***Instituto Superior de Psicologia Aplicada***

# ASSESSING PERSONALITY WITH THE SHEDLER AND WESTEN ASSESSMENT PROCEDURE (SWAP-200): A NEW APPROACH USING THE PSYCHOANALYSIS SESSION NOTES

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Dissertação Orientada por António Pazo Pires

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Família

E

Amigos,

Um muito obrigado pela força, companhia e partilha! ;)

***(**e especialmente, a ti…)*

## RESUMO

Diagnosticar as perturbações de personalidade sempre foi um desafio. Existem, ainda antes do princípio do séc. 20, teorias que tentam explicar as perturbações de personalidade e a sua respectiva distinção. As contribuições mais valiosas da psicologia clínica para a personalidade e a sua patologia, têm sido a criação de instrumentos que avaliam as perturbações de personalidade no contexto clínico. No entanto, esses instrumentos não espelham os procedimentos de avaliação usados na prática clínica, onde os clínicos obtêm a informação para avaliar os processos da personalidade através das narrativas e dos aspectos mais relevante do paciente (tais como as formas de regular as emoções, a capacidade para ter relações íntimas e o comportamento face ao clínico) e tiram as suas próprias conclusões. (Westen, 1997). Neste estudo, apresentamos uma abordagem alternativa para fornecer descrições clinicamente ricas e detalhadas da personalidade de uma forma empírica e quantitativa, a Shedler and Westen Assessment Procedure (SWAP-200; Shedler & Westen, 2004b; Westen & Shedler, 1999a, 1999b), que é baseada na Metodologia Q.

Deste modo, é analisada a sua fiabilidade e viabilidade, os grupos diagnósticos emergentes e o uso clínico deste instrumento. A literatura revista para uma alternativa em avaliar os perturbações de personalidade através da SWAP-200 demonstrou que este instrumento de avaliação, administrada pelo próprio clínico é significativamente uma medida clínica para a avaliação da personalidade, e pode providenciar futuras investigações para um melhor diagnostico dos perturbações da personalidade.



*Palavras-Chave*: SWAP-200, diagnóstico, avaliação, distúrbio, personalidade

## ABSTRACT

Diagnosing personality disorders (PDs) is always been a challenge. Even before the begging of the 20th century, there are theories that try to explain the PDs and the distinction between them. The most valuable contributions from clinical psychology to personality and its pathology consisted in the creation of instruments for the assessment of personality disorders in clinical context. However, these instruments do not mirror the assessment procedures used in clinical practice, whereas clinicians elicit the information to assessing personality processes through the narrative and the most relevant aspects from a subject (such as ways of regulating emotions, capacity for intimate relationships and the behavior toward the interviewer in the consulting room) and draw independent conclusions (Westen, 1997). In this study, we present an alternative approach to provide detailed, clinically rich personality descriptions in a empirical and quantifiable form, the Shedler-Westen Assessment Procedure (SWAP-200; Shedler & Westen, 2004a, 2004b; Westen & Shedler, 1999a, 1999b), based on the Q-methodology.

This way, it's analyzed the reliability and validity, the emerged diagnostic groupings and the clinical use of this instrument. The reviewed literature for an alternative in assessing personality disorders through the SWAP-200 demonstrated that this clinician administered instrument is a clinically significant diagnostic measure of personality, which can provide future investigations to personality disorders diagnosis.



*Keywords*: SWAP-200, diagnosis, assessment, personality, disorder

LITERATURE REVIEW



EMPIRICAL STUDY

# INTRODUCTION

A problem always present in the field of clinical psychology is that there are no "gold standards" for the diagnosis of personality disorders (Fridell & Hesse, 2006; Bradley, Hilsenroth & Westen, 2007, Livesley, 1995; Hunsley & Marsh, 2004). There are some dogmatic standards for comparing the absence/present of symptoms according to the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV; American Psychiatric Association, 1996, 2002) or the *International Classification of Diseases* (ICD-10; World Health Organization, 1993), but the core consensual of the diagnosis of personality disorders (PDs) it's not the same for every clinician. Even more, to diagnosis such PDs are necessary to use some standard clinical interviews, self-report measures or clinician-rated instruments. Hunsley and Mash (2008) in the book *A Guide to Assessments That Work* (p.416) rated the majority of the clinical instruments used for diagnosis. There are several arguments (reviewed further on this study) that the instruments for classifying PD remain clinically and empirically problematic. Also, it has not been proven satisfying to either researchers or clinicians, because clinicians relies on what they do best, i.e. making inferences and diagnosis based on the observation of a subject. In an attempt to clarify the problems in assessing personality, emerges the *Shedler and Westen Assessment Procedure – 200* (SWAP-200; Shedler & Westen, 2004a, 2004b; Westen & Shedler, 1999a, 1999b), a clinician-rated instrument designed to bridge the gap between science and practice. In order to verify if the SWAP-200 is a reliable instrument, it was search the concerning literature available mainly on the EBSCO database (such as the PsycINFO; PEP Archive) with the keywords *SWAP-200*, *diagnosis*, *assessment*.

In this study, we present the feedback of that search, including the context in which emerges the SWAP-200, the method for creating the SWAP-200, the reliability and validity, the instructions to use it and the empirically derived taxonomy.

# 1. PERSONALITY DISORDERS (PD's)

## 1.1 BRIEF HISTORICAL REVIEW OF PDS

The DSM-III (APA, 1996 and successive) definition of personality disorders, together with their distinction from other clinical syndromes (Axis I disorders), has provided a remarkable impulse to consider this psychopathological class has a research area.

It is possible to retrace the steps through where personality and pathology have been conceptualized and articulated in the history of psychiatry and clinical psychology. Traditionally, academic personality psychologists have been more interested in non-clinical populations and therefore, didn´t provided much attention, in their theories, to abnormal personalities or to the personality pathology. Retracing the history of clinical psychology, Vaillant and Perry (1985) regained already in publications of the nineteen century, the definition of personality disorder; in 1907, Kraeplin (1907, as cited in Belfiore, 2007) had already described four types of psychopathological personality, while in 1908, initiated the psychoanalytical study of character pathology. After this, follows the distinction made by Alexander Franz (1930, as cited in Belfiore, 2007) between the neurotic Character and the symptomatic Character, and the psychoanalytical treatment operated by Reich (1933, as cited in Belfiore, 2007) for the personality disorders.

The most valuable contributions from clinical psychology to personality and its pathology consisted in the creation of instruments for the assessment of personality disorders in clinical context. The birth of the classical approach to the assessment of personality in clinical setting, documented in the writtens of Rapaport, Gill & Shafer (1968, as cited in Belfiore, 2007), documented that the diagnostical assessment of personality had to do with different types of organization of spontaneous thought processes from the subject, and from attempts to interfere with the nature of his personality and his adaptative difficulties.

The focus of this method was mainly determined by the psychiatric diagnosis of that time and by the dominant approaches of the psychodynamical therapeutics.

Has an opposition to the traditional approach, based in a whole battery of tests, in 1943 is published for the first time, from Hathaway & McKinley, a self-report questionnaire, the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1999), that contained scales for the revelation of important clinical syndromes, such depression, hypochondria, schizophrenia and others. The fact that MMPI has been defined has a

personality test is a demonstration of the overlap of the concepts that belonged to the clinical field and from others related with personality or with personality pathologies. Considering the relevance given to the clinical interview in psychiatry, and confirming the progresses gattered in the 70´s, in the construction of structured interviews for the main humour disorders and for psychosis (e.g. the PSE or Present State examination and SADS or Schedule for Affective Disorders and Schizophrenia), it´s not surprising that has been being developed several semistructured interviews such as the Structural Clinical Interview for DSM – III – R (SCID – II; Spitzer, Williams & Gibbon, 1997) and the Personality Disorder Examination (PDE; Loranger, 1988, as cited in Belfiore, 2007), that validate personality disorders like they are decribed in the DSM system. Nowadays, the standard approach more used for the diagnosis of personality disorders is the structured interview.

### 1.2. DSM – III AND THE BIRTH OF AXIS II

Traditionally, personality psychologists related with the academical environment, have been mostly more interested in normal personality, its structure and development, while other psychologists from the clinical area have turned their attention from the beginning, to the pathological variations of personality operation. DSM – I (APA, 1952, as cited in Belfiore, 2007) provided 4 categories of psychiatric disorders:

1 – Pattern disorder

2 – Treatment disorder

3 – Impulse. Control and relationship disorder

4 – Sociopathic disorder

In DSM- II (APA, 1968, as cited in Belfiore, 2007), these categories were only used in cases where the patient didn´t entered other categories. Personality disorders, defined in a specific and separated axis, did their first appearance in DSM – III (APA, 1993) that used a multiaxial diagnosis system that made the distinction between clinical syndromes (Axis I) and personality disorders (Axis II). DSM – III brings out the controversy related with the nature and role of personality and its pathology in the history of psychiatry and modern research on personality. The introduction of a distinction between clinical syndromes and personality disorders, such as the explicit description of personality pathologies inside DSM – III, didn´t brought approval to the intellectual community; some sustained, through a basis of a long

clinical, that the disorders defined in Axis II had nothing to do with the clinical reality. These questions put in evidence some of the difficulties related with the benefits of an atheoretical approach sustained by researchers of DSM – III and their successors. The development of DSM – III looked for a diagnosis system that could provide explicit criteria, mainly behavioral, and therefore that could have been validated with a certain security. As a consequence, lots of researchers of the psychiatrical and clinical psychology field accepted the review of the diagnosis system that brought, not only an increase of the amount of diagnosis in Axis II in the clinical settings (Loranger, 1990), but also a remarkable increase of the number of researches on the personality pathologies, made in journal of general psychiatry and psychology (Archive of General Psychiatry, American Journal of Psychiatry, Journal of Abnormal Psychology).

The amount of investigations about personality pathologies had a sensational increase in the 25 years elapsed since the duplication of DSM – III; the benefit of such evolution consists in the possibility that is acquired by making testable and falsifiable models that are not only descriptive, but on the contrary emphasize the etiology, the mechanism and the long term evaluative consequences of personality pathologies. With the advent of specific diagnostic criteria and a polithetic approach to classification, Axis II of DSM – III represented the opportunity for articulated discussions and for the empirical research on the relations between conceptualized personality disorders of psychopathology and normal personality studied by academical personality psychologists. The theoretical discussion focused mostly on 3 conceptual key-questions, more precisely:

1 – The dimensional or categorical nature of personality disorders (Costa & Widiger, 2002):

2 – The difference between normal and pathological personality characteristics (e.g. social isolation as a possible explanation for low socialization vs. suicide attempts as not being present in some normal dimensions of personality (Wiggins, 1982).

3 – The nature of processes and the basic structure, underlying both personality disorders and normal personality (Rutter, 1987; Cloninger, Svrakic, Przybeck, 1993; Livesley, Jang, Vernon, 1998; Depue, Lenzenweger, 2001).

Although there have been some efforts to clarify PDs, some problems still remain, as it going to be discussed further.

### 1.3. PROBLEMS ON CLASSIFYING PERSONALITY DISORDERS

The DSM-IV classification of personality disorders (PDs) has not proven satisfying to either researchers or clinicians. Since its inception, the instruments for classifying PD remain clinically and empirically problematic. For example, they have marginal validity and poor retest reliability at intervals greater than 6 weeks (First et. al, 1995, as cited in Shedler & Westen, 1999a) and the comorbidity of axis II disorders are too high; a patient often can receive one or more diagnostics of PD, whether obtained by self-reports measures or structured interview (Watson & Sinha, 1998). Also the categories and criteria are not empirically based and often disagree with empirical findings from cluster and factor analyses (Blais & Norman, 1997; Morey, 1988). It artificially dichotomizes continuous variables into present/absent, which is neither theoretically nor statistically sensible, since the problems are not viewed as a continuum (Shedler & Westen, 1999a) and lacks the capacity to weight criteria that differ in their diagnostic importance (Davis, Blashfield & McElroy, 1994).

It fails to considerer personality strengths and to address the range of personality pathology, found in patients who seek treatment but do not fall within the 10 personality disorder categories included in axis II (Westen, 1997; Westen & Arkowitz, 1998), this way resulting that many problems cannot be diagnosed. But even diagnosed, the categories and criteria are not as clinically useful as they might be (because it tells us little about which treatments to use, which personality processes to target for treatment, and so on).

An additional problem is that these instruments do not mirror the assessment procedures used in clinical practice, whereas clinicians elicit narrative information relevant to assessing personality processes (such as ways of regulating emotions, capacity for intimate relationships', characteristic motives) and draw independent conclusions, based on inferences from patient's narrative descriptions of their life, relationships and behavior toward the interviewer in the consulting room (Westen, 1997).

