality. A potential limitation is that the research underlying these models (Clark, Livesley, Schroeder, & Irish, 1996; Markon, Krueger, & Watson, 2005) (including the new variant proposed by the *DSM-5* Axis II Work Group; <http://www.dsm5.org>) has relied heavily on self-report questionnaire data. This presupposes that (a) the data necessary and sufficient to derive a comprehensive and clinically relevant model of personality do not require expertise in psychopathology; (b) individuals with significant personality pathology have sufficient self-awareness and insight that their self-reports (or those of untrained peer observers) are sufficient to derive a comprehensive model of personality and its pathology; and (c) that the language of lay observation (or attempts to summarize it via factor analysis) is adequate for a diagnostic manual in-

tended to be useful to both clinical practitioners and psychopathology researchers.

Both meta-analytic investigations (Klonsky, Oltmanns, & Turkheimer, 2002) and data from recent large-*N* studies (Clifton, Turkheimer, & Oltmanns, 2005) have shown that self-reported pathological personality traits correlate only moderately (in meta-analytic research, $r = .36$) with the same traits assessed by lay informants and weakly with longitudinal evaluation by experts using all available data (Klein, Ouimette, Kelly, Ferro, & Riso, 1994; Pilkonis, Heape, Ruddy, & Serrao, 1991). By contrast, both traits and dimensional personality disorder diagnoses derived from data provided by experienced clinicians using a systematic clinical research interview correlate in the range of $r = .50$ to $.70$ with the same variables as assessed by treating clinicians (Westen & Muderrisoglu, 2003, 2006; Westen et al., 2012). Similarly, research on “illusory mental health” (Shedler, Mayman, & Manis, 1993) demonstrates that self-report measures of neuroticism (or negative affectivity) cannot distinguish psychologically healthy individuals from psychologically distressed individuals who lack self-awareness.

Whether superior in some respects or simply complementary to self-reports, quantified judgments made by clinically trained and experienced observers offer an alternative source of data for personality research, particularly for developing dimensional personality diagnoses intended to be useful in clinical as well as research contexts (Shedler & Westen, 2007; Westen & Shedler, 2007). Although much of our research to date using expert observers has focused on personality disorder prototypes (i.e., constellations of interrelated characteristics that together comprise a diagnostic syndrome), we have also developed dimensional trait models in both adult (Shedler & Westen, 2004a) and adolescent (Westen, Dutra, & Shedler, 2005) samples by factor analyzing adult and adolescent versions of the Shedler–Westen Assessment Procedure (SWAP). This article focuses on trait dimensions derived via factor analysis of the current version of the adult SWAP instrument.

The SWAP-200 (and its revised version, the SWAP-II) is a comprehensive set of 200 items capturing both personality pathology and aspects of adaptive personality functioning. A mental health professional with a thorough knowledge of the patient based on clinical examination ranks each item from 7 (*highly descriptive*) to 0 (*not descriptive*). The assessor must have first become familiar with the patient, specifically in a professional clinical-evaluative context through a comprehensive research-clinical interview (the Clinical Diagnostic Interview; see Westen & Muderrisoglu, 2003; www.psychsystems.net/manuals) or a minimum of six clinical hours of assessment and treatment. The instrument is thus designed specifically for use by clinical professionals functioning in professional contexts. The instrument is based on the Q-sort method: To maximize reliability and assure comparability of scores across assessors, assessors rank-order the personality-descriptive statements using a fixed distribution (in which

relatively few items receive the highest ranks, and progressively more items receive lower ranks, mirroring the natural distribution of psychopathological variables).

SWAP data can be analyzed via conventional factor analysis (a variable-centered approach) to identify underlying personality factors or trait dimensions. They can also be analyzed via Q-factor analysis (a person-centered approach) to identify groupings of patients who share a common personality syndrome (i.e., who are psychologically similar to one another and distinct from patients in other groupings). Thus, the SWAP instruments can be used to derive both (a) trait dimensions and (b) naturally occurring diagnostic grouping in the clinical population (i.e., diagnostic prototypes; Westen & Shedler, 1999b; Westen et al., 2012). Because the item sets for both adult and adolescent versions of the SWAP cover the domains included in *DSM-III-R* and *DSM-IV*, the instruments can additionally be used to derive (dimensional) *DSM* Axis II diagnoses.¹

Factor analyses of the SWAP-200 (the prior adult version of the instrument) yielded 12 conceptually coherent and clinically relevant factors (Shedler & Westen, 2004a), including Psychological Health, Psychopathy, Emotional Dysregulation, Dysphoria, Obsessionality, Thought Disorder, Sexual Conflict, and Histrionic Sexualization. Factor analysis of the SWAP-200-A (the adolescent version of the instrument) yielded 11 highly similar factors, although it also included some factors distinct to this developmental period (e.g., Delinquent Behavior, Attentional Dysregulation, and Peer Rejection). These SWAP factors (both adult and adolescent) showed expected patterns of correlations with a wide range of criterion variables, providing support for their construct validity. Efforts to identify higher-order factors by factor analyzing the factors did not yield coherent or interpretable higher-order factors, suggesting that the SWAP factors measured distinct constructs that were not reducible to FFM domains.

The major limitations of our prior factor-analytic studies using the SWAP-200 were sample size and representativeness. The largest sample used to derive personality traits was 530, and the sample was selected deliberately to include only patients with diagnosable *DSM-IV* personality disorders in relatively equal numbers. How sample selection may have influenced or biased the factors that emerged is unclear. The current study addresses these limitations.

We report on the factor structure underlying comprehensive personality descriptions of adult patients provided by experienced clinician-observers. Each clinician-observer described one randomly selected patient in his or her care who had any degree of personality impairment or dysfunction, irrespective of whether the patient did or did not meet criteria for a *DSM* personality disorder diagnosis. The clinician-observers described the pa-

1. Whereas the original presentations of the SWAP emphasized configural diagnosis, that is, *DSM-IV* diagnosis and empirical derived prototypes (Westen & Shedler, 1999a, 1999b), later research has taken the more agnostic, empirical approach we describe here, namely one that makes use of whatever data-analytic and conceptual approach or approaches prove most empirically valid and clinically useful (Shedler & Westen, 2004b; Westen & Shedler, 2007).

tients using the most recent version the adult SWAP instrument, the SWAP-II. The study used a normative sample of 1,201 North American patients and was specifically designed to develop alternative taxonomic approaches to personality diagnosis for *DSM-5*.

METHOD

SAMPLE

We used the national membership rosters of the American Psychological Association and Psychiatric Association to invite a random sample of psychiatrists and psychologists with at least 5 years of experience postresidency (MDs) or postlicensure (PhDs) to provide assessment data. The response rate was more than 30%. There were no differences on any demographic or other variables we examined between participants who responded to our initial invitation and those who responded to a subsequent follow-up invitation, suggesting that any sampling bias had minimal effects on results. The participating clinician-assessors received a consulting fee of \$200 to complete all research forms and instruments, which required approximately 2 hours.

We asked the clinician-observers to describe “an adult patient you are currently treating or evaluating who has enduring patterns of thoughts, feeling, motivation or behavior—that is, personality problems—that cause distress or dysfunction.” To obtain a broad range of personality pathology, we emphasized that patients need not have a personality disorder diagnosis. Patients had to meet the following additional inclusion criteria: ≥ 18 years of age, not in a current psychotic episode, and known well by the observer (using the guideline of ≥ 6 clinical contact hours but ≤ 2 years to minimize confounds imposed by personality change during treatment). To obtain a representative sample free from selection bias, we directed clinician-assessors to consult their calendars and select the last patient they saw during the previous week who met study criteria. In prior research, assessors reported that they followed these instructions as directed (e.g., Westen & Shedler, 1999a). To verify that this was the case in the present study, we recontacted a randomly selected group of 100 of the clinician-assessors who had provided data. Of the 46 who responded, 96% reported following the procedure as specified. Each assessor contributed data on one patient only (to minimize rater-dependent variance). Assessors had the option of providing SWAP-II data using a traditional card-sorting procedure (with items printed on index cards) or providing SWAP-II data online using a secure Internet site.

MEASURES

The Clinical Data Form (CDF) is a set of objective clinician-report ratings of variables relevant to demographics, diagnosis, adaptive functioning, developmental and family history, and etiology (Westen & Shedler, 1999a)

with which clinically trained observers who have worked with a patient over a number of hours are usually familiar (e.g., history of foster care, family history of criminality). In prior studies, these ratings predicted theoretically relevant criterion variables and reflected reasonable (and conservative) decision rules (e.g., Russ, Heim, & Westen, 2003; Wilkinson & Westen, 2000) (e.g., clinicians followed our instructions to report adverse childhood events such as abuse or history of psychiatric hospitalizations to be present only if they had substantial data supporting them, such as corroboration from informants at the time of abuse or psychiatric records). In what follows, aside from demographics and treatment characteristics, we report ratings of adaptive functioning from the CDF using the Global Assessment of Functioning (GAF) scale from the *DSM-IV* Axis V. Recent research has shown that these clinician-rated variables correlate strongly with independent assessments of the same variables (DeFife, Drill, Nakash, & Westen, 2010).

The SWAP-II is the latest revision of the Shedler–Westen Assessment Procedure, which has been used in numerous taxonomic studies (e.g., Shedler & Westen, 2004a, 2004b; Westen & Shedler, 1999a, 1999b, 2007). To describe a patient, a clinically experienced observer sorts 200 personality-descriptive statements into eight categories, from least descriptive of the patient (assigned a value of 0) to most descriptive (7). The instrument is based on the Q-sort method, which requires observers to arrange items into a fixed distribution. The psychometric advantages of the Q-sort method were described by Block (1978).

The SWAP-II allows clinically trained observers to provide systematic and quantifiable in-depth psychological descriptions of patients using a standard “vocabulary” of personality-descriptive statements. The statements are written without jargon in a manner that stays close to the observational data (e.g., “Tends to get into power struggles”; “Is capable of sustaining meaningful relationships characterized by genuine intimacy and caring”). Statements that require inference about internal psychological 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”). The use of jargon-free language minimizes unreliable interpretive leaps and makes the item set useful to clinicians of all theoretical perspectives.

The SWAP-II item was designed to subsume Axis II criteria included in *DSM-III* through *DSM-IV*, including their appendices. Additionally, it incorporates selected Axis I criteria relevant to personality (e.g., anxiety and depression), important personality constructs described in the clinical and research literatures over the past 50 years, and clinical observations from pilot studies. The SWAP-200 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 item set to describe their patients. We asked each consultant: “Were you able to describe the things you consider psychologically important about your patient?” We added, rewrote, and revised items based on the feedback, then asked new

consultants to describe new patients. We repeated this process over many iterations until most consultants answered “yes” most of the time.