In contrast, current instruments rely on direct questions and expect patients to report on their own personalities, especially when lack of insight and self-understanding is characteristic of some personality disorders. Instead of identifying the best diagnostic criteria and then finding ways to operationalize them, Axis II committees have tended to exclude criteria that cannot be assessed by direct questions (e.g. Livesley, 1995). Further, many studies document the distorting effects of psychological defenses on self-report data, especially when people are asked questions that have implications for self-esteem. For example, the attachment style

predicts discrepancies between self-reported anxiety and objective physiological measures of anxiety (Dozier & Kobak, 1995)

Self-report data tend to be more predictive of internalizing pathology whereas observer reports tend to be more predictive of externalizing pathology (Fiedler, Oltmanns, & Turkheimer, 2004). For Westen and Shedler (2007) clinically trained observers have access to internal distress and to less socially desirable aspects of the patient's personality, which are revealed through interpersonal interaction and descriptions of interactions. Neurophysiologic studies concluded that what clinicians can observe and infer about personality may be very different from what a patient can describe (Schacter, 1992; Westen, 1998).

Some of the issues reviewed above in this article show some problems in conceptualizing and measuring personality disorders. There as been some considerable strides in increasing the understanding of the course and etiology of some personality disorders, and current efforts largely assume the validity of the current nosology, rather than systematically testing alternatives. An alternative approach to provide detailed, clinically rich personality descriptions in a systematic and quantifiable form is the Shedler-Westen Assessment Procedure (SWAP-200; Shedler & Westen, 2004a, 2004b; Westen & Shedler, 1999a, 1999b) that is based on the Q-methodology.

## 2. *THE Q-METHODOLOGY*

### 2.1. Q-SORT AND FACTOR ANALYSYS

The Q methodology circumscribes both a data collection (Q-sorting) and a data analysis technique (Q-factor analysis), and it is qualitative through its assumptions and research logic and quantitative through the statistical apparatus sustaining data analysis (Brown, 1993). Further on, the core concepts of Q-methodology will be defined, and the steps of a Q-procedure sketched.

A Q-sort, in the context of personality disorders, is a set of statements that describe different aspects of personality and psychological functioning. A Q-card is the card a statement is written on, and each statement (printed on a separate index card) may describe a given patient well, somewhat, or not at all. A clinician or interviewer sorts the cards into categories, on the basis of the degree to which the statements describe the patient, from those

that are inapplicable or not descriptive to those that are highly descriptive (Westen & Shedler, 1999a).

The Q-sort method requires that clinicians assign a specified number of statements to each category. With standard rating scales, the clinician does not have discretion about how many items to put in each category. In psychometric terms, the clinician must arrange the items into a fixed distribution. The use of a fixed distribution has important psychometric advantages over standard rating procedures, because it minimizes error variance due to rater effects (Westen & Shedler, 2007). In another words, assessors assign scores with the same frequency.

Due to its forced distribution, Q-sort is an ipsative technique, i.e. the sum of the raw scores is constant for each respondent (Baron, 1996), and can be more valid than normative scales, i.e. values that approach a normal curve (e.g. The California Q-sort, Figure 1). Due to their conception, the former eliminate a number of biases, such as avoiding the use of extreme response categories; the tendency to agree to statements as presented; and the portray that the respondents have of themselves in a more positive manner. Also this method can ensure that assessors attend systematically to all constructs subsumed by the item set.

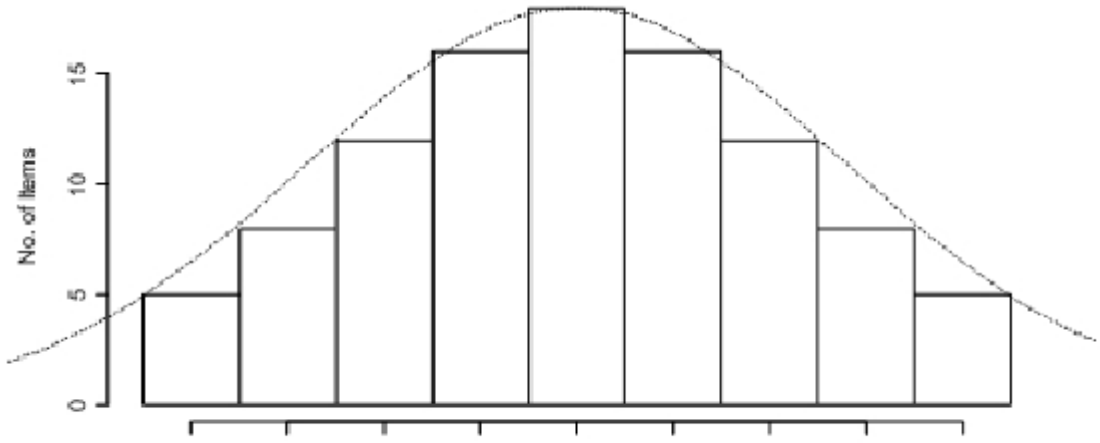


**FIGURE 1 - Item distribution of the California Q sort (solid lines) compared with the normal curve (dotted line).**

After collecting the data, a factor analysis is performed. What the researcher actually looks for in giving meaning to the data is a common cause running through the scores of the whole array in some degree, from one end of the array to the other. The factors are operants: matrices are looked at for what the data tell, not what can be projected upon them as hypotheses or categorizations. Therefore, first it is looked the normalized factor scores for a

factor and its distinguished statements. Then, it is looked the differences between factor arrays and the consensus statements (Boros, Visu-Petra & Cheie, 2007).

The procedure identifies groups who are similar to one another and dissimilar to others in other groups. Q-analysis can be understood by comparison with conventional factor analysis, which is a common statistical technique in psychological research. Factor analysis is used when a data set contains many variables, and these variables appear to be redundant measures of a few underlying dimensions (factors). The difference is that factor analysis identifies grouping of similar variables (i.e., columns in a data matrix) that are assumed to be markers of a common underlying factor. In contrast, Q-analysis identifies grouping of similar people (i.e., cases or rows in a data matrix) who are assumed to represent a common diagnostic syndrome or type (McKeown & Thomas, 1988)

### 2.2. THE SWAP-II : AN INNOVATIVE Q-SORT.

The SWAP is a set of personality descriptive statements (items), each of which may describe a given patient well, somewhat, or not at all. A clinical assessor sorts the statements into eight categories based on the degree to which the statements describe the patient, from 7 (highly descriptive) to 0 (not descriptive).

Items are written in straightforward, experience-near language (e.g., “Tends to be passive and unassertive” or “Has an exaggerated sense of self-importance”), and items that require inferences about internal mental processes are written without recourse to jargon (e.g., “Tends to see own unacceptable feelings or impulses in other people instead of in him/herself”). The standard vocabulary of the SWAP allows clinicians to provide in-depth psychological descriptions of patients in a systematic and quantifiable form and ensures that all clinicians attend to the same spectrum of clinical phenomena. (Shedler & Westen, 2007).

The instrument is based on the Q-sort method which requires clinicians to arrange items into a fixed distribution (Block, 1978, as cited in Shedler & Westen, 1999a), and assign each score a specified number of times (Shedler & Westen, 2007), minimizing the sources of error variance by calibrating assessors and ensuring that different assessors assign scores with the same frequency (relative to the 200 items, when an assessor assigns a score, it means that is the most defining of the patient’s personality).

To ensure that the fixed score distribution would be appropriated for describing most patients and not an arbitrary imposition, the authors observed how clinicians rated SWAP items when they did not impose a fixed distribution, to determine the distribution of the clinicians used naturally. They also included a broad range of item content to ensure that there would always be enough items that belong in the highest or most descriptive score categories (Westen & Shedler, 2007), so that the fixed distribution permit a normatively accurate portrayal of the individual.

Prior Q-sort instruments have treated items as extremely characteristic to extremely uncharacteristic (bipolar dimensions), and have used quasi-normal score distributions in which middle scores indicated neutrality on the dimension (e.g. Figure 1).

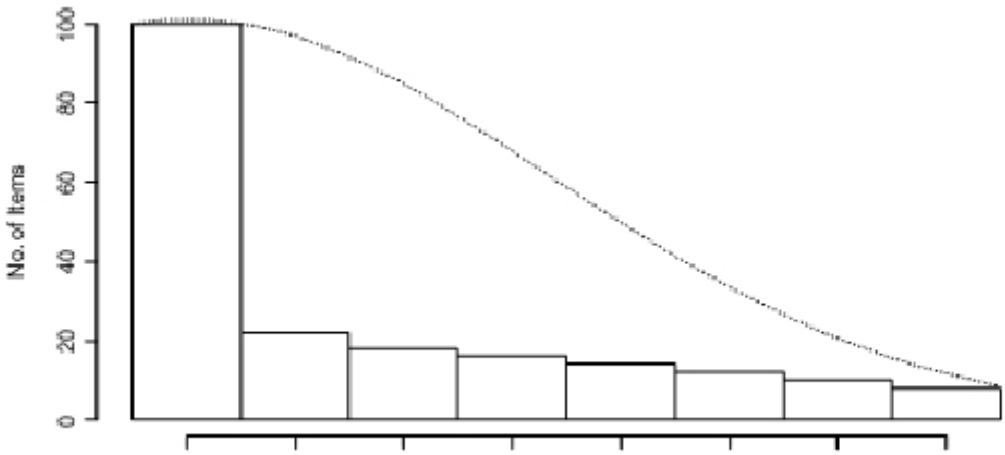


**FIGURE 2 -Item distribution of the Shedler–Westen Assessment Procedure–200 (solid lines) compared with the normal curve (dotted line)**

An innovation of the SWAP is that all items are written to assess unipolar constructs, and the fixed score distribution is therefore asymmetric, resembling half of a normal distribution (Figure 2). Half of the items receive scores of 0 (not applicable to the patient), and progressively fewer items receive higher values, in the same way people do not have a given form of pathology, and fewer have the pathology in more extreme form. Also, this distribution approximates the generated naturally by most clinicians that rated SWAP without a fixed distribution.

# 3. THE SHEDLER AND WESTEN ASSESSMENT PROCEDURE - 200

## 3.1. DEVELOPING THE ITEM SET

The SWAP-200 is an assessment instrument designed to bridge the gap between the clinical and empirical traditions in personality assessment and has been used to refine and dimensionalize existing Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 1994), to diagnostic categories without presupposing the DSM-IV typology of personality disorders and to identify factors or trait dimensions relevant to describing personality pathology.

The item set was developed and revised over a 7-year period and incorporates constructs drawn from a wide range of sources including Axis II diagnostic criteria included in DSM–III through DSM–IV; selected Axis I criteria that could reflect personality traits (e.g., depression and anxiety); research in personality psychology; research on normal personality traits; research on coping and defensive processes; research of interpersonal pathology in PD patients; clinical literature on PDs written over the past 50 years (Westen & Shedler, 2007); and the feedback of hundreds of psychologists and psychiatrists who used earlier versions of the instrument to describe their patients (Shedler & Westen, 1998; Westen & Shedler, 1999a). Each time a clinician used the instrument, it was asked one critical question: “Were you able to describe the things you considerer most psychologically important about this patient?”, whereas 86% of clinicians, agreed or strongly agreed (less than 5% disagreed). The results did not differ by profession or clinician theoretical orientations.

Because the SWAP is jargon free and clinically comprehensive, is has the potential to serve as a language for describing personality pathology that can be used by any skilled clinical observer. Writing items in this jargon free manner minimizes unreliable interpretive leaps and makes the item set useful to all clinicians regardless of their theoretical orientation. The items are also written in the form of diagnostic criteria. Items that prove to be empirically diagnostic for a disorder,can therefore be used directly as candidate diagnostic criteria, without the need for translation from the language of self-report to the language of clinical description, allowing the instrument to provide a comprehensive assessment encompassing personality strengths as well as pathology (Westen & Shedler, 2007).

The SWAP is meanly based on information provided by clinicians, in what they do well, namely, making specific observations and inferences about individual patient they treat and know well or interview systematically. Clinicians generally have access to both internal distress and to less socially desirable aspects of the patient's personality that are revealed through interpersonal interaction and descriptions of interactions. In this way, many personality processes may be inaccessible via self-report by virtue of cognitive architecture, whereas others may be inaccessible due to denial, self-deception, or self-presentation.

Shedler and colleagues (1993) demonstrated that widely used self-report measures could not distinguish between psychologically healthy individuals and psychologically troubled individuals who maintained a façade of mental health based on defensive denial. Although self-report instruments could not distinguish genuine from illusory mental health, clinical assessors could do so using written autobiographical narrative material and unstructured clinical interviews. This logic is analogous to the logic of intelligence testing. Instead of asking people their opinions about their vocabulary skills, psychologists present vocabulary word and draw independent conclusions regarding performances.

Westen and Shedler (2007) employed a method using the SWAP based on Meehl's book, *Clinical vs. Statistical Prediction*. Meehl's (1954, as cited in Westen & Shedler, 2007) demonstrated that statistical prediction is superior to prediction made without the benefit of quantified data and statistical methods (for a detailed discussion of this topic, see Westen & Weinberger, 2004, 2007). In this way, the specific observations and inferences of the clinicians relies on statistical algorithms, aggregating data to derive reliable, valid scales and indices and predict relevant criterion variables.