The SWAP-II incorporates the additional feedback of over 2,000 clinician-consultants of all theoretical orientations. We edited items for clarity and added new item content where feedback indicated omission of relevant personality constructs. For example, the burgeoning literature on harm-avoidance (Pezawas et al., 2005) suggested that the SWAP-200 did not adequately cover the construct, so we added an item to address it directly (“Decisions and actions are unduly influenced by efforts to avoid perceived dangers; is more concerned with avoiding harm than pursuing desires”). We also conducted item analyses of SWAP-200 items and deleted items that did not discriminate among patients in a national sample (i.e., that showed minimal variance across patients), and deleted or combined items where analyses indicated empirical redundancy. Overall, 23 items had significant *content* alterations from the SWAP-200 to the SWAP-II, and additional items were edited to clarify existing content. We have described the revision process and its outcome in additional detail in a prior publication (Westen & Shedler, 2007).

An increasing body of research supports the validity and reliability of the adult and adolescent versions of the SWAP in predicting a wide range of criterion variables including, for example, suicide attempts, history of psychiatric hospitalizations, adaptive functioning, interview diagnoses, psychiatric disorders in first- and second-degree biological relatives, and developmental and family history variables (see reviews in Shedler & Westen, 2007; Westen & Shedler, 2007; Westen et al., 2012).

Axis II Checklist. To maximize accuracy of *DSM-IV* personality disorder diagnoses, we presented clinician-consultants with a randomly ordered checklist of the criteria for all Axis II personality disorders. This method produces results that mirror findings based on structured interviews (Morey, 1988; Westen & Muderrisoglu, 2003). For each personality disorder, we generated *DSM-IV* diagnoses both categorically (by applying *DSM-IV* decision rules) and dimensionally (by counting the number of criteria met).

RESULTS

Table 1 presents demographics of the clinician-observers and patients. The patients ($N = 1,201$) averaged early middle age with substantial variance; were approximately equally split by gender; were roughly 80% Caucasian, with African American ($n = 79$) and Hispanic ($n = 71$) ethnicities reasonably represented; and reflected a roughly normal distribution with respect to social class. The mean of the GAF scores indicated substantial impairment overall, whereas their high variability indicated that the observers followed our instructions for random selection of patients who met study criteria (not only patients with *DSM-IV* Axis II diagnoses). The most common Axis I diagnoses were mood, anxiety, substance use, and adjustment disorders. As assessed by applying *DSM-IV* criteria to the Axis II Checklist, avoidant and borderline personality disorders (PDs) were the

TABLE 1. Sample Characteristics

Clinician demographics		%
Discipline	Psychiatry	29.5
	Psychology	70.5
Theoretical orientation	Integrative/Eclectic	43.2
	Psychodynamic	25.8
	Cognitive-behavioral	18.2
	Biological	3.7
Sex	Women	45.8
	Men	54.2
Years of experience	$M = 19.8$ ($SD = 9.2$)	
Patient demographics		
Age	$M = 42.3$ ($SD = 12.3$)	
Ethnicity/race	Caucasian	82.6
	African American	6.6
	Hispanic	5.9
	Other (e.g., Asian)	4.9
Sex	Women	53
	Men	47
Socioeconomic class	Poor	5.8
	Working	27.5
	Middle	38.8
	Upper/upper middle	27.9
Marital status	Married/cohabiting	39
	Single/divorced	61
Primary Axis I diagnosis	Dysthymia	46.3
	Depression	37.6
	GAD/anxiety NOS	32.7
	Adjustment disorder	16.1
	Substance use	18.8
Global functioning (GAF)	$M = 57.9$ ($SD = 10.8$)	
Treatment characteristics		
Length (months)	$M = 17.1$ ($SD = 20.5$) $Md = 14$	
Clinical setting ^a	Private practice	78.9
	Outpatient clinic	24.6
	Inpatient/residential	14.8
	Forensic	10.8
	Other	6.9

^aThe numbers here sum to >100% because many clinicians reported working in multiple settings.

most prevalent Axis II diagnoses, although all *DSM-IV* personality disorders were represented in relatively high numbers, with high rates of comorbidity similar to those found in studies using structured interviews. A total of 929 patients (77.4%) met criteria for a *DSM-IV* personality disorder diagnosis. The prevalence of *DSM-IV* diagnoses was as follows: Paranoid, $N = 277$ (23.1%); Schizoid, $N = 255$ (21.2%); Schizotypal, $N = 91$ (7.6%); Antisocial, $N = 219$ (18.2%); Borderline, $N = 350$ (29.1%); Histrionic, $N = 132$ (11.0%); Narcissistic, $N = 255$ (21.2%); Avoidant, $N = 491$ (40.9%); Dependent, $N = 227$ (18.9%); and Obsessive-Compulsive, $N = 209$ (17.4%).

IDENTIFYING PERSONALITY FACTORS USING SWAP-II DATA: STATISTICAL CONSIDERATIONS

Ideally, factor analysis is performed on continuous, normally distributed variables. Data in clinical psychology rarely if ever fit this description.

They tend to be sampled from the tails of the population distribution, resulting in skewed or otherwise nonnormally distributed variables (see Micceri, 1989). Furthermore, psychological rating scales tend to have relatively few response categories (Bernstein & Teng, 1989; Muthen & Kaplan, 1985). Factor analysis based on the commonly used maximum likelihood and generalized least squares methods can produce biased findings when applied to skewed and/or coarsely categorized data (West, Finch, & Curran, 1995), yielding so-called “difficulty factors” that are psychometric artifacts and substantively meaningless (McDonald, 1965; Waller, Tellegen, McDonald, & Lykken, 1996).

Many of these problems can be avoided by conducting factor analysis on tetrachoric or polychoric correlations rather than on Pearson correlations (Muthen & Speckart, 1983; Waller, 1999), or by utilizing “full-information” methods based on multidimensional item response theory (Mislevy, 1986; Wood et al., 2002). For these reasons, we factor analyzed the SWAP-II data using polychoric correlations and a least squares fit function using Micro-Fact 2.0 software designed for such applications (Waller, 2001).

Another methodological challenge concerns the treatment of sex differences in the item correlation matrix (men and women may produce different item endorsement rates and/or different item correlations). When these differences go unrecognized, factor-analytic findings can be biased because correlations calculated on (sex) mixed samples reflect both within- and between-group sources of covariation (see Waller & Meehl, 1998, pp. 12–16). In the current sample, although men and women produced similar factor patterns, their item endorsement rates differed. For example, women scored higher than men on eating disorder items, whereas men scored higher than women on indicators of psychopathy. Had we ignored these differences, a factor analysis of the (uncorrected) data could produce spurious factors with items from conceptually distinct domains and spurious item cross-loadings that increase factor complexity (Sass & Schmitt, 2010).

Figure 1 presents a more thorough picture of how the men and women in our sample differed on their expected SWAP II item scores. Figure 1A shows the item endorsement rates and illustrates that, across sex, the distributions of item means are comparable. To examine these data at a higher level of resolution, we created a histogram of standardized item-difference scores (the mean differences were scaled by the standard deviations from the sample of women). Figure 1B elucidates numerous item-level differences. These figures convinced us of the need to partial out these sex differences before calculating a polychoric correlation matrix for the combined sample. Thus, to control group differences in item level, we computed polychoric correlation matrices separately for each sex, then averaged the matrices to form a combined matrix.

Before we discuss the factor-analytic findings, one final point concerning the polychoric correlations deserves mention. We collapsed several categories of the response scale to improve the precision of the estimated

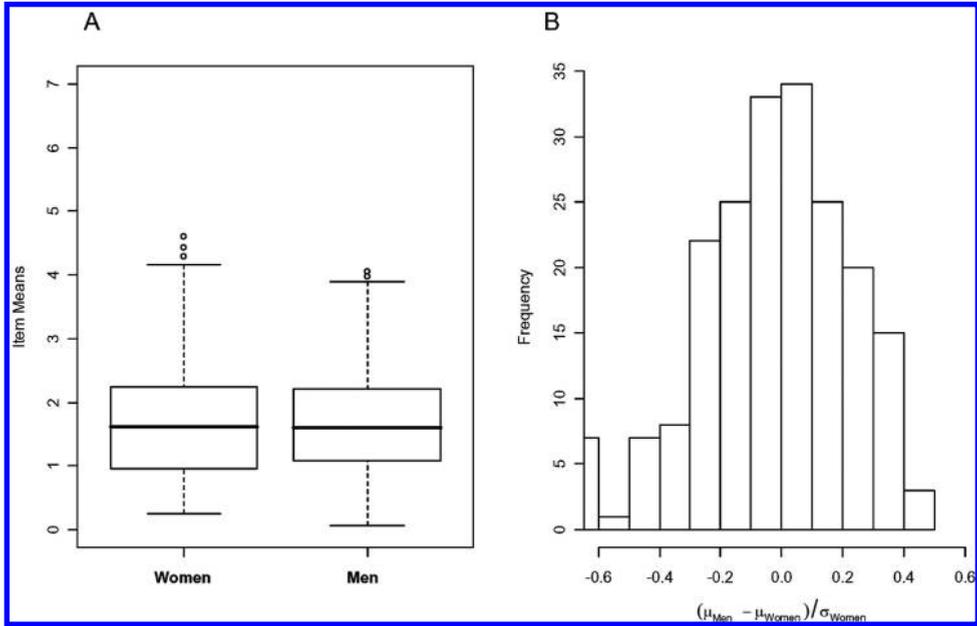


FIGURE 1. Distribution of item difficulties in male and female patients.

correlations. Although our sample is large relative to many psychopathology studies, the demands of our analytic procedures were extreme. When we cross-tabulated all item pairs, we noticed (using a computer program written for this task) that many cells in the 8-by-8 co-occurrence matrices had small joint frequencies. We expected this finding because many items had skewed distributions. Polychoric correlations may be poorly estimated under these conditions, and the estimates can have large standard errors. Thus, to calculate more stable correlations, we recoded the original 8-point scales into 3-point scales.²

Following the procedures outlined above, we used MicroFACT 2.0 (Waller, 2001) to calculate a polychoric correlation matrix on the aggregate sample. Next, we extracted the eigenvalues from this matrix. Because their scree plot was not definitive, we extracted and inspected rotated factor solutions with 4 through 20 factors with numerous rotation algorithms.³

2. Scores of 0–3 were recoded as 0; 4–5 were recoded as 1; and 6–7 were recoded as 2. If the assumptions underlying the polychoric correlations are satisfied (latent bivariate normality), then recoding the item responses will not bias the correlations. Moreover, even when the underlying distribution departs from multivariate normality, the polychoric correlations will be estimated accurately under a wide range of latent distributions (Flora & Curran, 2004; Quiroga, 1992). However, failure to recode the data in moderate to small samples can result in highly biased correlations if the joint frequencies are small (Muthen & Speckart, 1983).

3. Each solution was rotated to optimize the Geomin, Oblimin ($\gamma = .00$ or $.25$), and Promax (from an initial Varimax rotation raised to the third power) criteria using the gradient project algorithms of Robert Jennrich (Bernaads & Jennrich, 2005; Jennrich, 2002). Each

FACTOR-ANALYTIC RESULTS

Careful inspection of the analyses led us to choose a 16-factor solution rotated using Oblimin ($\gamma = .25$; solutions based on $\gamma = 0$ were virtually indistinguishable from those based on $\gamma = .25$). Solutions with fewer factors combined diagnostically distinct symptoms, whereas solutions with more factors produced doublets (two item factors) that reflected little more than semantic redundancy among item pairs. Consideration of the fit criteria convinced us that the 16-factor solution was optimal for these data. For instance, the average communality in the 16-factor solution was .47, with less than 5% of the items having communalities of .30 or less. This solution also reproduced the data matrix (i.e., the polychoric correlations) remarkably well; fully 80% of the reproduced correlations differed from their targets by .05 or less, and the overall root mean square residual (RMSR) = .05. These findings are well summarized by McDonald's GFI = .93. In contrast, the findings for lower-dimensional solutions were not impressive. For instance, in the 5-factor solution, the average communality was only .29, with over 55% of the items having communalities < .30. Consideration of the model residuals also suggested that a 5-factor solution was a severe underfactoring, because 15% of the reproduced correlations differed from their targets by .10 or greater (RMSR = .07) and McDonald's GFI was only .84.

On the basis of clear patterns of factor loadings, we labeled the 16 factors as follows: (1) Psychopathy, (2) Psychological Health, (3) Obsessionality, (4) Schizotypy, (5) Emotional Avoidance, (6) Emotional Dysregulation, (7) Narcissism, (8) Anxious Somatization, (9) Sexual Conflict, (10) Depression, (11) Social Anxiety/Avoidance, (12) Unstable Commitments, (13) Boundary Disturbance, (14) Histrionic Sexualization, (15) Hostility, and (16) Eating Disturbance.

We were unable to recover a higher-order structure resembling the FFM or the consensus four-factor model, which is derived from factor analyses of self-report and/or lay-report item sets. Because Factor 13 had limited internal consistency and Factor 16 can be interpreted as primarily an Axis I index (eating pathology), we recommend retaining the other 14 factors for future use, although we report data using all 16 scales here. Table 2 reports the factor loadings. Shaded items reflect items with high loadings that we retained in the final scales for each factor; a small number of items with reasonably high loadings (often in the opposite direction from the vast majority of loadings on a given scale) were deleted from those scales because of low item-scale correlations, reduced coefficient α 's when included in the scales, and conceptual inco-

rotation was performed 500 times from random (orthogonal) spins of the unrotated solution to identify the most psychologically interpretable pattern. This last step was undertaken for two reasons: Factor rotation algorithms can "get stuck" in local maxima or minima, and factor solutions at the global maxima or minima are not necessarily the most interpretable from among the various converged solutions (Browne, 2001; Rozeboom, 1992).

TABLE 2. Factor Pattern (Factor Loadings) for 16 Oblimin-Rotated SWAP-II Factors

SWAP-II Items	SWAP-II Factors															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
40 Tends to engage in unlawful or criminal behavior.	.73	-.07	-.02	.02	.00	.10	-.06	-.07	.00	-.12	.08	.13	.02	-.04	.06	.04
3 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.).	.68	-.08	-.10	-.04	-.04	-.07	.29	.02	-.04	-.03	-.05	-.10	-.04	.10	.01	-.09
20 Tends to be deceitful; tends to lie or mislead.	.65	-.09	-.02	-.09	.01	-.10	-.04	-.01	-.02	-.03	-.14	.07	-.05	.08	.03	.11
31 Tends to show reckless disregard for the rights, property, or safety of others.	.63	-.06	-.02	.12	.02	-.13	.20	-.03	.04	-.03	-.05	.07	.01	-.01	.05	-.06
113 Experiences little or no remorse for harm or injury caused to others.	.56	-.01	-.08	.09	.10	.06	.03	-.06	-.04	-.10	-.01	.02	.17	-.07	-.08	.05
115 Is prone to violence (e.g., may break things or become physically assaultive).	.52	.01	-.07	-.02	-.02	.18	-.17	-.03	.01	-.11	.02	-.03	.03	-.03	-.27	.22
112 Appears impervious to consequences; seems unable or unwilling to modify behavior in response to threats or negative consequences.	.49	-.14	.08	.07	.07	.02	-.14	-.11	-.11	-.02	-.18	.17	.06	.03	.05	.09
39 Appears to gain pleasure or satisfaction by being sadistic or aggressive toward others (whether consciously or unconsciously).	.49	-.12	-.15	.06	-.07	-.12	-.01	-.01	.27	-.08	-.07	-.19	.13	-.16	-.25	.02
65 Attempts to dominate a significant other (e.g., spouse, lover, family member) through violence or intimidation.	.41	-.10	-.05	-.04	-.06	-.04	-.02	.10	.07	-.13	-.16	-.16	-.03	.08	-.25	-.03
194 Tends to be manipulative.	.40	-.16	.00	-.01	.03	.04	.04	.11	-.02	.01	-.26	.10	.09	.10	-.12	-.18
134 Tends to act impulsively (e.g., acts without forethought or concern for consequences).	.39	-.15	-.07	.02	-.06	.29	-.09	-.18	-.15	-.10	-.10	.27	-.14	.13	-.02	-.01
147 Tends to abuse drugs or alcohol.	.39	-.08	-.13	-.05	.02	.21	-.08	-.09	-.03	.08	-.04	.15	-.15	.03	.03	-.01
71 Tends to seek thrills, novelty, excitement, etc.; appears to require a high level of stimulation.	.39	.09	.06	-.01	-.02	.13	.18	-.13	-.07	-.09	-.09	.19	-.28	.16	.13	.02

18 Tends to stir up conflict or animosity between other people (e.g., may portray a situation differently to different people, leading them to form contradictory views or work at cross purposes).

43 Tends to seek power or influence over others (whether in beneficial or destructive ways).

52 Has little empathy; seems unable or unwilling to understand or respond to others' needs or feelings.

101 Generally finds contentment and happiness in life's activities.

183 Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.

89 Appears to have come to terms with painful experiences from the past; has found meaning in, and grown from such experiences.

111 Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.

196 Finds meaning and satisfaction in the pursuit of long-term goals and ambitions.

63 Is able to assert him/herself effectively and appropriately when necessary.

68 Has a good sense of humor.

82 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.

121 Is creative; is able to see things or approach problems in novel ways.

19 Enjoys challenges; takes pleasure in accomplishing things.

106 Tends to express emotion appropriate in quality and intensity to the situation at hand.

.38	-.03	-.05	-.11	-.13	.03	.06	.14	-.15	-.09	.00	.14	.32	-.06	-.09	.02
.38	.01	-.03	-.04	.05	-.01	.34	.06	.09	-.04	-.11	-.23	.04	.02	-.09	-.16
.32	-.16	-.16	.15	.07	-.19	.25	.00	-.19	.04	-.03	-.11	-.02	-.08	-.19	-.03
.04	.73	-.01	.06	.05	-.03	-.08	.02	-.15	-.13	.00	-.11	.07	.10	.03	.03
-.09	.62	-.02	-.08	.07	.02	-.10	-.02	.22	-.02	.00	.07	-.01	-.02	-.06	-.07
.01	.61	-.05	-.02	-.03	-.08	-.12	.09	.03	-.06	.09	-.06	.02	.08	-.02	.12
-.03	.60	-.03	-.09	.07	-.07	-.12	.07	.14	-.11	.10	.04	-.11	-.01	.06	-.04
-.10	.58	.04	-.05	.09	-.02	.06	-.14	-.10	-.05	.00	-.12	.10	-.05	.04	-.08
-.05	.58	.09	-.03	.08	.04	.11	-.08	.02	.13	-.16	.01	-.09	.00	-.13	.05
-.08	.57	-.09	.03	-.14	-.05	-.04	-.04	.06	.04	-.06	.08	-.20	-.02	.03	-.03
-.08	.56	-.01	-.13	.03	-.02	-.07	.00	.11	-.10	.07	.10	-.11	.02	.02	-.02
-.08	.56	-.04	-.07	.11	.12	.06	-.08	.06	-.04	-.08	.14	.07	-.09	.05	-.06
-.02	.56	.15	-.05	.07	.08	.13	-.12	-.04	-.09	.00	-.13	-.05	-.01	.06	-.13
.00	.54	-.01	-.13	-.15	-.20	-.09	-.02	-.03	-.06	.02	.12	.08	-.04	-.04	.06

continued

TABLE 2. Continued

	SWAP-II Factors															
SWAP-II Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32 Is capable of sustaining meaningful relationships characterized by genuine intimacy and caring.																
2 Is able to use his/her talents, abilities, and energy effectively and productively.	-.07	.54	-.09	.00	-.16	-.01	-.04	.03	-.03	-.06	-.09	-.11	-.08	-.16	.18	-.08
92 Is articulate; can express self well in words.	-.06	.53	.09	-.09	.15	.05	.08	-.09	-.08	-.07	-.07	-.20	-.04	.05	.12	-.05
55 Finds meaning and fulfillment in guiding, mentoring, or nurturing others.	-.14	.53	.05	-.18	.02	-.01	.04	-.04	.24	.00	-.04	.12	.02	.00	-.13	-.12
59 Is empathic; is sensitive and responsive to other peoples' needs and feelings.	.00	.52	-.03	-.07	-.13	-.12	-.17	.02	.01	.01	-.11	-.20	.09	-.09	.10	-.02
51 Tends to be liked by other people.	-.04	.51	-.12	-.07	-.09	-.06	-.21	.00	.05	-.06	-.02	-.07	.04	-.10	.27	-.12
95 Appears comfortable and at ease in social situations.	-.07	.49	-.10	-.10	-.07	-.13	-.07	-.02	.01	-.08	-.13	-.07	-.18	.03	.25	.04
94 Has an active and satisfying sex life.	.08	.47	-.12	-.09	.04	-.09	.11	.04	-.06	-.03	-.21	-.03	-.20	.20	.02	.04
179 Tends to be energetic and outgoing.	.00	.45	-.13	.00	-.07	-.03	.10	.16	-.10	-.06	.02	-.12	-.18	.25	-.01	.04
120 Has moral and ethical standards and strives to live up to them.	-.01	.43	.00	.09	-.03	.03	.15	-.12	.00	-.16	-.27	.04	-.27	.14	.06	-.03
175 Tends to be conscientious and responsible.	-.19	.41	.20	-.03	.01	-.12	-.17	-.09	.01	-.01	.02	-.13	.08	-.26	.05	-.10
37 Finds meaning in belonging and contributing to a larger community (e.g., organization, neighborhood, church).	-.16	.40	.32	-.10	.11	-.10	-.17	-.15	.03	-.02	.05	-.22	.03	-.06	.02	-.09
163 Appears to want to "punish" self; or actively avoids opportunities for pleasure and gratification.	-.12	.40	.03	.07	-.13	-.14	-.04	-.05	-.11	-.08	-.13	-.12	.19	-.24	.14	.01
36 Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.	.01	-.28	-.04	-.17	.05	-.11	-.20	-.10	.27	.15	-.21	-.01	-.06	-.16	.15	.05
54 Tends to feel s/he is inadequate, inferior, or a failure.	-.14	-.27	-.03	-.02	-.25	-.13	-.22	.14	-.03	.13	.04	-.07	-.12	-.14	.03	.01
167 Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered).	-.12	-.25	-.06	-.18	-.24	-.10	-.11	-.19	.08	.22	.23	.01	-.11	-.07	.20	-.02
	-.17	-.24	-.03	-.21	.19	.02	-.04	-.05	.07	.10	-.05	-.04	.15	.09	-.20	.07