### 3.2. RELIABILITY AND VALIDITY

The Q-sort method allows researchers to combine descriptions of different patients, to obtain a composite personality description of a particular type of patient. This is accomplished by averaging the values assigned to each SWAP-200 item across a number of patients. A statistical consequence of averaging is that only items ranked highly by all clinicians will have high ranking in the composite description, and it is obtained a list of the psychological features that virtually all clinicians consider important to the diagnosis (Westen & Shedler, 2007).

Composite descriptions can be a diagnostic prototype (description of hypothetical, prototypical patients with a given personality disorder in its purest form), which is a richly detailed description of the personality disorder that reflects the clinical and theoretical understanding of many practicing clinicians, or actual patients in a given diagnostic category, described by the authors as the composite description. The composite description is a richly detailed description of actual patients with the personality disorder.

Shedler and Westen (1999a) made a validation of the SWAP-200 doing an enquiry, selecting a random sample of experienced psychologists (the divisions of clinical psychology, psychotherapy and psychoanalysis) and psychiatrists and focused a study on recent DSM axis II diagnoses to validity the SWAP-200 as a method for assessing personality disorders.

On the basis of their responses, it was asked for two-thirds of the clinicians to use the SWAP-200 to describe a current, actual patient from a specific diagnostic category and for the other one-third to describe a hypothetical, prototypical patient from a specific diagnostic category. It was also asked descriptions of healthy, high-functioning patients (both prototypical and actual).

In addiction, it was provided to clinicians a list of all personality disorders, in order to rate the extent which the patient met criteria for each disorder, on a 1-7 rating scale (1= not at all, 4=has some features, 7=fully meets criteria).

First, it was examined whether actual patients with a personality disorder diagnosis resembled the diagnostic prototype for that personality disorder. A validity analysis showed that SWAP-200 descriptions of actual patients who shared a diagnosis (composite descriptions of actual patients) matched the hypothesized portraits of prototypical patients with the same axis II diagnosis (diagnostic prototypes), which were provided by different clinicians, and did not match the diagnostic prototypes for unrelated diagnoses.

The second way of assessing validity looked at the relations between personality disorder scores and clinicians' 7-point ratings. A personality disorder score is a correlation between a patient's SWAP-200 description and a diagnostic prototype, indicating the degree of match. The analysis showed high convergent and discriminant validity with clinicians' ratings of the degree to which patients met diagnostic criteria for each personality disorder.

A third way of examining validity, sets aside diagnosis and focuses instead on the ability of the SWAP-200 to predict patients' general level of functioning, as measured by the Global Assessment of Functioning Scale (DMS-IV; APA, 1996), and it was found a strong relation between SWAP-200-based psychological health scores and the GAF scale.

The results of the sorts can also be scored for empirically derived personality groupings, called Q-factor scores, by correlating the data describing a real or prototypical patient with empirically derived categories derived from prototypical sorts. The Q-factors came from Q-analyses in which factor analysis was carried out on the basis of groups of people rather than variables (Westen & Shedler, 1999b). Personality Disorder and Q-factor scores are transformed into T scores (M = 50, SD = 10), based on empirically derived normative prototypes (Westen & Shedler, 1999a, 1999b).

The results of the sorts can be scored for 12 personality or trait factors, derived from factor analysis of SWAP data (Westen & Muderrisoglu, 2003). The r-factor scores are also transformed into T scores on the basis of normative prototype scores. The resulting T scores can be used categorically, with scores at 55 or above indicating traits and scores of 60 or above leading to a categorical diagnosis, or dimensionally, so that higher scores indicate more presence of the category.

Finally, the endorsement of individual items can be considered. For example, the items most characteristic of a group can be listed. The relative endorsement of items by various groups can also be compared.

The internal consistencies of the PD scores are in the .90s (Westen & Shedler, 1999a). The SWAP-200 descriptions of patients are highly correlated with clinician rating of personality disorders for the patients (e.g., Westen & Muderrisoglu, 2003; Westen & Shedler, 1999a).

The empirically derived Q-factor scores have also been evaluated, and both reliability and validity are good (e.g., Westen and Shedler, 1999b). The validity of the r-factor scores has been explored by correlating the r-factor scores of treating clinicians and scores of independent clinicians viewing videotaped interviews, providing cross-informant agreement (Westen & Muderrisoglu, 2003). The SWAP-200 scores also differ between clinical groups in expected ways (e.g., Cogan & Porcerelli, 2005; Porcerelli, Cogan, & Hibbard, 2004).

### 3.3. DIAGNOSTIC GROUPS

An important consideration for personality researchers is whether diagnostic assessment should focus on personality syndromes or personality traits. Syndromes are multifaceted constellations of personality processes (encompassing cognition, affectivity,

interpersonal functioning, impulse regulation, etc.; APA, 2002, p. 686) that are understood to be interdependent. All editions of the DSM to date have focused on syndromes. In contrast, trait approaches focus on discrete dispositions typically derived through factor analysis (e.g., extroversion, neuroticism). Some investigators mistakenly conflate trait approaches with dimensional diagnosis, and syndromal approaches with categorical diagnosis (e.g., the DSM–IV typology of PDs is syndromal and also categorical). However, these are independent considerations whose association is purely historical (Westen, Gabbard & Blagov, 2006). The dimensional/categorical distinction refers to whether people are assumed to fall into discrete categories or to vary along a continuum. The syndromal/trait distinction refers to whether the unit of diagnosis is a constellation of interrelated personality characteristics or separate characteristics.

In the following sections, it will be described two syndromal approaches and one trait approach, all based on SWAP–II data. All of the approaches are dimensional. In the case of the syndromal approaches, diagnostic groupings are defined by empirically derived prototypes - descriptions that represent each diagnostic syndrome in its ideal or pure form (based on all 200 SWAP items). Individual patients are diagnosed dimensionally (on a continuum) based on the degree of resemblance or match with the prototype. (Westen, Shedler & Bradley, 2006).

#### **3.3.1.** *CURRENT PD TAXONOMY*

The SWAP scoring algorithms generate a dimensional score for each PD included in the DSM-IV (Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent, Obsessive-Compulsive). However, there are some differences. The empirically derived portrait of narcissistic personality disorder is highly similar to its DSM-IV description, suggesting that the axis II work groups have, in fact, captured most of the important features of the disorder seen in clinical practice. The major difference is that narcissistic patients appear to be more controlling, more likely to get into power struggles, and more competitive than DSM-IV suggests. The narcissistic composite also includes a defense: externalization, which is missing from the DSM-IV description and includes the tendency to be articulate. In contrast, he empirically derived portrait of actual patients with borderline personality disorder is substantially different from its DSM-IV description. The data show that actual borderline patients are most distinguished by their intense, poorly modulated affect and, more generally, by their omnipresent dysphoria and desperate efforts to regulate it. This suggests that questions about the comorbidity of borderline personality disorder and

depression may be somewhat artifactual, since intense affect states, including depression (and related interpersonal concerns such as abandonment), are, in fact, defining features of borderline personality disorder (Shedler & Westen, 1999a, 2004a).

### **3.3.2.** *EMPIRICALLY IDENTIFIED DIAGNOSTIC GROUPINGS*

According to Shedler and Westen (1999b) to identify the different diagnostic groupings, it was made a Q-analysis based on the SWAP-200 descriptions of actual patients, diagnosed by their clinicians as meeting axis II criteria for a personality disorder diagnosis, whereas hypothetical patients and healthy, high functioning patients were excluded from the group.

So, with the composite descriptions of the patients, which was retained Q-factors (principal components) with eigenvalues of 1 or higher (Kaiser's criteria)[1]. From the procedure, after a varimax rotation (i.e., orthogonal rotation, designed to create independent or uncorrelated Q-factors), it was obtained seven principal Q-factors.

Tables 1 to 7 (Appendix B) lists the SWAP-200 items that best describe the patient in each of the seven Q-factors or diagnostic categories. The second column shows the factor score for each item, which indicates its centrality or importance in defining the Q-factor. The items are arranged in descending order of importance, from highest to lowest. Several aspects are worthy of note. Although many of the categories resemble current axis II diagnostic criteria, the Q-factors reflect the empirical solution that maximizes their distinctiveness and minimizes comorbidity.

Second, the largest number of patients was classified as belonging in the first Q-factor, which is not in the DSM-IV, labeled as dysphoric personality disorder (patients that experience feeling of inadequacy, shame, guilty, depression, anxiety, and fear of rejection or abandonment). The category included patients diagnosed by their treating clinicians as having depressive, dependent, avoidant, self-defeating, or borderline personality disorder.

Third, a single schizoid Q-factor emerged that included many patients currently diagnosed as schizoid and schizotypal, as well as a subset of patients diagnosed as avoidant. A second divergence from the Axis II was that patients diagnosed as borderline tended to fall into either the dysphoric or histrionic Q-factors. Other divergence is that a large percentage of patients currently diagnosed as having obsessive-compulsive personality disorder appear to be

[1] For an understandment on this topic see: http://www.statsoft.com/textbook/stfacan.html (retrieved November 20, 2008)

less disturbed than the current conceptualization. They are emotionally constricted, prone to intellectualization, and overly concerned with rules, but they are not particularly dysfunctional and they are conscientious and productive to a fault. Because the first Q-factor contained so many patients, it was conducted a second Q-analysis to identify subgroups of patients within the dysphoric Q-factor, whereas five Q-factors proved to be most clinically coherent (Appendix B; Tables 1.a to 1.e.). The first subgroup was labeled as dysphoric: avoidant, and were characterized by SWAP-200 statements indicating some characteristics in descending order of importance., such as being shy or reserve, avoid social situations because fear of embarrassment, lack social skills, among other factors. The second subfactor was labeled dysphoric: high-functioning neurotic and it was characterized by SWAP-200 statements indicating psychological strengths, mixed with items indicating chronic dysphoria. Being articulated, having moral and ethical standards, being empathic, mixed with a tendency to blame themselves or feel responsible for bad things that happen, are some of the characteristic of these patients.

A third subfactor, which included many patients diagnosed as borderline, was labeled dysphoric: emotionally dysregulated, and were characterized as having emotions that spiral out of control, struggles with genuine suicidal whishes, an inability to soothe or comfort themselves when distressed, among others characteristics. The fourth subfactor, labeled dysphoric: dependent-masochistic, includes patients who appear to be much more disturbed than those in the current axis II dependent category. These patients tend to get drawn into or remain in relationships in which they are emotionally or physically abused, are ingratiating or submissive, became attached quickly or intensely, as others factors described in the tables (Appendix B; Tables 1a. to 1.e). The final subfactor was labeled dysphoric: hostile-externalizing and contained patients who were hostile and prone to blame others for their difficulties, with passive-aggressive features.

### **3.3.3.** *TRAIT DIMENSIONS IDENTIFIED VIA FACTOR ANALYSIS*

Finally, the SWAP-200 factor analysis identified 12 clinically relevant personality dimensions. 1) Psychological Health, that assesses the positive presence of psychological strengths and inner resources, including the capacity to love, finding meaning in life experiences, and gain insight into self and others. 2) Psychopathy, that includes features such as lack of remorse, a seeming imperviousness to consequences, impulsivity, and a tendency to abuse alcohol and drugs. 3) Hostility, is straightforward and requires no interpretation. 4)

Narcissism, and it reflects self-importance, grandiosity, entitlement, and the tendency to treat others as audiences to provide admiration. 5) Emotional Dysregulation, and refers to a deficiency in the capacity to modulate and regulate affect, so that affect tends to spiral out of control, change rapidly, get expressed in intense and unmodified form, and overwhelm reasoning. 6) Dysphoria, which captures depression, anhedonia, shame, humiliation and a number of cognitive and affective correlates. 7) Schizoid Orientation, it refers that patients high on this dimension do not just keep to themselves. They are also concrete in their thinking, barren in their representations of others (as reflected by an inability to describe others in meaningful ways), have constricted emotions, and have little capacity for empathy. 8) Obsessionality, that describes not only hyperconscientiousness but a cognitive and defensive style that includes absorption in details, intellectualization, preoccupation with dirt and contamination, intrusive and obsessional thoughts, stinginess, and difficulty discarding things. 9) Thought Disorder (or schizotypy), and distinguishes schizotypal personality disorder from all other personality disorders, even schizoid and borderline. 10) Oedipal Conflict, it includes a constellation of items reflecting triangulated romantic relationships that always involve a third-party competitor, choosing romantic partners who are unavailable or inappropriate, sexual jealousy, and excessive or inappropriate seductiveness. 11) Dissociation, that describes incongruity and disconnectedness between affect, cognition, and memory that is often associated with a developmental history of trauma or abuse. This construct is of crucial clinical import, especially for individuals who have been victims of complex trauma and for many patients diagnosed with borderline personality pathology. 12) Sexual conflict, as it describes a conflicted orientation toward sexuality, including the association of sexuality with danger (whether consciously or unconsciously), and guilt, shame, revulsion, or disgust in connection with sexuality (Shedler & Westen, 2004b; Mullins-Sweatt & Widiger, 2007).