192 Tends to be overly concerned with rules, procedures, order, organization, schedules, etc.	.04	-.11	.67	.03	-.04	-.08	-.02	.00	-.13	-.02	-.08	.06	-.03	-.03	-.06
123 Tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered.	-.02	-.11	.62	.01	.10	.03	.22	-.03	-.08	.12	-.13	-.04	.02	-.01	.06
173 Tends to become absorbed in details, often to the point that s/he misses what is significant.	-.06	-.06	.61	.19	-.03	-.06	-.09	.04	-.11	-.10	-.06	.09	-.01	-.05	-.03
174 Expects self to be "perfect" (e.g., in appearance, achievements, performance, etc.).	-.16	-.01	.45	-.34	.07	.01	.18	-.13	-.03	-.11	-.01	-.09	-.07	-.06	.17
28 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.).	-.01	-.07	.44	.06	-.02	-.04	-.03	.24	.12	-.02	.02	-.03	.03	.01	.18
200 Tends to ruminate; may dwell on problems, replay conversations in his/her mind, become preoccupied with thoughts about what could have been, etc.	-.21	-.12	.40	.07	-.27	-.05	-.06	-.02	.01	.09	.13	-.03	-.05	.05	-.06
6 Is troubled by recurrent obsessional thoughts that s/he experiences as intrusive.	-.07	-.11	.38	.13	-.16	.13	-.02	.13	.16	.12	-.03	-.16	-.11	-.08	.08
66 Is excessively devoted to work and productivity to the detriment of leisure and relationships.	.03	.17	.35	-.20	.18	-.02	-.01	-.17	-.11	.07	.04	-.13	.02	.01	.09
164 Tends to be self-righteous or moralistic.	-.03	.01	.32	.06	-.04	-.15	.13	-.06	-.03	.04	-.15	-.06	.22	-.20	-.09
180 Has trouble making decisions; tends to be indecisive or to vacillate when faced with choices.	-.17	-.24	.29	-.01	-.05	-.23	-.17	.15	-.06	-.09	.16	-.04	.10	.12	-.04
67 Tends to be stingy and withholding (e.g., of time, money, affection, ideas).	.14	.01	.27	.00	.14	-.16	.02	.08	-.06	.03	.03	-.12	.11	.07	.17
130 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).	-.02	-.15	.15	.57	.01	.07	-.06	-.01	.10	-.08	.02	-.03	.04	.00	-.01

continued

TABLE 2. Continued

	SWAP-II Factors															
SWAP-II Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
145 Thought processes or speech tend to be circumstantial, vague, rambling, digressive, etc. (e.g., may be unclear whether s/he is being metaphorical or whether thinking is confused or peculiar).	-.03	-.11	.06	.55	.04	.00	-.04	-.02	.06	-.09	.01	.14	.11	.02	.18	-.02
125 Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or "off").	-.01	-.12	.09	.51	.01	-.06	-.04	.07	.09	-.03	.13	.08	-.01	-.07	-.01	.05
75 Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance.	-.01	-.14	-.01	.49	.02	-.04	-.06	-.10	-.23	-.07	-.03	-.09	-.09	-.08	.07	.10
29 Has difficulty making sense of other people's behavior; tends to misunderstand, misinterpret, or be confused by others' actions and reactions.	-.24	-.12	-.04	.40	-.05	.00	-.02	-.15	-.23	-.10	.14	-.06	-.08	-.01	-.17	.05
44 When distressed, perception of reality can become grossly impaired (e.g., thinking may seem delusional).	.03	-.16	-.09	.38	-.10	.33	-.07	.02	.05	-.03	-.01	-.13	.01	-.11	.05	.05
136 Tends to believe in supernatural, paranormal, or superstitious phenomena or to be drawn to "alternative" belief systems (e.g., astrology, tarot, crystals, psychics, auras).	.05	.00	-.06	.37	-.04	.11	.14	.12	.25	.10	-.14	-.11	.17	-.11	.15	.00
146 Tends to elicit boredom in others (e.g., may talk incessantly, without feeling, or about inconsequential matters).	-.05	-.09	.24	.34	-.02	-.17	.01	.13	-.07	.09	-.03	-.03	-.03	.03	.01	-.03
91 Is self-critical; sets unrealistically high standards for self and is intolerant of own human defects.	-.14	-.08	.22	-.34	-.03	.02	-.01	-.19	.05	.03	.16	-.08	-.09	-.19	.18	.06
118 Has difficulty maintaining attention and focus on tasks; is easily distracted by sights, sounds, unrelated thoughts, or other competing stimuli.	-.11	-.09	.05	.33	-.06	.02	-.05	.16	.01	-.03	-.15	.24	-.16	-.07	.16	.02

87 Sense of identity revolves around a "cause," movement, or label (e.g., adult child of alcoholic, adult survivor, environmentalist, born-again Christian, etc.); may be drawn to extreme or all-encompassing belief systems.	-.02	.01	.10	.30	-.18	-.05	.05	-.08	.05	.06	-.15	.09	.20	-.20	.05	-.04
72 Tends to perceive things in global and impressionistic ways (e.g., misses details, glosses over inconsistencies, mispronounces names).	-.15	-.15	-.15	.26	-.05	.03	.02	-.05	-.24	-.13	-.14	-.13	-.13	.09	.15	.01
184 Verbal statements seem incongruous with accompanying affect, or incongruous with accompanying nonverbal messages.	-.08	-.18	.04	.25	.21	.01	-.06	-.11	.16	-.08	-.19	.04	.11	.02	.05	.08
144 Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential.	-.09	.00	.20	-.01	.52	-.09	.09	-.04	-.08	.10	-.17	-.10	.01	-.08	-.04	-.07
159 Tends to deny or disavow own need for nurturance, caring, comfort, etc. (e.g., may regard such needs as weakness, avoid depending on others or asking for help, etc.)	-.02	.01	.02	-.07	.46	-.03	-.03	-.20	.00	.08	-.12	-.01	-.12	-.16	.10	-.01
141 Is invested in seeing and portraying self as emotionally strong, untroubled, and emotionally in control, despite clear evidence of underlying insecurity, anxiety, or distress.	-.15	-.09	.09	-.18	.44	.02	.17	-.04	-.04	-.18	-.18	-.05	-.02	-.06	.02	-.06
126 Appears to have a limited or constricted range of emotions.	.03	-.16	.02	.21	.39	-.12	-.16	.02	-.13	.13	.11	-.16	-.03	.03	.02	-.01
104 Appears to have little need for human company or contact; is emotionally detached or indifferent.	.21	.08	.03	.32	.39	-.09	-.08	-.07	-.07	.26	.21	-.05	.03	.01	-.03	.03
73 Tends to "catastrophize"; is prone to see problems as disastrous, unsolvable, etc.	-.10	-.20	.15	-.07	-.38	.09	-.05	.16	-.06	.19	.07	-.08	-.04	.00	-.07	-.03
74 Expresses emotion in exaggerated and theatrical ways.	-.05	-.06	-.05	.16	-.37	.20	.14	.09	-.09	-.01	-.19	-.04	.05	.15	-.08	-.03
119 Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.	-.13	-.10	.04	-.04	.36	-.22	-.17	-.01	-.03	-.04	.24	-.14	.00	-.09	.18	-.01

continued

TABLE 2. Continued

	SWAP-II Factors															
SWAP-II Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
100 Tends to think in abstract and intellectualized terms, even in matters of personal import.	-.12	.15	.21	.13	.31	-.06	.16	.02	.07	.00	-.03	.07	.14	-.10	.04	-.18
152 Tends to repress or "forget" distressing events, or distort memories of distressing events beyond recognition.	-.24	-.05	-.08	.13	.29	.00	-.11	.10	.00	-.13	-.18	.06	.09	-.05	.07	.23
77 Tends to be needy or dependent.	-.18	-.24	-.07	-.07	-.27	-.08	-.10	.21	-.21	-.04	-.04	-.04	.10	.24	.16	-.13
131 Appears conflicted about experiencing pleasurable emotions; tends to inhibit excitement, joy, pride, etc.	-.14	-.16	-.02	-.13	.23	-.20	-.13	-.01	.15	.07	.02	-.08	-.04	-.09	.09	.09
5 Tends to be emotionally intrusive (e.g., may not respect other people's needs for autonomy, privacy, etc.).	.21	-.04	.06	.04	-.23	.01	.09	.06	-.10	-.09	-.22	-.06	-.03	.03	-.16	-.12
58 Has little or no interest in sex.	.04	-.05	.09	.03	.16	-.07	-.03	.04	-.09	.15	.16	-.06	.03	-.16	.04	.16
191 Emotions tend to change rapidly and unpredictably.	.02	-.13	-.06	-.04	-.06	.59	-.03	.03	-.05	.00	-.15	.11	.06	.07	.05	-.02
12 Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, etc.	-.10	-.15	-.08	-.10	-.27	.58	.00	.01	-.14	.07	-.11	-.05	-.06	-.04	-.05	.06
157 Tends to become irrational when strong emotions are stirred up; may show a significant decline from customary level of functioning.	-.15	-.13	-.01	.20	-.15	.49	-.18	.02	-.03	-.05	-.16	-.04	-.03	-.06	-.18	.08
138 Tends to enter altered, dissociated states when distressed (e.g., the self or world feels strange, unreal, or unfamiliar).	-.02	-.02	-.15	.16	.14	.45	-.04	.23	.25	.05	.08	-.08	.15	-.05	.24	.01
185 Is prone to intense anger, out of proportion to the situation at hand (e.g., has rage episodes).	.18	-.11	-.10	-.01	.00	.45	-.13	-.04	.01	-.02	-.03	-.09	.04	-.04	-.42	-.05
109 Tends to engage in self-mutilating behavior (e.g., self-cutting, self-burning, etc.).	.04	-.12	-.11	-.07	.09	.43	-.08	.01	.08	.10	-.03	-.04	.12	.02	.13	.06