### 3.4. INSTRUCTIONS AND DATA RESULTS

Researchers can use the instrument in one of two ways. Clinicians can use the Q-sort to describe patients based on what they have observed over the course of treatment, as long as they have had a minimum of 5 or 6 contact hours with the patient. Alternatively, clinically trained interviewers can describe a patient using the SWAP-200 after completing the Clinical Diagnostic Interview (CDI; Westen & Muderrisoglu, 2003, 2006). The structured PD

interviews does not primarily ask patients to describe themselves (although it does not avoid face-valid questions about behaviors, intentions, or phenomenology, e.g., whether the patient has self-mutilated or thought about suicide). Instead, it asks patients to provide detailed narratives about their symptoms, their education and work history, and their relationship history, focusing on specific examples of emotionally salient experiences. From these data (or from all available clinical data, if the clinician is describing a patient in ongoing treatment), the clinician informant makes judgments about the ways the patient characteristically thinks, feels, regulates impulses and emotions, views the self and others, and behaves in significant relationships, reflected in the placement (ranking) of the items (Bradley, Hilsenroth & Westen, 2007)

The SWAP-200 is a set of 200 statements that allows describing a patient's psychological functioning. Each statement is printed on a separate card, approximately the size of a business card. Each statement will apply to a given patient more, less, or not at all.

The task is to arrange the statements into eight categories or piles, according to the degree to which the statements apply to the patient that is being described. The first pile (pile 0) will contain statements that are not true of the patient, are irrelevant, or concern matters about which has no information about him. This will be the largest pile by far. The next pile (pile 1) will contain statements that may apply to the patient just a little bit; the next (pile 2) will contain statements that apply a little bit more, and so on. The last pile (pile 7) will contain statements that describe the patient especially well and that seem to capture what is most central about his or her personality. It should be placed the statements higher (i.e., closer to pile 7) depending either on the pervasiveness or the extremeness of the characteristic in question (or both). For example, one might give high placement to the statement "Tends to be overly needy and dependent" (item 77) either because the patient often appears needy, or because, on occasions when the patient is needy, the level of neediness seems extreme.

Each of the eight piles must contain a specific number of cards. When one has finished arranging the cards, it should have the following number of cards in each pile:

| **Pile:** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
|---|---|---|---|---|---|---|---|---|
| **Number of Cards:** | **100** | **22** | **18** | **16** | **14** | **12** | **10** | **8** |

To get the right number in each pile, one will have to make choices that may sometimes seem arbitrary. For example, one may have to choose whether it is true that the

patient “Fantasizes about finding ideal, perfect love” (item 128) or more true that s/he “Tends to act impulsively, without regard for consequences” (item 134). Such choices are difficult, but are a necessary part of the procedure.

First, to begin it should be sorted the cards into four or five piles to read each card in turn. If a statement does not describe the patient at all, it should be putted it in the left-hand pile. If it describes the patient extremely well, it should be putted it in the right-hand pile. The middle piles are for statements that fall somewhere in between. It should be picked the eight statements that best describe the patient, from the cards in the right-most pile. These statements will become pile 7. Then, it should be picked the next 10 most descriptive statements, which will make up pile six (if a clinician do not have enough cards, it should choose the most applicable statements from the next lower pile and move them up). Then, it should be repeated the process for each pile, working from right to left, until the clinician have the correct number of cards in each pile.

The intent of many of the SWAP-200 statements is to describe subtle psychological processes. Evaluating these statements requires clinical inferences that go beyond the face value of the patient’s words and actions. People often have conflicting or contradictory attributes, and the SWAP-200 is designed to reflect this, so it can be given high placements to statements that seem mutually contradictory.

To objective is to obtain a description that reflects the patient’s stable or enduring qualities, not simply momentary states. If in doubt, it should be described the patient as s/he has been during the past two years. For example, if a clinician is describing a patient who is a recovered alcoholic, who has not had a drink in several years and does not continue to wrestle with strong impulses to drink, the statement “tends to abuse alcohol” (item 147) should receive very low placement in the sort (e.g., pile 0 or 1). The clinician should, however, give the item low to moderate placement (e.g., pile 2, 3, or 4) if the patient continues to struggle intensely with impulses to drink but has managed to refrain from doing so.

After the clinicians arrange the statements into eight categories, clinicians can obtain individualized personality portraits (narrative descriptions) by listing the statements that receive the highest rankings in a patient’s description (i.e., items with scores of 5, 6 and 7), and then use these statements to anchor their clinical inferences and formulations (for examples on this approach, see Lingiardi, Shedler & Gazzilo, 2006; Westen & Shedler, 1999b)

Clinicians also can derive dimensional PD scores that measure the similarity between a patient’s SWAP description and prototype descriptions, representing each DSM-IV PD

(Westen & Shelder, 1999a) resembling MMPI profiles (MMPI; Hathaway & McKinley, 1999), empirically derived categories and trait dimensions (Shedler & Westen, 2004a; Westen & Shelder, 1999b).

The SWAP statements can be combined in patterns to capture a wide range of clinical phenomena and convey meanings that transcend the content of the individual items. Also, it as the ability to describe and quantify psychological conflict and contradiction, and because the SWAP addresses underlying personality processes that give rise to these characteristics, it suggests some answers for treatment strategy's (Shedler & Westen, 2007).

## 4. CLINICAL INFERENCES: REFINING THE PDS DIAGNOSIS

For Cogan and Porcerelli (2005) a reliable, valid and standardized clinician-report measure has several potential advantages. Clinicians are sophisticated observers of behavior who consider patient's explicit reports, and also consider patters of relating that occur between therapist and patient within the consulting room. The production of clinical inferences, with their different levels of complexity and accuracy, is an important parameter of therapists' activity. It guides and shapes therapists' actions, such as the elaboration of clinical judgments, the formulation of a differential diagnosis, the establishment of long and short-term therapeutic goals, and the development of therapeutic strategies. (Roussos, Boffi-Lissin & Duarte, 2007). According to Wolizky (2007) clinical inference refers to the clinician's cognitive-affective experience as he or she observes, scans, selects, organizes, and gives psychological meanings to the patient's verbal and nonverbal behavior and affective tone in the context of stored memories of the patient as all of this material is filtered through the lenses of the clinician's views of the dynamics of mental life in general and of the patient in particular. Many clinicians would say that the process ideally involves an empathic, transient identification with the patient and an alertness to possible countertransference reactions and theory-driven reactions. Whether inferences based more on theory than on empathy are less accurate or have less clinical utility, has not been established. In any case, the products of this complex process are inferences at varying degrees of remove from the observations that gave rise to them. Clinical interpretation involves communicating aspects of one's clinical inferences to the patient to facilitate the patient's self-understanding.

For a refined personality disorder diagnosis independent clinicians should be able to arrive at the same diagnosis, the diagnoses should be relatively distinct from one another, and each diagnosis should be associated with unique and theoretically meaningful correlates (Shedler & Westen, 2004a).

Efforts to define personality disorders more precisely have led to eroding the distinction between personality disorders such as multifaceted syndromes, and simple personality traits such as single dimensions, whereas some diagnostic criteria are essentially redundant indicators of one trait. According to Shedler and Westen (2004b), after using the SWAP for identifying core features of personality, the criterion sets from the DSM-IV are not clinically accurate and adequately distinct. Also, clinicians' conceptions of the personality disorders differed systematically from the DSM-IV descriptions and included psychological features absent from the DSM criterion sets. In general, clinicians emphasized aspects of patients' mental life or inner experience, as well as overt behaviors, whereas the axis II criterion sets place more emphasis on behaviors.

The DSM-IV criterion sets are too narrow. They do not capture the richness and complexity of personality syndromes and limits the number of diagnostic criteria to eight or nine items per disorder, and it's impossible for such small item sets both to describe personality syndromes in their complexity, and to describe distinct syndromes. Certain traits play role in more than one personality disorder. Excluding such traits from personality disorder criterion sets leads to clinically inaccurate descriptions, but including the same item in multiple criterion sets leads to comorbidity. One way to make the diagnostic categories more distinct is to expand the size of criterion sets and to diagnosing personality traits disorders as configurations or gestalts rather than by tabulating individual symptoms (Shedler & Westen, 2004b). A depressive or dysphoric personality disorder category should be considered according to the overlap of features from avoidant and dependent personality. Also, patients diagnosed with borderline and histrionic share too many features to allow clear conceptual or empirical distinctions, and the DSM-IV fail to capture the intense emotional pain that appear central to borderline personality. There are two groups that these patients can fall into: emotional dysregulation – that is, intensely painful affect that spirals out of control and often elicits desperate attempts to regulate it; and the other group is defined by a dramatic style of affect expression, sexual seductiveness, an impulsive cognitive style, and somatization. It should also be considered the patients diagnosed with schizoid and schizotypal personality disorders, because they share so many overlapping features that they are empirically indistinguishable.

## CONCLUSION

Current concepts of assessing personality disorders are problematic, as they mostly rely on self-report measures or structured interviews. The SWAP-200 is a valid alternative to the assessment of personality, based on the clinical experiences of the clinicians. It has proven to have good reliability and validity, interrater reliability, and results in assessing change in psychotherapy (Lingiardi, Shedler & Gazillo, 2006; Porcerelli, Dauphin, Ablon & Leitman, 2007; Josephs, Anderson, Bernard, Fatzer & Streich, 2004; Cogan, 2007; Cogan & Porcerelli, 2005). Even more, it as a reliable clinical utility, presenting three different taxonomies (current DSM taxonomy, empirically identified diagnostic groupings an trait dimensions identified via factor analysis*)* that captures a wider range of pathology. Also, it can provide a narrative description sorting the most descriptive items of the subject, which can be useful for case formulation and treatment planning (Shedler & Westen, 2007). Another contribution is that being a clinician-report measure does not raise the problems of obtaining confidential patient information, since clinicians can describe their patients anonymously.

Thus, the empirical taxonomy has a major contribution for reanalyzing the DSM diagnosis, because the SWAP-200 approach to personality disorder is different from that of DSM. First, the diagnostic categories and "criteria" are empirically derived and therefore faithful to the data. To the extent allowed by contemporary data analysis methods, they reflect the categories that exist in nature. By contrast, the DSM categories and criteria reflect the opinions of committees. Thus, the inclusion of a depressive personality category is based on evidence. The SWAP-200 therefore provides the technology to establish personality disorder taxonomy on a stronger empirical foundation than DSM. Second, the method allows conceptualizing personality disorders as continua, not categories. For example, clinicians can describe borderline pathology on a continuum ranging from mild through moderate to severe, rather than classifying borderline personality disorder as present/absent. Third, the SWAP-200 incorporates intra-psychic and dynamic factors such as motives, fantasies, object representations, conflict, and defense, whereas DSM emphasizes manifest symptoms (Shedler, 2002).

However, some authores argue the fundaments of the SWAP-200 (Wood, Garb, Nezworski & Koren, 2007), but although it can have some limitations, the reviewed literature for an alternative in assessing personality disorders through the SWAP-200 demonstrated that this clinician-rated instrument is a clinically significant diagnostic measure of personality, and deserves future investigations.

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## RESUMO

O diagnóstico das perturbações da personalidade tem sido um desafio para os investigadores. Há vários métodos para tal, incluindo as intervistas clínicas, os questionários de auto-preenchimento e a avaliação clínica. Na avaliações clínicas, os clínicos baseam-se em inferências sobre os pacientes no intuito de avaliar a personalidade. Neste contexto, para avaliar um diagnóstico através de um avaliador externo, as gravações de áudio de sessões e as transcrições têm sido a principal fonte de dados. No entanto, este método pode levantar certos problemas, tais como os processos de transferência-contratransferência entre paciente e clínico, e problemas de ética ao usar material clínico do paciente. Este estudo apresenta uma alternativa a estes problemas em avaliar a personalidade, apresentando uma ilustração de caso de um paciente acompanhado em psicanálise. A Shedler e Westen Assessment Procedure -200 (SWAP-200), é um instrumento administrado pelos próprios clínicos com boa fiabilidade e viabilidade, em relação a uso clínico e ao uso de avaliadores externos, através de gravações áudio de sessões. Neste estudo, a SWAP-200 é aplicada por um avaliador externo através das notas das sessões. Três perfis (DSM T-scores, Q-factor T-scores, r-factors) e uma descrição narrativa são obtidos através dos resultados da SWAP do paciente, apresentado um diagnóstico da personalidade. Estes resultados sugerem que a SWAP é um instrumento fiável para o diagnóstico da personalidade através das notas das sessões. Embora este paciente não apresente nenhuma perturbação da personalidade que encaixe na classificação do DSM-IV, a taxonomia alternativa da SWAP providenciou um diagnostico de patologia neste paciente, nomeadamente a Disforia que captura a depressão, anhedonia, vergonha, humilhação e um número de correlações cognitivas e afectivas (Shedler & Westen, 2004b).

Palavras-Chave: SWAP-200, diagnóstico, notas-de-sessões, psicanálise

## ABSTRACT

The diagnosis of personality disorders has been a challenge to researchers. There are several methods including clinician interviews, self-reports questionnaires and clinician evaluation. In the clinician evaluation, the clinician relies on inferences of the patients in order to assess personality. In this context, to evaluate a diagnosis trough an external rater, the audio recordings of sessions and transcripts has been the main source of data. However, this method can raise particular problems, such as the patient and clinician transference-countertransference, and the ethical use of the clinical material. This study presents an alternative to such problems in assessing personality, presenting a case illustration of one patient treated in psychoanalysis. The *Shedler and Westen Assessment Procedure – 200* (SWAP-200), it's clinician-rated instrument with good reliability and validity in relation to clinicians' and external raters diagnosis of personality disorder, mainly used by the clinicians self-appliance or by external raters appliance trough the transcripts of audio taped sessions. In this study, the SWAP-200 is applied by an external rater trough the therapist note-taking of sessions. Three profiles (*DSM T-scores, Q-factors T-scores, r-factors*) and a narrative description were obtained from the SWAP-200 results of the patient, presenting a diagnosis of personality. This results suggest that the SWAP-200 is a reliable instrument for the diagnosis of personality disorder trough the therapist note-taking of sessions. Although this patient hadn't a personality disorder profile that fit in the *DSM-IV* classification, the alternative taxonomy of the SWAP provided a diagnosis of personality pathology in this patient, namely *Dysphoria* that captures depression, anhedonia, shame, humiliation, and a number of their cognitive and affective correlates (Shedler & Westen, 2004b).

*Keywords:* SWAP-200, note-taking, diagnosis, psychoanalysis

# INTRODUCTION

The construct validity of personality disorders (PDs) has long been a challenge to researchers, and probably will remain so for years to come. No "gold standard" exists for the diagnosis of PDs, and several methods, including: 1) clinician-administered interviews, 2) self-report questionnaires, and 3) clinician evaluations, are utilized in both clinical practice and research settings (Fridell & Hesse, 2006).

There are several arguments in favor of clinician evaluations. According to Shedler (2002), clinicians do not limit themselves to information that is overt and manifest, or base diagnostic formulations exclusively on patients' answers to direct questions. Some researchers have suggested that the approach used for diagnosing PDs in semistructured clinical interviews and questionnaires is not in accordance with clinical practice (Westen, 1997; Westen & Arkowitz-Westen, 1998). Clinicians tend to rely on observations of the client's behavior in the clinical setting, along with the client's narratives, rather than direct inquiry, when assessing personality deviance. Patients with personality pathology generally lack the insight to describe their own personality characteristics. Narcissistic patients, for example, may well describe themselves as caring people and wonderful friends. Sophisticated clinicians infer traits such as grandiosity and entitlement from patients' accounts of their important relationships, and from their behavior toward the clinician in the consulting room (Westen & Shedler, 2007). Also, if a patient is evaluated by the treating clinician in psychotherapy with self-report measures, he can feel some resistance, such as doing some "paperwork" and also he can easily fake the answers (Josephs, Anderson, Bernard, Fatzer & Streich, 2004).

Josephs and colleagues (2004) presented a case study assessing personality change of a patient, using audiotaped session and showing what the impact of taping is, and supplement that case study with an analysis of verbatim transcripts. According to their words:

> "Ms. Q perceived the analyst's wish for good results, his anxiety that he wouldn't obtain them, and his defensive inhibition in the presence of the recording device. Her complementary response was a wish to please, guilt that she couldn't, shame over exposure of that inability, and resentment about the situation. Nevertheless, the presence of this enactment around the recording device did not preclude incremental improvement." (pp.1209)

Although there was been some behavior bias being audiotaped, the patient had have incremental improvement of the psychopathology and her behaviors. So, it should be questionable

if audiotaping a therapy session is a good and reliable data to the assessment of personality. And it's not just the patient that is in question. Josephs et al. also wrote:

> "(…) clinicians are often more anxious about being taped than are appropriately selected patients. The analyst's performance anxieties will not be explicitly revealed in audiotapes. (…) A case study provides a very special and indispensable form of data: the analyst's retrospective understanding of a treatment relationship of which he or she was a participant observer. This unique perspective on the clinical situation is something that an audiotape can never supply." (pp.1210)

Results have consistently demonstrated that being able to see and hear an interview, as opposed to reading a transcript of the interview, does not lead to an increase in validity. Judgments based on transcriptions are generally as accurate as judgments based on observations (Garb, 2003).

In this point, we see that using audiotaped sessions, a way of assessing data in the psychotherapy, is no better than the transcripts of the same session. Another problem we face on doing research or assessing personality on psychotherapy is how we use the data obtained from the patient. The use of clinical material for educational purposes or for publication presents the analyst with a conflict of interest between the protection of the patient's privacy and the educational and scientific needs of the field, and also that it places analysts in the position of using confidential patient material in the service of their own professional advancement. The strategies of dealing with this dilemma can be classified as follows: thick disguise, patient consent, the process approach, the use of composites and the use of a colleague as author (for a further detail on this subject, see Gabbard, 2000; Kantrowitz, 2004).

Another way of obtaining data to research or assessing personality from psychotherapy is the note-taking of analytic sessions. There are few studies about this subject, and after a search on EBSCOhost database on *note-taking* and *psychotherapy/psychoanalysis* only some responses were obtained. These notes can be taken during the analysis, or after the analysis. The analyst can write what he recalls from the session, the contratransference processes, observations, hypothesis and psychological defenses of the patient. In one of these studies, Plaut (2005) discusses the lack of a consistent approach to note taking amongst analysts and sets out to demonstrate that systematic note taking can be helpful to the analyst. Also, suggested distinguishing between four classes of notes: tracking or ordinary, countertransference, summarizing and technical.

In this article, we present an alternative to the problems above reviewed in assessing personality trough self-report instruments or audiotaped sessions, and without putting the patient into a situation of evaluation. The aim of this study is to assess personality of a patient with a clinician-rated instrument, the *Shedler and Westen Assessment Procedure-200* (SWAP–200; Shedler & Westen, 1998, 2004a, 2004b; Westen & Shedler, 1999a, 1999b), using the

psychoanalytic notes of the therapist, written after the sessions. Some authors have used the SWAP-200 to assess change in the therapy (Lingiardi, Shedler & Gazillo, 2006; Porcerelli, Dauphin, Ablon & Leitman, 2007; Josephs et. al, 2004), to perceive the ideal benefits of the analysis (Cogan, 2007) and to describe the personality pathology and adaptive functioning of patients beginning and ending analysis (Cogan & Porcerelli, 2005). However, all of these studies resign on audio or video taped sessions and transcripts from the sessions to assess personality, or even by the analyst himself applying the SWAP.

This way, we report the SWAP-200 results of a single case study, of an individual treated in psychoanalysis for relatively 7 months. It was collected assessment data of 37 sessions of note-taking from the analyst, since the beginnings of the therapy until it was over, due to reasons that are above from the scope of this study.

## 1. METHOD

### 1.1 SUBJECT

The subject on focus in this study, forwardly treated as Mr. R, is a 41 years old male, working as a civil constructor, who self-indicated for psychoanalysis with the second author of this study, analyst in training. Mr. R search for an analysis, referring that he doesn't feel bad, but sometimes "goes down" and from time to time needs to talk with the psychiatrist, in order to take some medication.

When young, Mr. R lived with his father and mother, being the only child from this marriage. The father was a military, and Mr. R describes his father as a critical and distanced man expressing authority, incapable of value him and to show affectivity, He mainly grew up apart from his father and developed a privileged relationship with his mother, although he feels anxious spending time with her. Mr. R adolescence was marked by moments of love adventures, even experimenting one time a homosexual relationship. He was involved in risked behaviors, such as drinking and occasionally toke some hard drugs. Nowadays, smokes two shots of cannabis every day. Mr. R is divorced and from the first marriage, he has two sons. By the time of the analysis he lives together for the past 5 years with the ex-wife of a friend, and her two sons.

During the course of the analysis, Mr. R refers feeling preoccupied with the oldness, emerging some depressive aspects on his speech, saying that he feels without libido and without a meaning of life. Relatively to the analysis, he doubts if it can help him and if it's really useful for

something. Mr. R relationships are marked by conflicts, on the one hand with his female companion, where he doesn't feel a satisfactory sexual life and questions her love for him. Note worthy, is the competition aspects of Mr. R, in such a way that he begun the analysis, short after the ex-husband of his actual companion had finished the relationship with another woman. Mr. R has a dependent relation with his companion, not only affectively (where she has a caregiver posture) but also economically. Nevertheless, he experiences genuine feelings towards her. On the other hand, he conflicts with the mother of his companion, feeling that he competes with her the attention and dedication of his woman. However, he takes a submissive posture respectively to his interests and defenses of them. With the male figures, Mr. R is somehow hypocritical, never showing enough of him, caring out social masks, toggling into competitive feelings or contempt in the relations.

This resembles with the attitude toward the analyst. The relation with the analyst is marked by careful attitudes in the sessions, where at first he didn't lied down on the diva. Mr. R appears to be afraid to depend on the analyst as someone who can help him. He denies the interpretations of the analyst most of the time. How more the sessions increase, the closer the proximity in the relation. However, this proximity is felt as to be careful and suspicious, starting to emerge some persecutory ideas within the relation. After 27 sessions (about four months of sessions) Mr. R refers that in the analysis "the essential is done", reducing the two weekly sessions to one session per week. In the 38 session he stops on going to the analysis. Mr. R calls some days later to tell that he was separated from the actual companion and that he moved to the house that he has in another city, and was searching for a job.

### 1.2 TREATMENT

The treatment was established for two times per week. Regarding to an evaluation of personality, none was realized in the beginning, neither during the analysis. Near the four months of analysis, the patient reduces for one weekly session.

### 1.3. PROCEDURE

The analyst after each session wrote notes regarding to the analysis from the patient, systematically in every session. The notes have a descriptive character, transcribing sentences said by the patient during the course of the analysis, and also a subjective character, with ideas from the analyst regarding to the analysis processes. The anonymity of the patient was preserved. Relatively to the Shedler and Westen Assessment Procedure – 200 (SWAP 200, Shedler & Westen, 1999a,

1999b), it was widely read and studied the concerning literature to apply the assessment. After repeatedly lectures of the analysis, it was applied the SWAP-200, by the second author that had done the assessment and inserted the data in the Excel template obtain through the website www.SWAPassessment.org/excel.html. The data was again analyzed and compared with the analysis, in order to sustain the profile obtained by the SWAP-200 and the most descriptive items of the patient.

### 1.4. INSTRUMENT

The *Shedler–Westen Assessment Procedure—200* (SWAP-200; Shedler & Westen, 1998) is a Q-sort instrument that includes 200 descriptive statements describing both pathological and health aspects of personality. The statements are sorted into eight categories, ranging from 0 (irrelevant to the patient) to 7 (highly descriptive of the patient). SWAP-200 statements are written in a manner close to the data (e.g., “Tends to be passive and unassertive” or “Living arrangements are chaotic and unstable”), and items that require inference about internal processes are written in clear and unambiguous language (e.g., “Is unable to describe important others in a way that conveys a sense of who they are as people; descriptions lack fullness and color” or “Tends to blame others for own failures or shortcomings; tends to believe his or her problems are caused by external factors”). Reliable descriptions with the SWAP-200 have been obtained from clinicians from a variety of theoretical orientations (Westen & Shedler, 1999a, 1999b). Clinician ratings are converted to t scores (M= 50; SD=10) or each of the DSM–IV PDs. The SWAP-200 also includes a Healthy Functioning scale, a dimensional measure of psychological strengths and adaptive functioning. T-scores from 55 to 59 indicate PD features, whereas a t-score of 60 is the cutoff for PD (J. Shedler, personal communication, January 20, 2003). Thus the scale can be used categorically and/or dimensionally. The SWAP-200 scales have good internal consistency (Westen & Shedler, 1999b), interrater reliability (Marin-Avellan, McGauley, Campbell, & Fonagy, 2005; Westen & Muderrisoglu, 2003, 2006), and convergent/discriminant (Marin-Avellan et al., 2005; Westen & Shedler, 1999a), incremental (Westen & Harnden-Fischer, 2001), and known groups validity (Porcerelli, Cogan, & Hibbard, 2004).