64 Mood tends to cycle over intervals of weeks or months between excited and depressed states (high placement implies bipolar mood disorder).	-.09	.00	-.03	.07	-.05	.39	-.13	-.01	-.04	-.07	-.09	.20	.01	-.05	.23	-.04
78 Tends to express anger in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).	-.15	-.24	-.17	-.10	.09	-.35	-.08	.14	-.03	-.11	-.09	.07	-.08	-.01	.05	-.09
199 Tends to be passive and unassertive.	-.04	-.26	.00	.00	.01	-.35	-.33	.05	-.08	-.04	.20	-.07	-.04	.07	.25	-.18
117 Is unable to soothe or comfort him/herself without the help of another person (i.e., has difficulty regulating own emotions).	-.18	-.27	-.03	-.09	-.24	.28	-.09	.05	-.12	-.05	-.13	-.11	-.04	.26	-.05	.05
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.).	-.22	-.23	-.07	.03	-.07	.28	.08	-.02	-.19	-.10	-.08	-.01	.08	.00	-.22	.07
93 Seems naïve or innocent; appears to know less about the ways of the world than might be expected given his/her intelligence or background.	-.08	.06	.05	.17	-.03	-.27	-.07	-.11	-.24	-.19	.21	.04	.16	.05	.17	.12
161 Tends to deny, disavow, or squelch his/her own realistic hopes, dreams, or desires to protect against anticipated disappointment (whether consciously or unconsciously).	-.16	-.12	-.05	-.12	.20	-.26	-.05	.01	.20	.10	.06	.15	-.02	-.10	-.01	.04
166 Tends to alternate between undercontrol and overcontrol of needs and impulses (e.g., sometimes acts on desires impulsively while at other times denying them entirely).	-.06	-.16	.11	-.05	.03	.23	-.10	-.14	.04	-.13	-.21	.11	-.06	-.03	.05	.17
76 Manages to elicit in others feelings similar to those s/he is experiencing (e.g., when angry, acts in such a way as to provoke anger in others; when anxious, acts in such a way as to induce anxiety in others).	-.01	-.17	-.10	.00	.07	.23	-.03	-.01	-.09	.01	-.17	.02	.10	.01	-.13	-.06

continued

TABLE 2. Continued

	SWAP-II Factors															
SWAP-II Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
49 Has fantasies of unlimited success, power, beauty, talent, brilliance, etc.	-.01	-.07	.02	-.02	-.08	-.08	.70	-.18	.03	.04	.04	.03	.05	-.04	.08	.09
4 Has an exaggerated sense of self-importance (e.g., feels special, superior, grand, or envied).	.08	-.09	.00	.01	.01	.05	.69	.00	-.03	-.07	-.04	.01	.02	-.13	-.07	-.02
48 Seeks to be the center of attention.	-.05	-.01	.02	-.01	-.04	.02	.60	.07	-.04	-.03	-.17	.05	-.12	.14	.01	-.10
53 Seems to treat others primarily as an audience to witness own importance, brilliance, beauty, etc.	.14	-.11	-.07	.01	.02	-.07	.60	.08	.00	.01	-.06	-.14	.04	.10	.11	-.02
143 Tends to believe s/he can only be appreciated by, or should only associate with, people who are high-status, superior, or otherwise "special."	-.04	-.09	-.06	-.07	.08	-.03	.57	.11	-.02	-.10	.03	-.09	.23	.09	-.08	.03
190 Appears to feel privileged and entitled; expects preferential treatment.	.12	-.04	-.03	-.04	.04	-.05	.52	.17	-.07	-.05	-.09	.08	.15	.00	-.14	-.08
97 Tends to use his/her physical attractiveness to an excessive degree to gain attention or notice.	.00	.03	-.10	-.03	.09	.03	.49	-.05	-.03	-.01	-.02	-.03	-.07	.31	.13	.14
84 Tends to be competitive with others (whether consciously or unconsciously).	-.14	-.01	.09	-.10	.07	-.09	.43	-.15	.13	-.18	-.05	-.02	-.13	-.03	-.28	-.01
42 Tends to feel envious.	-.12	-.13	-.08	-.15	-.18	-.19	.38	-.10	.02	-.01	.12	-.01	.02	-.02	-.27	.02
133 Tends to be dismissive, haughty, or arrogant.	.16	-.13	.13	-.05	.14	-.04	.34	.06	.05	-.11	-.05	.00	.20	-.07	-.33	-.10
26 Tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused, or needlessly puts self in dangerous situations (e.g., walking alone or agreeing to meet strangers in unsafe places).	.03	-.17	-.11	-.04	.00	-.09	-.30	-.02	.04	-.03	-.24	.00	-.01	.14	.29	-.08
61 Tends to disparage qualities traditionally associated with own gender (e.g., a woman who disdains nurturance and overvalues power; a man who disdains power and overvalues emotional sensitivity).	-.09	.04	.00	.05	.00	-.06	.21	.04	.20	.03	-.06	.11	.11	-.08	.06	.07

135 Is hypochondriacal; has exaggerated fears of contracting medical illness (e.g., worries excessively about normal aches and pains).	-.08	.00	.16	.00	.02	.02	-.01	.66	.04	.06	.01	.08	.00	-.01	-.04	.00
22 Tends to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.).	-.11	.04	.04	.00	-.09	-.01	.08	.56	-.06	-.01	-.02	-.05	.00	-.13	.07	.02
13 Tends to use his/her psychological or medical problems to avoid work or responsibility (whether consciously or unconsciously).	.06	-.10	-.01	-.03	-.13	-.13	.01	.46	-.13	.06	-.14	.21	-.05	-.11	-.02	.14
27 Has panic attacks (i.e., episodes of acute anxiety accompanied by strong physiological responses).	-.10	.03	.01	-.03	-.02	.28	-.05	.43	.01	-.01	.10	-.09	-.03	-.10	.16	.00
35 Tends to feel anxious.	-.19	-.02	.08	-.12	-.17	.18	-.05	.34	.09	-.07	.29	-.07	-.16	-.08	.11	-.08
187 Tends to feel guilty or ashamed about his/her sexual interests or activities (whether consciously or unconsciously).	-.09	-.07	-.04	.03	.00	-.16	-.06	-.06	.59	-.09	.01	-.02	-.07	.22	.02	.10
140 Sexual fantasies or activities are unusual, idiosyncratic, or rigidly scripted (e.g., dominance, submission, voyeurism, fetishes, etc.).	.19	.04	-.03	.17	.01	.01	.23	-.06	.42	.09	.01	-.07	.01	.20	.04	.01
137 Is confused, conflicted, or uncertain about his/her sexual orientation (e.g., may struggle to keep homosexual feelings out of awareness, have an exaggerated fear of homosexuality, etc.).	.02	.00	-.06	.25	-.12	-.01	.01	-.01	.38	.07	-.04	.03	-.02	.05	.04	.02
99 Appears to associate sex with danger (e.g., injury, punishment, contamination), whether consciously or unconsciously.	.05	-.06	-.04	.06	-.10	-.07	-.07	-.02	.37	-.09	.09	-.14	-.03	-.06	.00	.32
148 Has little psychological insight into own motives, behavior, etc.	.24	-.27	-.03	.18	.20	-.02	.01	.06	-.37	-.04	-.04	.05	-.10	.03	-.05	-.02
41 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.	-.11	-.05	-.25	.20	.19	-.21	.06	.07	-.28	-.14	-.03	-.12	.00	.10	-.11	.18

continued

TABLE 2. Continued

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SWAP-II Items	SWAP-II Factors															
85 Has consensuous homosexual desires (moderate placement implies bisexuality, high placement implies homosexuality).	-.10	.08	-.08	.21	-.12	.14	-.05	-.08	.27	.07	-.07	.08	.01	.03	.07	-.07
102 Has a deep sense of inner badness; sees self as damaged, evil, or rotten to the core (whether consciously or unconsciously).	.03	-.16	-.13	-.16	.02	.16	-.03	-.16	.26	.13	.12	-.03	.02	-.15	.19	.14
81 Repeatedly re-experiences or re-lives a past traumatic event (e.g., has intrusive memories or recurring dreams of the event; is startled or terrified by present events that resemble or symbolize the past event).	-.07	.02	-.13	.07	.01	.18	-.07	.16	.24	.11	.04	-.13	.03	-.16	.09	-.01
158 Appears afraid of commitment to a long-term love relationship.	-.01	-.05	.04	-.04	.19	-.19	.03	-.08	.20	-.03	.15	.16	-.08	.18	-.04	.00
169 Is afraid or conflicted about becoming like a parent (or parent figure) about whom s/he has strong negative feelings (e.g., may go to lengths to avoid or reject attitudes or behaviors associated with that person).	-.17	.17	-.06	-.12	.00	-.13	.01	-.02	.20	-.05	-.02	.08	.05	-.10	-.11	.07
50 Tends to feel life has no meaning.	-.15	-.17	-.10	.03	.03	-.01	.06	-.06	.02	.62	-.03	.04	-.07	-.03	.00	.02
56 Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities.	-.12	-.20	-.12	-.02	.08	-.10	-.07	.07	-.06	.57	.06	-.04	-.13	-.08	-.03	.03
189 Tends to feel unhappy, depressed, or despondent.	-.21	-.20	-.06	-.13	-.08	-.03	-.20	.07	-.06	.54	-.01	.00	-.01	.03	-.05	-.01
195 Tends to be preoccupied with death and dying.	.09	-.02	.00	.05	.04	.06	.05	.10	.14	.51	-.03	-.09	.09	-.02	.19	-.04
168 Struggles with genuine wishes to kill him/herself.	-.03	-.09	-.14	-.02	.06	.26	-.09	-.07	.06	.47	-.01	-.04	.05	-.01	.03	.03
30 Tends to feel listless, fatigued, or lacking in energy.	-.15	-.09	-.03	-.09	-.03	-.16	-.02	.29	-.15	.45	-.04	.03	-.07	-.07	.15	-.03
90 Is prone to painful feelings of emptiness (e.g., may feel lost, bereft, abjectly alone even in the presence of others, etc.).	-.23	-.08	-.17	-.05	.00	.19	-.05	-.02	.05	.39	.14	.07	.09	.20	-.03	-.05

178 Has a pervasive sense that someone or something necessary for happiness has been lost forever, whether consciously or unconsciously (e.g., a relationship, youth, beauty, success).