Investigators can obtain individualized (ideographic) personality portraits by listing the statements that receive the highest rankings in a patient’s SWAP–200 description (i.e., items with scores of 5, 6 and 7). Investigators can also derive dimensional PD scores that measure the similarity or “match” between a patient’s SWAP–200 description and prototype SWAP–200 descriptions representing each DSM–IV PD (Westen & Shedler, 1999a). The PD scores can be

expressed as T scores and graphed to create a PD profile resembling a Minnesota Multiphasic Personality Inventory (MMPI; Butcher, Dahlstrom, Graham, Tellegen,& Kaemmer, 1989) profile and it generate a personality profile that is consistent with an established self-report measure, the MCMI-III (Millon, Davis, & Millon, 1997., in Josephs, Anderson, Bernard, Fatzer & Streich, 2004). A healthy-functioning index is included as well.

## 2. RESULTS

### 2.1. PERSONALITY DISORDER (PD) T-SCORES

The line in figure one show Mr. R's PD scores for the 10 PDs included in DSM-IV as well as his score on the healthy functioning index. For ease of interpretation, it was converted the PD scores to T scores (Mean (M) = 50, Standard Deviation (SD) =10) based on norms established in a psychiatric sample of patients with Axis II diagnoses (Westen & Shedler, 1999a). To maintain continuity with the DSM-IV categorical diagnostic system, Shedler and Westen have suggested T=60 as a threshold for making a categorical PD diagnosis and T=55 as a threshold for diagnosing "features".

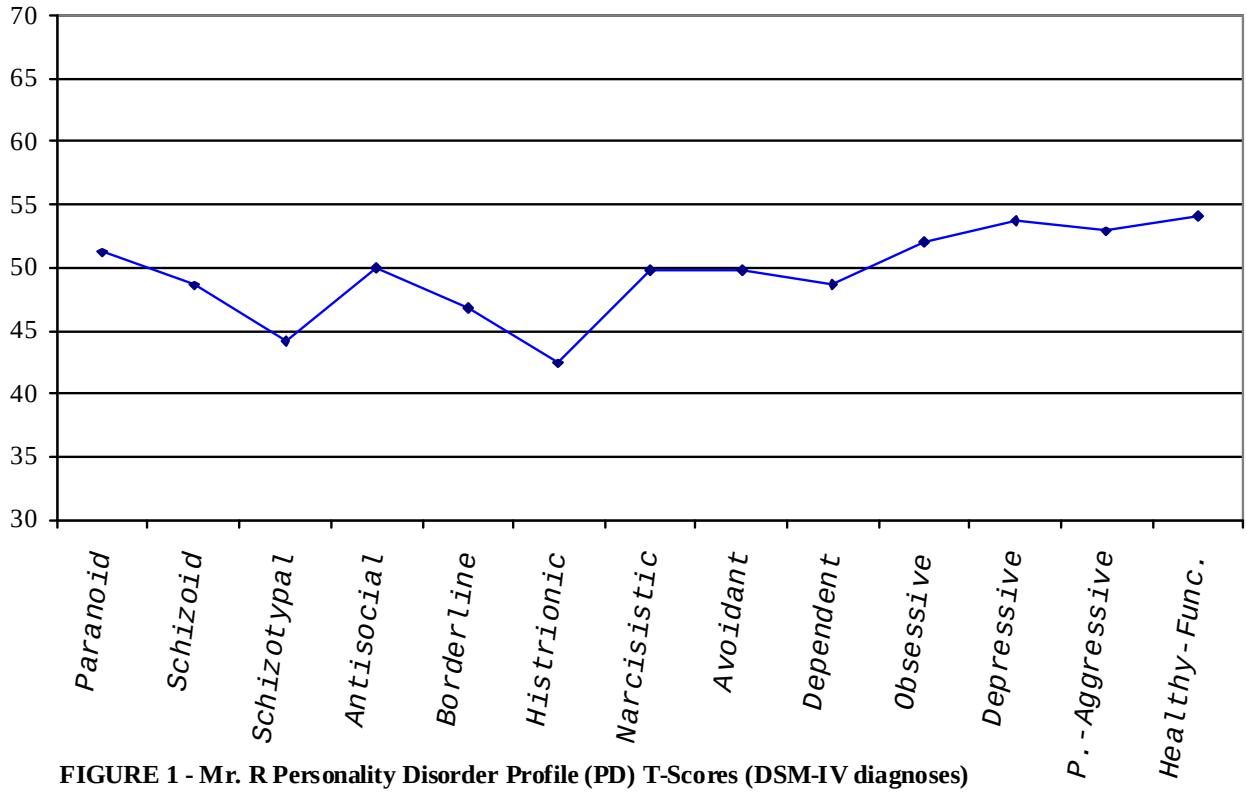


**FIGURE 1 - Mr. R Personality Disorder Profile (PD) T-Scores (DSM-IV diagnoses)**

Mr. R's PD profile show that the highest score is the high-functioning (T=54,1, approximately ½ SD above the sample mean) category, with a secondary elevation for depressive PD (T=53,7), passive-aggressive PD (T=52,9), obsessive PD (T=52,1), paranoid PD (T=51,2) and anti-social PD (T=50,0).

Although the scores are situated nearly the mean of the sample, there's no strong match between the patients' SWAP-200 description and the diagnostic prototypes for PD's (only some nearly qualities), and none has a higher value than the high-functioning index.

So in this profile we can see that Mr. R as more psychological healthy characteristics than the reference sample of patients with Axis II diagnoses, but essentially share some depressive and passive-aggressive features (with a few obsessive, paranoid and antisocial traits).

### 2.2. Q-FACTOR T-SCORES

Figure 2 presents Mr. R's Q-score profile, showing the match between Mr. R's SWAP-200 description and each of the 7 primary Q-factors , and also for the secondary Q-factors (relative to the Dysphoric Index). For ease of interpretation, it was again transformed the raw Q-scores (which are correlation coefficients) into T scores, which have a mean of 50 and standard deviation of 10.

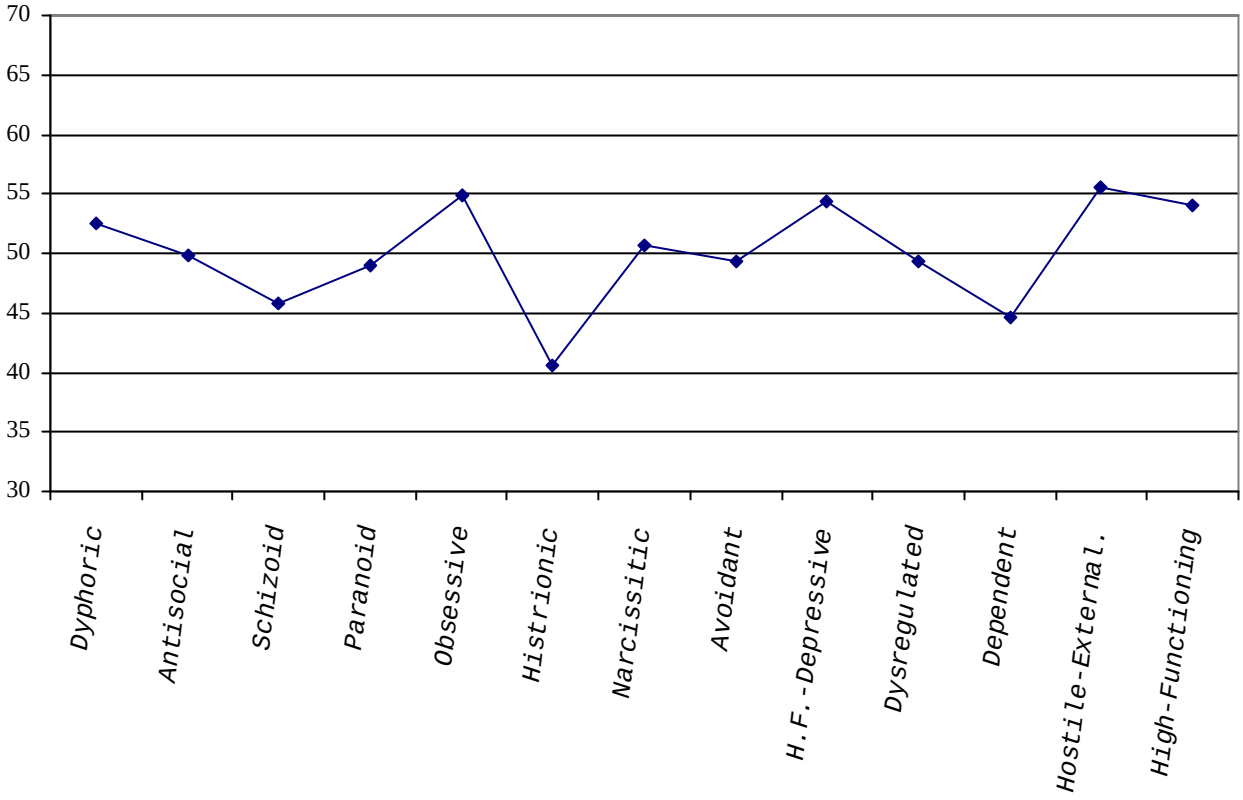


**FIGURE 2 - Mr. R Factor Q-Factor T-Scores (Diagnostic Groupings)**

Shedler and Westen have suggested T=60 (one standard deviations above the mean) is the appropriate cutoff for making a categorical PD diagnosis, using the diagnostic categories derived by Q-analysis (Shedler & Westen, 1999b). The prototypes were empirically derived using an empirical clustering procedure, Q-factor analysis, which treats patients as the items to be factored in order to group patients together based on their similarity across all 200 items. A Q-factor analysis was conducted on 530 SWAP Q-sorts from a sample of 530 subjects, most of whom had prior DSM-IV Axis II diagnoses.

The twelve prototypes that emerged from the factor analysis were dysphoric; antisocial psychopathic; schizoid; paranoid; obsessive; histrionic; narcissistic; avoidant dysphoric; high-functioning depressive dysphoric; emotionally dysregulated dysphoric; dependent masochistic dysphoric; and hostile externalizing dysphoric.

Thus, Mr. R's Q-score profile (Figure 2) indicates some hostile-externalizing (T=55.5), obsessive (T=54.9) and high-functioning depressive (T=54.3) features, whereas the high-functioning index is lower (T=54.1) than this features.

The scores are situated nearly in a half standard deviation above the sample mean, this way indicating some psychological features of Mr. R, but not a severe personality disorder in comparison with the reference sample.

### 2.3. FACTOR T-SCORES

The factors (more technically, "r-factors") should not be confused with the Q-factor diagnostic groupings. The r-factors are derived from conventional factor analysis of the SWAP-200 item set. In contrast, Q-factors identify groupings of patients (not variables) who share similar personality characteristics.

Figure 3 shows the Mr. R's T-score for each factor and illustrates the profile, showing the match between the 12 personality trait dimensions identified by Westen and Shedler (2004b). A factor analysis of the SWAP-200 item set identified 12 conceptually meaning factors.

The most relevant values are the personality dimension of Dysphoria (T=62.6) that is more than 1½ SDs above the mean (>10.6) and superior than the Psychological Health (T=57.6). Oedipal Conflit (T=55.1) and Hostility (T=54.7) are the second higher values above the mean.

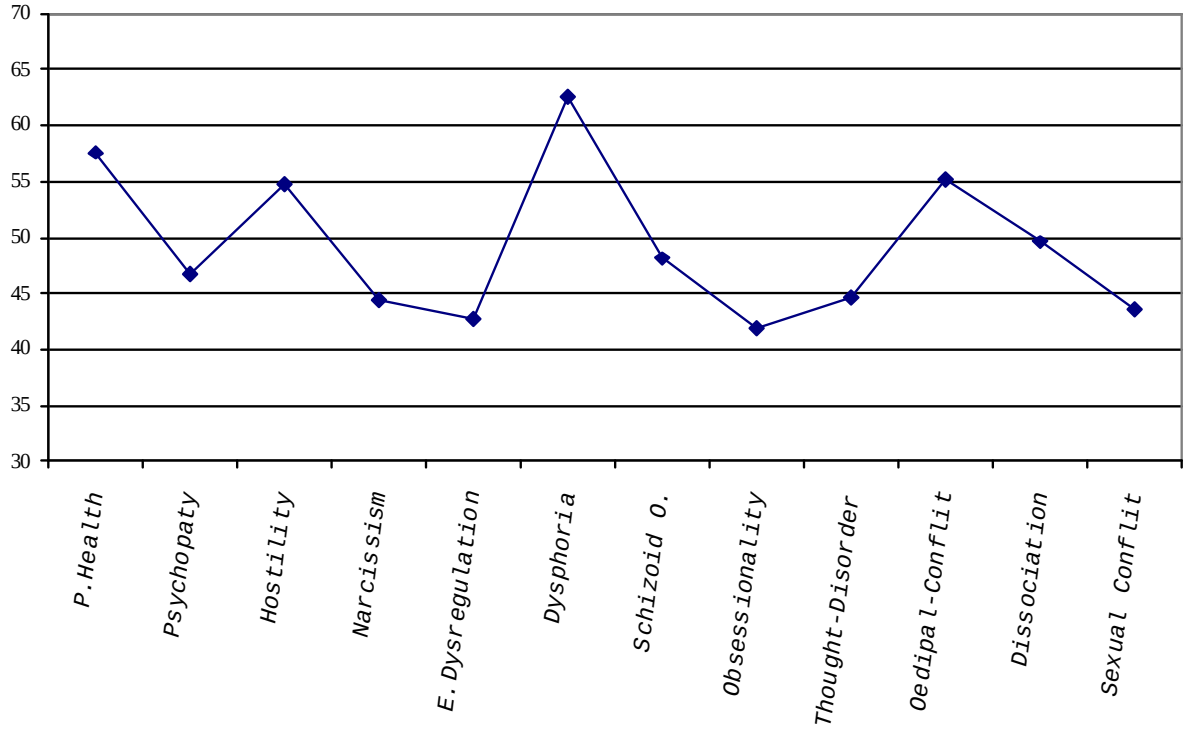


**FIGURE 3 - Mr. R Factor T-Scores (Trait Dimensions)**

With this profile, we can see that Mr. R have a strong correlation of personality characteristics with the Dysphoric patient's of the reference sample, although he has psychological healthy personality characteristics, along with some traits of oedipal-conflit and hostility.