142 Tends to make repeated suicidal threats or gestures, either as a "cry for help" or as an effort to manipulate others.

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.).

162 Expresses contradictory feelings or beliefs without being disturbed by the inconsistency; has little need to reconcile or resolve contradictory ideas.

60 Tends to be shy or self-conscious in social situations.

124 Tends to avoid social situations because of fear of embarrassment or humiliation.

193 Lacks social skills; tends to be socially awkward or inappropriate.

86 Tends to feel ashamed or embarrassed.

149 Tends to feel like an outcast or outsider.

160 Lacks close friendships and relationships.

197 Tends to seek out or create interpersonal relationships in which s/he is in the role of caring for, rescuing, or protecting the other.

98 Tends to fear s/he will be rejected or abandoned.

	-.23	-.04	-.02	.00	-.12	-.11	.00	-.14	.10	.39	-.09	-.07	.09	.07	-.10	.05
	.12	-.15	-.03	-.20	.09	.25	-.18	.09	-.18	.30	-.14	.08	.24	.16	.06	.04
	.00	-.14	-.05	.09	.11	.03	-.04	.07	.18	-.30	-.16	-.12	.16	.01	.03	.17
	.12	.01	-.09	.11	.09	.10	-.13	.10	-.18	-.21	-.04	.12	.20	.00	-.10	.16
	-.02	.04	.06	-.01	-.03	-.11	-.12	-.01	-.03	-.01	.65	-.05	-.01	-.08	.14	-.03
	-.07	-.13	.04	-.02	-.03	-.08	.03	.13	.09	.01	.61	-.01	-.04	-.03	.07	-.01
	.00	-.16	.11	.35	.05	-.05	-.01	-.11	-.10	.06	.53	.05	-.06	-.01	-.04	-.05
	-.14	-.11	-.07	-.17	-.10	.02	-.06	-.09	.14	-.04	.46	-.06	-.06	-.08	.21	-.01
	-.19	-.03	-.09	.07	.03	.05	-.05	-.09	.04	.23	.36	.16	-.03	-.10	-.19	-.04
	.06	-.15	.10	.15	.26	-.07	-.02	-.04	-.16	.21	.33	.10	.00	-.01	-.13	.02
	-.05	.18	.06	-.07	.01	-.16	-.31	-.17	.09	-.02	-.32	-.08	.07	.10	.13	-.14
	-.24	-.11	-.18	-.20	-.15	.07	-.11	-.13	-.12	-.07	.30	-.01	.13	.21	-.02	-.05

continued

TABLE 2. Continued

	SWAP-II Factors															
SWAP-II Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
69 Decisions and actions are unduly influenced by efforts to avoid perceived dangers; is more concerned with avoiding harm than pursuing desires.	-.07	-.13	.06	-.04	.03	-.15	-.10	.19	.14	-.08	.29	-.02	-.05	-.03	.07	.01
79 Attempts to deny or "override" fear or anxiety by rushing headlong into feared situations, taking unnecessary risks, etc.	.15	-.13	.11	.07	.10	.11	-.12	-.18	.11	-.16	-.26	.07	-.03	.07	.06	.05
172 Seems unable to settle into, or sustain commitment to, identity-defining life roles (e.g., career, occupation, lifestyle, etc.).	-.06	-.08	-.14	.04	-.02	-.13	-.02	.05	.06	.00	.05	.61	.01	.03	-.05	.02
188 Work-life and/or living arrangements tend to be chaotic or unstable (e.g., job or housing situation seems always temporary, transitional, or ill-defined).	.16	-.09	-.14	.07	.03	.09	-.16	.04	-.09	.02	-.13	.49	.10	.07	.08	-.09
24 Tends to be unreliable and irresponsible (e.g., may fail to meet work obligations or honor financial commitments).	.29	-.06	-.18	-.04	-.10	-.15	.14	.07	-.14	-.03	.04	.48	-.08	-.14	.09	.08
153 Relationships tend to be unstable, chaotic, and rapidly changing.	.10	-.07	-.11	.00	-.02	.26	-.11	-.10	-.11	-.02	-.02	.33	.19	.25	-.08	.07
33 Is conflicted or inhibited about achievement or success (e.g., achievements may be below potential, may sabotage self just before attaining important goals, etc.).	-.20	-.07	-.09	-.14	-.06	-.31	-.05	-.04	.20	-.05	-.08	.33	-.10	-.18	.04	.03
177 Repeatedly convinces others of his/her commitment to change but then reverts to previous maladaptive behavior; tends to convince others that "this time is really different."	.21	-.10	-.02	-.18	-.01	-.03	-.09	.01	-.08	-.10	-.15	.28	.06	.10	.03	.13
15 Lacks a stable sense of who s/he is (e.g., attitudes, values, goals, and feelings about self seem unstable or ever-changing).	-.10	-.16	-.24	.03	-.04	.24	.13	.03	.05	-.05	.14	.24	.03	.00	.16	.05

150 Tends to identify with admired others to an exaggerated degree, taking on their attitudes, mannerisms, etc. (e.g., may be drawn into the "orbit" of a strong or charismatic personality).	-.03	-.05	.03	.14	-.04	.02	.10	-.03	.09	-.07	-.06	.08	.52	.08	.12	.10
176 Tends to confuse own thoughts, feelings, or personality traits with those of others (e.g., may use the same words to describe him/herself and another person, believe the two share identical thoughts and feelings, etc.).	.05	-.07	-.03	-.04	.10	.07	-.02	.03	-.05	.00	-.02	.18	.40	.16	-.15	.21
154 Tends to draw others into scenarios, or "pull" them into roles, that feel alien or unfamiliar (e.g., being uncharacteristically insensitive or cruel, feeling like the only person in the world who can help, etc.).	-.20	-.04	-.12	-.06	-.15	.07	.27	-.10	-.05	-.14	-.08	-.14	.30	.08	.21	.00
45 Is prone to idealizing people; may see admired others as perfect, larger than life, all wise, etc.	.12	-.15	-.03	-.20	.09	.25	-.18	.09	-.18	.30	-.14	.08	.24	.16	.06	.04
181 Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.	.09	.01	.02	.01	-.02	-.10	-.06	-.09	.08	.02	-.07	.17	.16	.51	.06	-.06
110 Tends to become attached to, or romantically interested in, people who are emotionally unavailable.	-.09	-.04	-.03	-.11	-.12	-.23	-.07	-.19	.08	.00	.01	.00	.13	.51	.04	-.05
23 Tends to become involved in romantic or sexual "triangles" (e.g., is drawn to people who are already attached, sought by someone else, etc.).	-.01	.04	-.09	.01	-.02	-.08	.02	-.04	.15	.04	-.16	-.12	-.09	.51	.04	.03
34 Tends to be sexually seductive or provocative (e.g., may be inappropriately flirtatious, preoccupied with sexual conquest, prone to "lead people on," etc.).	.17	.03	-.10	.00	-.01	.04	.28	-.03	.11	-.06	-.02	-.03	-.26	.46	.14	.01
171 Appears to fear being alone; may go to great lengths to avoid being alone.	-.05	-.09	.02	-.09	-.05	.10	-.08	.09	-.14	.00	-.08	.07	.04	.44	.16	-.06
128 Fantasizes about ideal, perfect love.	-.24	.03	.00	.00	-.14	-.11	.19	-.19	.06	-.04	-.09	-.05	.15	.43	.02	.05

continued

TABLE 2. Continued

	SWAP-II Factors															
SWAP-II Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
80 Tends to be sexually possessive or jealous; is preoccupied with concerns about real or imagined infidelity.	.03	.01	-.03	.04	-.08	.02	-.10	-.06	-.03	-.06	-.01	-.17	-.03	.38	-.16	.08
132 Tends to have numerous sexual involvements; is promiscuous.	.25	.15	-.06	.02	.02	.05	.14	-.07	.09	.02	-.06	.23	-.11	.38	.07	.12
11 Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.	-.14	-.06	-.12	-.04	-.18	.21	.04	-.08	-.15	-.15	-.09	.02	.15	.38	.12	-.02
57 Religious or spiritual beliefs are central to his/her identity and experience.	-.09	.22	.05	.16	-.22	-.16	.06	-.03	.04	.10	-.15	-.09	.21	-.27	.16	.02
114 Tends to be critical of others.	-.06	-.02	.06	-.05	.01	-.13	.17	-.01	-.07	.01	-.03	-.04	.01	-.09	-.65	-.06
139 Tends to hold grudges; may dwell on insults or slights for long periods.	-.03	-.16	.08	.05	-.08	-.04	.02	.01	-.06	.12	-.05	.02	-.08	-.03	-.59	-.09
122 Attempts to avoid feeling helpless or depressed by becoming angry instead.	-.08	-.03	-.06	-.03	.08	.15	-.03	-.03	.06	-.11	-.05	-.04	-.10	.08	-.56	-.04
16 Tends to be angry or hostile (whether consciously or unconsciously).	.14	-.22	-.18	-.05	-.04	.11	.00	-.15	-.02	.05	-.11	-.10	-.07	-.24	-.47	-.04
8 Tends to get into power struggles.	.15	-.05	.01	-.06	-.09	.06	.04	-.02	-.07	-.12	-.18	.10	-.01	-.14	-.45	-.12
116 Tends to see own unacceptable feelings or impulses in other people instead of in him/herself.	.03	-.15	-.11	-.01	.11	-.01	.00	.06	-.09	-.18	-.07	-.02	.05	-.04	-.44	.09
127 Tends to feel misunderstood, mistreated, or victimized.	-.01	-.18	-.09	.11	-.21	-.06	-.15	-.02	-.09	.09	-.09	.07	.08	-.07	-.44	-.06
170 Tends to be oppositional, contrary, or quick to disagree.	.01	-.07	.01	.00	.09	-.01	.05	.04	.02	.00	-.09	.15	.12	-.15	-.43	-.11
103 Tends to have extreme reactions to perceived slights or criticism (e.g., may react with rage, humiliation, etc.).	.01	-.22	-.07	-.02	-.15	.33	.03	-.08	-.02	-.10	.16	-.11	.06	-.01	-.43	-.06
182 Tends to be controlling.	.12	-.02	.20	-.11	.15	.06	.09	.12	.01	-.09	-.25	-.17	-.03	.01	-.42	-.10
46 Tends to be suggestible or easily influenced.	-.08	-.07	-.02	.12	-.24	-.11	.04	-.01	-.16	-.22	.12	-.02	.04	-.03	.39	-.04

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.	.10	-.19	-.17	.07	-.09	-.11	.13	.16	-.22	-.06	-.15	.12	-.08	-.05	-.39	-.03
1 Tends to feel guilty (e.g., may blame self or feel responsible for bad things that happen).	-.11	-.03	.03	-.20	-.07	.00	-.19	-.06	.05	.08	-.14	-.10	-.13	.38	-.08	
96 Tends to elicit dislike or animosity in others.	.25	-.03	.02	.04	-.06	.00	.03	.05	-.12	.11	.00	.11	.03	-.03	-.37	-.05
105 Is suspicious; tends to assume others will harm, deceive, conspire against, or betray him/her.	.11	-.09	.03	.35	-.02	.04	-.06	.01	.04	.12	.12	-.08	.05	-.01	-.35	-.04
25 Has difficulty acknowledging or expressing anger.	-.17	-.10	-.15	-.09	.24	-.12	-.15	.01	-.01	-.20	.00	-.17	-.09	-.19	.34	-.14
17 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).	-.04	-.25	-.10	-.15	-.14	-.29	-.22	-.02	-.01	-.28	.03	-.10	-.01	.01	.34	-.14
88 Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves.	-.07	-.09	-.07	-.18	.19	-.16	-.25	-.08	.02	-.07	.14	-.08	-.04	-.14	.33	-.05
129 Tends to be conflicted about authority (e.g., may feel s/he must submit, rebel against, win over, defeat, etc.).	-.05	-.13	-.11	.02	.02	-.04	.00	-.12	.15	-.28	-.03	.17	-.04	-.17	-.32	-.10
38 Tends to feel s/he is not his/her true self with others; may feel false or fraudulent.	-.12	-.14	-.05	-.09	.00	.05	.12	-.05	.19	.00	.06	-.01	-.02	-.12	.30	.04
47 Attempts to avoid or flee depressive feelings through excessive optimism, activity, energy, etc.	-.15	-.01	.03	.05	.19	.02	.16	-.16	-.01	-.26	-.20	.06	-.17	.01	.27	-.04
21 Tends to be hostile toward members of the opposite sex, whether consciously or unconsciously (e.g., may be disparaging or competitive).	.14	-.07	-.13	.06	.00	-.14	.12	-.11	.19	-.09	.05	-.19	.01	.02	-.24	.09
70 Has uncontrolled eating binges followed by "purges" (e.g., makes self vomit, abuses laxatives, fasts, etc.); has bulimic episodes.	.08	-.01	.06	-.09	-.09	.04	.02	-.02	.00	.07	-.10	.01	.06	-.06	.18	.58

continued

TABLE 2. Continued

SWAP-II Items	SWAP-II Factors															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
108 Tends to restrict food intake to the point of being underweight and malnourished.	.05	-.01	.10	-.05	-.02	.02	.02	.20	.14	.01	.06	-.04	.07	.05	.02	.53
156 Has a disturbed or distorted body-image (e.g., may see self as unattractive, grotesque, disgusting, etc.).	.03	-.02	.03	-.08	-.08	.09	.00	-.13	.07	.19	.16	.05	-.07	-.05	.09	.41
62 Tends to be preoccupied with food, diet, or eating.	-.03	.00	.22	-.07	-.16	-.03	.01	.01	.08	.03	.01	.08	-.09	-.14	.06	.39
83 Beliefs and expectations seem cliché or stereotypical, as if taken from storybooks or movies.	-.09	-.04	-.01	.13	.00	-.15	.14	-.08	-.27	-.08	-.02	.03	.12	.03	.14	.37
155 Tends to describe experiences in generalities; is reluctant to provide details, examples, or supporting narrative.	-.13	-.06	-.18	.20	.24	-.24	-.05	.06	-.14	-.13	-.16	-.06	-.07	-.03	-.10	.36
186 Has difficulty directing both tender feelings and sexual feelings toward the same person (e.g., sees others as nurturing and virtuous or sexy and exciting, but not both).	-.04	-.03	-.01	.01	.11	-.08	.00	-.02	.26	-.05	-.19	-.09	.00	.28	-.05	.31
151 Appears to experience the past as a series of disjointed or disconnected events; has difficulty giving a coherent account of his/her life story.	-.13	-.12	-.13	.27	.20	.07	-.04	.01	-.01	-.10	-.02	.09	.05	-.06	.09	.29
10 Believes that some important other has a special, seemingly magical ability to know his/her innermost thoughts or feelings (e.g., imagines rapport is so perfect that ordinary communication is superfluous).	-.02	-.13	-.05	.14	-.10	.01	.08	.00	-.01	-.11	-.17	-.18	.10	.04	.13	.21
7 Appears conflicted about his/her racial or ethnic identity (e.g., undervalues and rejects, or overvalues and is preoccupied with, own cultural heritage).	-.04	.02	-.11	.16	-.09	-.05	.08	-.05	.10	-.08	.00	.00	.06	-.05	-.11	.20
107 Tends to express qualities or mannerisms traditionally associated with own gender to an exaggerated or stereotypical degree (i.e., a hyper-feminine woman; a hyper-masculine, "macho" man).	.14	.10	-.07	.10	-.02	-.06	.11	-.07	-.10	-.03	-.05	-.17	-.10	.12	.00	.19

Notes. Loadings $\geq .1251$ in boldface. Factor names: 1: Psychopathy; 2: Psychological Health; 3: Obsessionality; 4: Schizotypy; 5: Emotional Avoidance; 6: Emotional Dysregulation; 7: Narcissism; 8: Anxious Somatization; 9: Sexual Conflict; 10: Depression; 11: Social Anxiety/Avoidance; 12: Unstable Commitments; 13: Boundary Disturbance; 14: Histrionic Sexualization; 15: Hostility; 16: Eating Disturbance.

herence with the scale (e.g., negatively scored suggestibility in a Hostility factor). Table 3 reports the factor correlations for the 16 obliquely rotated factors.

Two aspects of the data deserve comment. First, Table 3 illustrates a very clean simple structure solution. Second, as can be seen in Table 3, although the factors were allowed to correlate, with few exceptions most correlations were close to zero. This is a desirable quality for a multiscale inventory because it implies that each scale offers nonredundant information about the patient. Such information can be profitably summarized by factor scores because all 16 factors have high factor score validity coefficients (Grice, 2001; McDonald & Mulaik, 1979), a situation uncommon among psychology scales (Guttman, 1955). Factor score validity coefficients represent the correlations between the factor score estimates and the actual factor scores (see McDonald & Mulaik, 1979, for a relatively nontechnical discussion). Although the factors are clearly distinct, when we created factor-based scores from items with the highest loadings (described above), some of the seemingly anomalous findings (e.g., the absence of any relationship between Depression and Anxious Somatization) disappeared. For example, Psychopathy correlated $r = .43$ with Narcissism and $.54$ with Unstable Commitments, and Depression correlated $r = .23$ with Anxious Somatization.

TABLE 3. Factor Correlation Matrix for 16 Oblimin-Rotated SWAP-II Factors: Factor Score Validities on Diagonal

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	.95															
2	-.11	.95														
3	-.18	.15	.89													
4	.15	-.16	.00	.89												
5	.09	.09	.14	.08	.88											
6	.12	-.11	-.11	.03	-.12	.92										
7	.22	.05	.03	.03	.03	.01	.92									
8	.01	-.15	.01	.09	-.07	.01	-.05	.86								
9	-.06	.15	.02	-.14	.03	.00	-.03	-.10	.88							
10	-.10	-.15	-.00	-.04	-.02	.07	-.14	.09	.09	.89						
11	-.21	-.10	.11	-.00	-.00	-.12	-.23	.01	.07	.18	.91					
12	.17	-.13	-.14	.04	-.05	.07	-.02	-.01	-.07	.05	-.06	.87				
13	.06	-.07	-.01	-.10	.00	.08	.03	.02	-.02	-.01	-.06	-.04	.86			
14	.10	.01	-.17	-.02	-.05	.09	.14	-.06	-.08	-.10	-.14	.09	-.01	.88		
15	.27	-.18	-.01	.10	.03	.14	.21	.03	-.09	.03	-.13	.03	.07	-.07	.93	
16	.05	-.10	-.06	.15	.06	.06	.01	-.01	.02	-.02	-.02	.07	.04	-.08	-.02	.85

Note. Factor Score validity coefficients on the diagonal. Factor Score Validities and Factor Correlations in boldface. Factor names: 1: Psychopathy; 2: Psychological Health; 3: Obsessionality; 4: Schizotypy; 5: Emotional Avoidance; 6: Emotional Dysregulation; 7: Narcissism; 8: Anxious Somatization; 9: Sexual Conflict; 10: Depression; 11: Social Anxiety/Avoidance; 12: Unstable Commitments; 13: Boundary Disturbance; 14: Histrionic Sexualization; 15: Hostility; 16: Eating Disturbance. As with most factor analyses, the directionality of loadings (i.e., whether they are primarily positive or negative) is arbitrary and of no consequence to interpretation of the findings (e.g., the predominantly negative loadings of items associated with the Hostility factor).

DISCUSSION

This study provides the first normative data on the factor structure of comprehensive personality descriptions obtained using the SWAP-II in a large, representative national clinical sample. The sample included patients with personality dysfunction ranging from mild to severe, drawn from a wide range of settings including private practice, outpatient clinics, residential treatment settings, and forensic facilities. Factor analysis using polychoric correlations with Oblimin rotation produced a simple structure that resembled the structure identified in previous research using an earlier version of the SWAP instrument and different factor-analytic methods (Pearson correlations with a Promax rotation; Shedler & Westen, 2004a). Several similar factors emerged in both samples, notably Psychological Health, Psychopathy, Hostility, Narcissism, Emotional Dysregulation, Obsessionality, Histrionic Sexualization, and Sexual Conflict. With the exception of the latter scale, the same factors emerged from factor analysis of the SWAP-200-A for adolescents.

The major differences between the factor structures uncovered using data from the SWAP-200 and the SWAP-II were: (1) the SWAP-200 data yielded a Dysphoria factor, whereas the SWAP-II data yielded more differentiated Depression, Anxious Somatization, and Social Anxiety/Avoidance scales; (2) SWAP-200 factors related to schizoid, schizotypal, and avoidant pathology were reconfigured, producing SWAP-II Schizotypy, Emotional Avoidance, and Social Anxiety factors; (3) items that loaded on the SWAP-200 Dissociation factor tended to load on the SWAP-II Emotional Dysregulation factor; (4) an Unstable Commitments factor emerged with the SWAP-II; and (5) a Boundary Disturbance factor emerged with the SWAP-II.

Although continuity with the factor structure observed with the earlier edition of the SWAP is greater than discontinuity, with several scales remarkably similar in item content, as noted here, differences did emerge between the previous analysis and the current analysis, and attributing these differences to one source versus another can be difficult. For example, the current findings reflect substantial improvements in sampling, including greater than double the sample size; inclusion of patients regardless of whether they met criteria for a *DSM-IV* PD; and random selection of patients (rather than clinicians choosing potentially prototype patients with a given PD). These are very substantial sampling improvements that were central to the design of the current study.