### 2.4. IIDIOGRAPHIC CASE DESCRIPTION

Table 1 lists the SWAP–200 items that received the highest ratings (top 30 items) arranged in descending order by score. To demonstrate the use of the SWAP–200 for providing narrative case description, it was rearranged the items into paragraph form below. The narrative description groups together conceptually related items, and it was made minor grammatical changes and added connecting text to aid the flow of the text. However, the SWAP–200 items are reproduced essentially verbatim:

Mr. R. experiences intensive dysphoria. He's mood tends to cycle over intervals of weeks or months between excited and depressed states, and to be anxious. He bounds between a excited state, where he becomes more hostile, and tends to be oppositional, contrary, or quick to disagree, and to be competitive with others (whether consciously or unconsciously). When he enters the depressed state, he tends to feel

empty or bored, appears to find little or no pleasure, satisfaction, or enjoyment in life's activities and to feel listless, fatigued, or lacking in energy. In is day life, he tends to abuse illicit drugs. Moreover, he tends to feel like an outcast or outsider; feels as if he does not truly belong, and to feel life has no meaning, feeling guilty and blaming self or feel responsible for bad things that happen. He feels unhappy, depressed, or despondent.

**TABLE 1**

**Most Descriptive SWAP-200 Items**

| *Item* | *Text* | *Score*[a] |
|---|---|---|
| 84 | Tends to be competitive with others (whether consciously or unconsciously) | 7 |
| 90 | Tends to feel empty or bored | 7 |
| 105 | Tends to avoid confiding in others for fear of betrayal; expects things s/he says or does will be used against him/her | 7 |
| 149 | Tends to feel like an outcast or outsider; feels as if s/he does not truly belong | 7 |
| 161 | Tends to abuse illicit drugs | 7 |
| 167 | Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered) | 7 |
| 170 | Tends to be oppositional, contrary, or quick to disagree | 7 |
| 189 | Tends to feel unhappy, depressed, or despondent | 7 |
| 1 | Tends to blame self or feel responsible for bad things that happen | 6 |
| 8 | Tends to get into power struggles | 6 |
| 17 | Tends to be ingratiating or submissive (e.g., may consent to things s/he does not agree with or does not want to do, in the hope of getting support or approval) | 6 |
| 56 | Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities | 6 |
| 64 | Mood tends to cycle over intervals of weeks or months between excited and depressed states (high placement implies bipolar mood disorder) | 6 |
| 77 | Tends to be overly needy or dependent; requires excessive reassurance or approval | 6 |
| 80 | Tends to be sexually possessive or jealous; tends to be preoccupied with concerns about real or imagined infidelity | 6 |
| 92 | Is articulate; can express self well in words | 6 |
| 98 | Tends to fear s/he will be rejected or abandoned by those who are emotionally significant | 6 |
| 160 | Lacks close friendships and relationships | 6 |
| 23 | 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.) | 5 |
| 30 | Tends to feel listless, fatigued, or lacking in energy | 5 |
| 35 | Tends to be anxious | 5 |
| 50 | Tends to feel life has no meaning | 5 |
| 57 | Tends to feel guilty | 5 |
| 95 | Appears comfortable and at ease in social situations. | 5 |
| 114 | Tends to be critical of others | 5 |
| 159 | Tends to deny or disavow own needs for caring, comfort, closeness, etc., or to consider such needs unacceptable | 5 |
| 171 | Appears to fear being alone; may go to great lengths to avoid being alone | 5 |
| 175 | Tends to be conscientious and responsible | 5 |

Mr. R lacks close friendships and relationships. He tends to avoid confiding in others for fear of betrayal; expects things s/he says or does will be used against him/her. But he is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered). He's affect

regulation is poor. He tends to be ingratiating or submissive (e.g., may consent to things s/he does not agree with or does not want to do, in the hope of getting support or approval), and to be overly needy or dependent; requires excessive reassurance or approval, fearing he will be rejected or abandoned by those who are emotionally significant. Appears to fear being alone; may go to great lengths to avoid being alone, and to deny or disavow own needs for caring, comfort, closeness, etc., or to consider such needs unacceptable. Mr. R attitudes toward woman and sexuality are problematic. He 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.). More, he tends to be sexually possessive or jealous; and to be preoccupied with concerns about real or imagined infidelity. Along with his manifestations of pathology, Mr. R has considerable psychological strengths and is well adapted to his day life. He can express self well in words, tends to be conscientious and responsible, appears comfortable and at ease in social situations and is articulate.

The preceding narrative description provides a detailed and clinically poignant portrait of this patient. The description is consistent with the spirit of clinical case formulation and helps illustrate the difference between empirical (nomothetic) and clinical (idiographic) approaches to personality assessment. In this instance, however, all findings are derived from the same assessment instrument and grounded in quantitative data.

# DISCUSSION

This study presents an innovation in the field of personality disorders (PDs) evaluation, finding a reliable clinical diagnosis of a psychoanalysis patient, through the note taking of the analysis sessions. With the SWAP-200, it was obtained a personality diagnosis of Mr. R: Dysphoria, which cycles between healthy functioning and hostile-externalizing features.

First, comparing with the DSM-IV (APA, 1994; Livesley, 1995) PDs categories (Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent, Obsessive-Compulsive), Mr. R doesn't appear to have any personality disorder. In fact, Mr. R has more healthy functioning features than the reference sample of Axis II patients.

Second, relatively to the Q-factor analysis emerges a category indicating a marketable feature, namely the Hostile-Externalizing category, mainly predicting patients that are hostile and prone to blame others for their difficulties, with passive-aggressive features. The SWAP-200 statements described a tendency to get into power struggles; to be angry or hostile; to blame others for their own failures, or shortcomings; to feel misunderstood, mistreated, or victimized; to be critical of others; to be conflicted about authority (to feel they must submit, rebel against, win over, defeat, and so on); to hold grudges; to express aggression in passive and indirect ways; to be oppositional and contrary; and to feel helpless or powerless (Westen & Shedler, 1999b).

Finally, the main discovery was in the r-factor categories, where the patient has a strong correlation with the dysphoric patients of the reference sample. According to Shedler and Westen (2004b) dysphoria captures depression, anhedonia, shame, humiliation, and a number of their cognitive and affective correlates. Without the clinical diagnosis of the SWAP, it would not be possible to capture the dysphoria within this patient, with empirically and statistically results. No other test captures this personality disorder category.

Effectively, the SWAP can produce a distinguished diagnosis, and this study has demonstrated that it is possible to obtain a clinical diagnosis of a patient by an external rater through the note-taking of the sessions, without putting the patient in a situation of evaluation. The clinical utility of this diagnosis can be useful for the analyst to understand and reflect about the patient, comparing his point of view by having an external rating of the patient through his own notes. This can be relevant because clinicians tend to summarize PDs under just a few categories. In the case of private practitioners, a study (Herkov & Blashfield, 1995) found that most PDs were either labeled as borderline or narcissistic PD, even when the same clinicians reported criterion-level information consistent with several other diagnoses. Moreover, it can provide data to make a

case formulation, and because the SWAP addresses underlying personality processes it can give rise to some answers for treatment.

Nevertheless, this study has some limitations. For Josephs and Weinberger (2002) "transcript is an objective record of what actually happened" (pp.425) and this way it's questionable if the note-taking of the sessions are a valid and reliable source of clinical data, because it doesn't report what actually happened in the session. The sessions transcripts capture the all dialogue and the note taking capture the richness of the reflections, of the main sentences and subjectivity that was felt by the analyst in the relation with the patient. Moreover, the results are only based only in one external rater.

Finally, the SWAP relies on clinicians to do what they can do well, namely, making specific observations and inferences about individual patients they treat and know well or interview systematically (Westen & Shedler, 2007). This way, the note-taking of the therapists are inferences and observations wrote on paper, capable of serving data to evaluate a patient, and it's questionable the use of the transcripts, the mainly data used to score the SWAP-200 by independent raters. Meanwhile, future investigations can use audio/video record of the sessions, by one hand, and the notes of the analyst, by other, and have at least two external raters to assess the SWAP-200: one rater with the transcripts, other with the notes, and see the results from the two different data. Furthermore, to achieve a higher interrater reliability, other possibility is to use the data and compare it with the data obtained from the SWAP application of the therapist.

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# APENDIX A

ITEMS CLASSIFICATION

| | | |
|---|---|---|
| 1 | 6 | 001. Tends to blame self or feel responsible for bad things that happen. |
| 2 | 3 | 002. Is able to use his/her talents, abilities, and energy effectively and productively. |
| 3 | 0 | 003. Takes advantage of others; is out for number one; has minimal investment in moral values. |
| 4 | 0 | 004. Has an exaggerated sense of self-importance. |
| 5 | 0 | 005. Tends to be emotionally intrusive; tends not to respect others' needs for autonomy, privacy, etc. |
| 6 | 0 | 006. Is troubled by recurrent obsessional thoughts that s/he experiences as senseless and intrusive. |
| 7 | 0 | 007. Appears conflicted about his/her racial or ethnic identity (e.g., undervalues and rejects, or overvalues and is preoccupied with, own cultural heritage). |
| 8 | 6 | 008. Tends to get into power struggles. |
| 9 | 1 | 009. Tends to think others are envious of him/her. |
| 10 | 0 | 010. Feels some important other has a special, almost magical ability to understand his/her innermost thoughts and feelings (e.g., may imagine rapport is so perfect that ordinary efforts at communication are superfluous). |
| 11 | 0 | 011. Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship. |
| 12 | 0 | 012. Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc. |
| 13 | 0 | 013. Tends to use his/her psychological or medical problems to avoid work or responsibility (whether consciously or unconsciously) . |
| 14 | 0 | 014. Tends to blame others for own failures or shortcomings; tends to believe his/her problems are caused by external factors. |
| 15 | 2 | 015. Lacks a stable image of who s/he is or would like to become (e.g., attitudes, values, goals, and feelings about self may be unstable and changing). |
| 16 | 0 | 016. Tends to be angry or hostile (whether consciously or unconsciously). |
| 17 | 6 | 017. Tends to be ingratiating or submissive (e.g., may consent to things s/he does not agree with or does not want to do, in the hope of getting support or approval). |
| 18 | 0 | 018. When romantically or sexually attracted, tends to lose interest if other person reciprocates. |
| 19 | 1 | 019. Enjoys challenges; takes pleasure in accomplishing things. |
| 20 | 0 | 020. Tends to be deceitful; tends to lie or mislead. |
| 21 | 0 | 021. Tends to be hostile toward members of the opposite sex, whether consciously or unconsciously (e.g., may be disparaging, competitive, etc.). |
| 22 | 0 | 022. Tends to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.). |
| 23 | 5 | 023. 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.). |
| 24 | 0 | 024. Tends to be unreliable and irresponsible (e.g., may fail to meet work obligations or honor financial commitments). |
| 25 | 4 | 025. Has difficulty acknowledging or expressing anger. |