In addition, the SWAP-II has the advantage of making use of the feedback of hundreds of clinicians who used the SWAP-200 and alerted us about items that were ambiguous or difficult to score as well as personality constructs that were not adequately covered in the previous item set. It additionally reflects psychometric refinements based on examination of poorly performing items (e.g., those with minimal variance, extremely low base rates, or highly overlapping content leading to correlations $\geq .70$). This study also employed much more sophisticated factor-analytic proce-

dures, such as the use of polychoric correlations and the partialing out of potential biases due to gender differences. These data-analytic improvements no doubt helped produce some “cleaner” factors, although factor analysis of the current sample using simple Pearson’s correlations with an Oblimin rotation, extracting 16 factors from the raw data (not adjusted by gender), produced factors highly similar to those reported here (though less well defined in terms of item univocality). Thus, the factors appear robust across factor-analytic methods.

The scales generally showed good internal consistency with a mean α of .73, although two (Boundary Disturbance and Sexual Conflict) were on the low side at .44 and .55, most likely because of the relatively small number of items (4 and 6, respectively) that loaded highly on these factors. Space limitations preclude reporting validity data for the SWAP-II factors here; however, convergent validity and discriminant validity between two independent observers for the original SWAP-200 traits are very strong, with correlations along the diagonal (convergent validity) averaging $\geq .70$ and off the diagonal (discriminant validity) averaging approximately 0.0 (Westen & Muderrisoglu, 2006). Preliminary analysis of data from a new sample of more than 200 patients for which we have independent data from multiple sources (e.g., three independent interviewers as well as treating clinicians), to be reported elsewhere, suggests that these traits have similar properties in terms of convergent and discriminant validity between two independent sources, and that they predict multiple measures of adaptive functioning assessed by independent informants.

TRAIT STRUCTURE

Several aspects of the trait structure of the SWAP-II are notable. The first is the identification of a Psychopathy factor that resembles, in many respects, the psychopathy construct as described by Cleckley (1941) and operationalized via the Psychopathy Checklist-Revised (PCL-R; Hare, 2003). Importantly, this factor emerged empirically, and did so in both the SWAP-200 and the SWAP-II, even though neither instrument was designed with this construct or measure in mind. Furthermore, the items characterizing the Psychopathy factor were clearly a subset of the SWAP-II items that emerged empirically as most descriptive of 91 incarcerated men who had scores ≥ 30 (the clinical cutoff) on the PCL-R in an independent assessment (Blagov et al., 2011). The factor resembles the *DSM-IV* Antisocial PD construct, but it also incorporates additional constructs of theoretical and etiological relevance, including failure to learn from negative consequences, thrill and sensation seeking, and deficits in empathy. These findings lend support to the psychopathy construct and suggest that a single instrument may be able to assess not only psychopathy but also other forensically relevant constructs, such as emotional dysregulation and other Axis II personality disorders. Compared to Cleckley’s psychopathy construct, the SWAP-II’s empirically derived Psychopathy factor features more

prone to violence and less narcissism, with the latter comprising an independent construct.

Second, as was the case with the SWAP-200, SWAP-II Obsessionality describes something quite different from high conscientiousness (or its opposite, which emphasizes impulsivity) as described by the FFM or the consensus four-factor model. Rather, it describes a construct closer to the classic clinical concept of an obsessional personality style (Blagov, Bradley, & Westen, 2007; Shapiro, 1965), which includes such characteristics as excessive concern with rules, self-righteousness, stinginess, preoccupations with dirt and cleanliness, rumination, and excessive devotion to work to the detriment of leisure and relationships.

More broadly, the factors that emerged tend to focus on a greater range of personality processes and dimensions than most trait measures. Some overlap with *DSM* syndromes (e.g., narcissistic personality disorder) but nevertheless capture trait narcissism; others capture what might be called endophenotypes, such as Schizotypy; and still others describe psychological processes, focusing on the kinds of internal states, transformations, and conditional “if... then” processes increasingly emphasized by general personality theorists across theoretical orientations (Mischel & Shoda, 1995; Westen, Muderrisoglu, Fowler, Shedler, & Koren, 1997; e.g., “Tends to become irrational *when strong emotions are stirred up . . .*” [emphasis added]). All of these would be consistent with the broad construct of “trait” as first described by Allport (1937). These trait constructs may prove useful as modifiers of syndromal diagnoses, whether the traditional personality disorder diagnoses of *DSM* or empirically derived diagnostic prototypes as we have proposed elsewhere (e.g., Schizoid Personality Disorder with high or low Schizotypy) (Westen et al., 2012).

A third aspect of the factor structure concerns the clear distinction between emotional dysregulation and factors reflecting negative affectivity. This distinction between emotional dysregulation and negative affectivity has been replicated across multiple studies using both editions of the SWAP, with both adults and adolescents; the Affect Regulation and Experience Q-sort (Westen et al., 1997); and a range of other measures (Bradley, DeFife, et al., 2011; Miller & Pilkonis, 2006). Emotional Dysregulation as identified here is conceptually very similar to an identically named supraordinate factor uncovered empirically in both clinical and general samples by Livesley et al. (1998) using the Dimensional Assessment of Personality Disorder–Basic Questionnaire (DAPD-BQ). The SWAP-II factor captures a number of facets that overlap with subscales of the DAPD-BQ, including emotional instability, intense negative emotions, cognitive dysregulation (irrationality and dissociation) under stress, and identity diffusion. These findings, as well as recent findings linking emotional dysregulation to distinct genes not associated with negative affectivity (Bradley, Westen, et al., 2011), suggest that emotional dysregulation—the tendency to experience extreme feeling states and to resort to highly maladaptive strategies to try to regulate them—is distinct from the stably negative af-

fect seen in such disorders as dysthymia and generalized anxiety disorder. Although emotional dysregulation and negative affectivity coexist in many patients (particularly those with borderline personality disorder), they appear to have distinct etiologies and treatment implications.

Fourth, the emergence of an Emotional Avoidance trait was an unexpected but conceptually and clinically meaningful finding with obvious links to such personality constructs as obsessional style (Shapiro, 1965), illusory mental health (Shedler et al., 1993), repressive coping (Weinberger, 1995), avoidant, dismissing, or deactivating attachment patterns (Dozier & Kobak, 1992), and emotional avoidance (Hayes & Melancon, 1989).

Fifth, the Schizotypy factor is consistent with prior research on the schizotypal personality disorder and the schizophrenia prodrome (e.g., Hawkins et al., 2004), capturing both positive (e.g., odd and idiosyncratic reasoning and perception) and negative (e.g., concreteness of thinking, subthreshold disorganization in thinking) symptoms. It is conceptually related to the Eccentric Perceptions scale of the Schedule of Nonadaptive and Adaptive Personality (SNAP), and its content is conceptually similar to the *DSM-IV* diagnosis of Schizotypal PD.

Finally, it is noteworthy that the SWAP-II does not produce a higher-order structure resembling the FFM (e.g., Digman, 1990), the consensus four-factor model (Markon et al., 2005), or the five factor personality pathology trait model recently proposed for *DSM-5*. Perhaps the greater complexity of some of the SWAP items, designed to capitalize on expertise gained through professional training and experience, permits assessment of clinically important aspects of personality that have not been adequately captured by item sets that rely primarily on personality constructs salient to untrained laypersons. For example, the following SWAP-II items address personality phenomena that are readily recognizable to clinicians but would be extremely difficult to capture via self-report and do not resemble the level of discourse commonly used by lay observers:

“Is invested in seeing and portraying self as emotionally strong, untroubled, and emotionally in control, despite clear evidence of underlying insecurity, anxiety, or distress.”

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

“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.”

LIMITATIONS

This study concerns the factor structure and content validity of the SWAP-II and does not address questions of interrater and test-retest reliability of the instrument or its construct validity. We present such evidence else-

where (see also Westen & Shedler, 2007). Future research should evaluate the replicability of the factors presented here using confirmatory factor analysis. Furthermore, we cannot be certain that this sample is representative of the population of patients treated for personality pathology in some absolute sense, although it is more representative than virtually any other sampling approach of which we are aware (in comparison, e.g., to sampling patients who meet PD criteria based on structured interviews from a single setting or small number of clinics affiliated with a university hospital).

CONCLUSIONS AND IMPLICATIONS

The findings suggest that the factor structure of an instrument designed to quantify the concepts and observations of experienced clinicians does not reproduce the FFM or any of its variants. This finding makes sense in light of the lexical hypothesis underlying the FFM, which suggests that language evolves to fit its purposes. The purposes of lay observation and clinical observation of personality are markedly different (as is the level of expertise of the observer). Just as oncologists tend to use more refined concepts than “bumps” or “growing red dots” to describe different forms of cancer, the language required by clinical observers who regularly observe and treat the more pathological end of the personality spectrum should be more differentiated than the language of lay observers (particularly when the latter is constrained for methodological reasons not to exceed a sixth-grade reading level). Factor analysis of the SWAP-II produced a coherent solution with simple structure whose factors were generally highly reliable, clinically and empirically recognizable, and could not be reduced to a hierarchical structure with a small number of superordinate factors.

More broadly, the finding of clinically coherent factors is consistent with an increasing body of evidence, congruent with research in other medical disciplines (e.g., Arocha, Wang, & Patel, 2005), that clinically trained observers can make reliable, quantifiable diagnostic inferences when these inferences are made at a level of abstraction close to that used in everyday practice (at which doctoral-level clinicians have expertise; DeFife et al., 2010; Westen & Weinberger, 2004). We have yet to observe substantial differences in the way clinically trained observers of different theoretical orientations use the SWAP. This suggests that, when asked to describe a particular patient (as opposed to their hypotheses or beliefs about psychopathology), experts in psychopathology are able to do what most people are able to do, namely to describe a person with an appropriate level of fidelity using language appropriate to their level of expertise.

With the next revision of the *DSM* on the horizon, that revision should be made in the light of data comparing the validity and reliability of alternative methods of assessing and classifying personality pathology, particularly dimensional diagnosis. Virtually no data exist that compare dimensional traits versus diagnostic prototypes (descriptions of constellations of functionally related personality characteristics that comprise clinical syn-

dromes) on indices of validity (Westen, Gabbard, & Blagov, 2006). Likewise, no data of which we are aware compare traits derived from self-report measures with those derived using item sets designed for clinically expert informants. We are currently testing the comparative validity of multiple alternative approaches to dimensional diagnosis of personality in a study using a multitrait-multimethod approach with a sample size large enough to discriminate the relative validity of these alternative approaches. If future editions of the *DSM* are to reflect the best available science, then appropriate scientific comparison of alternative diagnostic systems is a prerequisite.

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