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| **26** | 0 | | 026. Tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused. |
| **27** | 0 | | 027. Has panic attacks lasting from a few minutes to a few hours, accompanied by strong physiological responses (e.g., racing heart, shortness of breath, feelings of choking, nausea, dizziness, etc.). |
| **28** | 0 | | 028. 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.). |
| **29** | 0 | | 029. Has difficulty making sense of other people's behavior; often misunderstands, misinterprets, or is confused by others' actions and reactions. |
| **30** | 5 | | 030. Tends to feel listless, fatigued, or lacking in energy. |
| **31** | 0 | | 031. Tends to show reckless disregard for the rights, property, or safety of others. |
| **32** | 2 | | 032. Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring. |
| **33** | 1 | | 033. Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential. |
| **34** | 0 | | 034. 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.). |
| **35** | 5 | | 035. Tends to be anxious. |
| **36** | 0 | | 036. Tends to feel helpless, powerless, or at the mercy of forces outside his/her control. |
| **37** | 0 | | 037. Finds meaning in belonging and contributing to a larger community (e.g., organization, church, neighborhood, etc.). |
| **38** | 2 | | 038. Tends to feel s/he is not his/her true self with others; tends to feel false or fraudulent. |
| **39** | 4 | | 039. Appears to gain pleasure or satisfaction by being sadistic or aggressive toward others (whether consciously or unconsciously). |
| **40** | 0 | | 040. Tends to engage in unlawful or criminal behavior. |
| **41** | 1 | | 041. Appears unable to describe important others in a way that conveys a sense of who they as people; descriptions of others come across as two-dimensional and lacking in richness. |
| **42** | 2 | | 042. Tends to feel envious. |
| **43** | 3 | | 043. Tends to seek power or influence over others (whether in beneficial or destructive ways). |
| **44** | 0 | | 044. Perception of reality can become grossly impaired under stress (e.g., may become delusional). |
| **45** | 0 | | 045. Tends to idealize certain others in unrealistic ways; sees them as "all good," to the exclusion of commonplace human defects. |
| **46** | 1 | | 046. Tends to be suggestible or easily influenced. |
| **47** | 0 | | 047. Is unsure whether s/he is heterosexual, homosexual, or bisexual. |
| **48** | 0 | | 048. Seeks to be the center of attention. |
| **49** | 0 | | 049. Has fantasies of unlimited success, power, beauty, talent, brilliance, etc. |
| **50** | 5 | | 050. Tends to feel life has no meaning. |
| **51** | 2 | | 051. Tends to elicit liking in others. |
| **52** | 0 | | 052. Has little empathy; seems unable to understand or respond to others' needs and feelings unless they coincide with his/her own. |
| **53** | 0 | | 053. Seems to treat others primarily as an audience to witness own |

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| | | | importance, brilliance, beauty, etc. |
| **54** | 1 | | 054. Tends to feel s/he is inadequate, inferior, or a failure. |
| **55** | 3 | | 055. Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others. |
| **56** | 6 | | 056. Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities. |
| **57** | 5 | | 057. Tends to feel guilty. |
| **58** | 0 | | 058. Has little or no interest in having sexual experiences with another person. |
| **59** | 2 | | 059. Is empathic; is sensitive and responsive to other peoples' needs and feelings. |
| **60** | 0 | | 060. Tends to be shy or reserved in social situations. |
| **61** | 0 | | 061. Tends to disparage qualities traditionally associated with own sex while embracing qualities traditionally associated with opposite sex (e.g., a woman who devalues nurturance and emotional sensitivity while valuing achievement and independence). |
| **62** | 1 | | 062. Tends to be preoccupied with food, diet, or eating. |
| **63** | 4 | | 063. Is able to assert him/herself effectively and appropriately when necessary. |
| **64** | 6 | | 064. Mood tends to cycle over intervals of weeks or months between excited and depressed states (high placement implies bipolar mood disorder). |
| **65** | 0 | | 065. Seeks to dominate an important other (e.g., spouse, lover, family member) through violence or intimidation. |
| **66** | 0 | | 066. Is excessively devoted to work and productivity, to the detriment of leisure and relationships. |
| **67** | 0 | | 067. Tends to be stingy and withholding (whether of money, ideas, emotions, etc.) |
| **68** | 0 | | 068. Appreciates and responds to humor. |
| **69** | 0 | | 069. Has difficulty discarding things even when they are worn-out or worthless; tends to hoard, collect, or hold onto things. |
| **70** | 0 | | 070. Has uncontrolled eating binges followed by "purges" (e.g., makes self vomit, abuses laxatives, fasts, etc.); has bulimic episodes. |
| **71** | 1 | | 071. Tends to seek thrills, novelty, adventure, etc. |
| **72** | 0 | | 072. Perceptions seem glib, global, and impressionistic; has difficulty focusing on specific details. |
| **73** | 0 | | 073. Tends to "catastrophize"; is prone to see problems as disastrous, unsolvable, etc. |
| **74** | 0 | | 074. Expresses emotion in exaggerated and theatrical ways. |
| **75** | 0 | | 075. Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance. |
| **76** | 1 | | 076. Manages to elicit in others feelings similar to those he or she 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). |
| **77** | 6 | | 077. Tends to be overly needy or dependent; requires excessive reassurance or approval. |
| **78** | 1 | | 078. Tends to express aggression in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.). |
| **79** | 0 | | 079. Tends to see certain others as "all bad," and loses the capacity to perceive any positive qualities the person may have. |

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| **80** | 6 | | 080. Tends to be sexually possessive or jealous; tends to be preoccupied with concerns about real or imagined infidelity. |
| **81** | 1 | | 081. 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). |
| **82** | 1 | | 082. 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. |
| **83** | 0 | | 083. Beliefs and expectations seem cliché or stereotypical, as if taken from story-books or movies. |
| **84** | 7 | | 084. Tends to be competitive with others (whether consciously or unconsciously). |
| **85** | 0 | | 085. Has conscious homosexual interests (moderate placement implies bisexuality; high placement implies exclusive homosexuality). |
| **86** | 1 | | 086. Tends to feel ashamed or embarrassed. |
| **87** | 3 | | 087. Is quick to assume that others wish to harm or take advantage of him/her; tends to perceive malevolent intentions in others' words and actions. |
| **88** | 2 | | 088. Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves. |
| **89** | 0 | | 089. Appears to have come to terms with painful experiences from the past; has found meaning in, and grown from such experiences. |
| **90** | 7 | | 090. Tends to feel empty or bored. |
| **91** | 1 | | 091. Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects. |
| **92** | 6 | | 092. Is articulate; can express self well in words. |
| **93** | 0 | | 093. Seems to know less about the ways of the world than might be expected, given his/her intelligence, background, etc.; appears naive or innocent. |
| **94** | 1 | | 094. Has an active and satisfying sex life. |
| **95** | 5 | | 095. Appears comfortable and at ease in social situations. |
| **96** | 4 | | 096. Tends to elicit dislike or animosity in others. |
| **97** | 0 | | 097. Tends to use his/her physical attractiveness to an excessive degree to gain attention or notice. |
| **98** | 6 | | 098. Tends to fear s/he will be rejected or abandoned by those who are emotionally significant. |
| **99** | 0 | | 099. Appears to associate sexual activity with danger (e.g., injury, punishment, contamination, etc.), whether consciously or unconsciously. |
| **100** | 1 | | 100. Tends to think in abstract and intellectualized terms, even in matters of personal import. |
| **101** | 0 | | 101. Generally finds contentment and happiness in life's activities. |
| **102** | 2 | | 102. Has a specific phobia (e.g., of snakes, spiders, dogs, airplanes, elevators, etc.). |
| **103** | 0 | | 103. Tends to react to criticism with feelings of rage or humiliation. |
| **104** | 0 | | 104. Appears to have little need for human company or contact; is genuinely indifferent to the presence of others. |
| **105** | 7 | | 105. Tends to avoid confiding in others for fear of betrayal; expects things s/he says or does will be used against him/her. |
| **106** | 4 | | 106. Tends to express affect appropriate in quality and intensity to the situation at hand. |

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| **107** | 2 | 107. Tends to express qualities or mannerisms traditionally associated with own sex to an exaggerated degree (i.e., a hyper feminine woman or hyper masculine, “macho” man). |
| **108** | 0 | 108. Tends to restrict food intake to the point of being underweight and malnourished. |
| **109** | 0 | 109. Tends to engage in self-mutilating behavior (e.g., self-cutting, self-burning, etc.). |
| **110** | 0 | 110. Tends to become attached to, or romantically interested in, people who are emotionally unavailable. |
| **111** | 3 | 111. Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings. |
| **112** | 0 | 112. Tends to be unconcerned with the consequences of his/her actions; appears to feel immune or invulnerable. |
| **113** | 0 | 113. Appears to experience no remorse for harm or injury caused to others. |
| **114** | 5 | 114. Tends to be critical of others. |
| **115** | 0 | 115. Tends to break things or become physically assaultive when angry. |
| **116** | 4 | 116. Tends to see own unacceptable feelings or impulses in other people instead of in him/herself. |
| **117** | 1 | 117. Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect. |
| **118** | 0 | 118. Tends to see sexual experiences as somehow revolting or disgusting. |
| **119** | 3 | 119. Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses. |
| **120** | 4 | 120. Has moral and ethical standards and strives to live up to them. |
| **121** | 3 | 121. Is creative; is able to see things or approach problems in novel ways. |
| **122** | 0 | 122. Living arrangements tend to be chaotic or unstable (e.g., living arrangements are temporary, transitional, or ill-defined; may have no telephone or permanent address). |
| **123** | 0 | 123. Tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered. |
| **124** | 0 | 124. Tends to avoid social situations because of fear of embarrassment or humiliation. |
| **125** | 0 | 125. Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or “off”). |
| **126** | 3 | 126. Appears to have a limited or constricted range of emotions. |
| **127** | 2 | 127. Tends to feel misunderstood, mistreated, or victimized. |
| **128** | 0 | 128. Fantasizes about finding ideal, perfect love. |
| **129** | 0 | 129. Tends to be conflicted about authority (e.g., may feel s/he must submit, rebel against, win over, defeat, etc.). |
| **130** | 0 | 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). |
| **131** | 4 | 131. Has difficulty allowing self to experience strong pleasurable emotions (e.g., excitement, joy, pride). |
| **132** | 0 | 132. Tends to have numerous sexual involvements; is promiscuous. |
| **133** | 4 | 133. Tends to be arrogant, haughty, or dismissive. |
| **134** | 0 | 134. Tends to act impulsively, without regard for consequences. |

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| **135** | 0 | 135. Has unfounded fears of contracting medical illness; tends to interpret normal aches and pains as symptomatic of illness; is hypochondriacal. |
| **136** | 3 | 136. Tends to be superstitious or believe in magical or supernatural phenomena (e.g., astrology, tarot, crystals, ESP, “auras,” etc.). |
| **137** | 0 | 137. Shows evidence of unconscious homosexual wishes or interests (e.g., may be excessively homophobic, or may show signs of unacknowledged attraction to a person of the same sex). |
| **138** | 0 | 138. Tends to enter altered, dissociated state of consciousness when distressed (e.g., the self or the world feels strange, unfamiliar, or unreal). |
| **139** | 3 | 139. Tends to hold grudges; may dwell on insults or slights for long periods. |
| **140** | 2 | 140. Has a sexual perversion or fetish; rigidly-scripted or highly idiosyncratic conditions must be met before s/he can experience sexual gratification. |
| **141** | 0 | 141. Is extremely identified with a social or political “cause,” to a degree that seems excessive or fanatical. |
| **142** | 2 | 142. Tends to make repeated suicidal threats or gestures, either as a “cry for help” or as an effort to manipulate others. |
| **143** | 0 | 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.” |
| **144** | 3 | 144. Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential. |
| **145** | 0 | 145. Speech tends to be circumstantial, vague, rambling, digressive, etc. |
| **146** | 3 | 146. Tends to elicit boredom in others (e.g., may talk incessantly, without feeling, or about inconsequential matters). |
| **147** | 1 | 147. Tends to abuse alcohol. |
| **148** | 4 | 148. Has little psychological insight into own motives, behavior, etc.; is unable to consider alternate interpretations of his/her experiences. |
| **149** | 7 | 149. Tends to feel like an outcast or outsider; feels as if s/he does not truly belong. |
| **150** | 0 | 150. Tends to identify with admired others to an exaggerated degree; tends to become an admirer or “disciple” (e.g., may take on the other’s attitudes, beliefs, mannerisms, etc.). |
| **151** | 0 | 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. |
| **152** | 2 | 152. Tends to repress or “forget” distressing events, or distort memories of distressing events beyond recognition. |
| **153** | 0 | 153. Interpersonal relationships tend to be unstable, chaotic, and rapidly changing. |
| **154** | 3 | 154. Tends to elicit extreme reactions or stir up strong feelings in others. |
| **155** | 2 | 155. Tends to describe experiences in generalities; is unwilling or unable to offer specific details. |
| **156** | 0 | 156. Has a disturbed or distorted body-image; sees self as unattractive, grotesque, disgusting, etc. |
| **157** | 0 | 157. Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning. |
| **158** | 0 | 158. Appears afraid of commitment to a long-term love relationship. |

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| **159** | 5 | 159. Tends to deny or disavow own needs for caring, comfort, closeness, etc., or to consider such needs unacceptable. |
| **160** | 6 | 160. Lacks close friendships and relationships. |
| **161** | 7 | 161. Tends to abuse illicit drugs. |
| **162** | 3 | 162. Expresses contradictory feelings or beliefs without being disturbed by the inconsistency; has little need to reconcile or resolve contradictory ideas. |
| **163** | 4 | 163. Appears to want to "punish" self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification. |
| **164** | 4 | 164. Tends to be self-righteous or moralistic. |
| **165** | 1 | 165. Tends to distort unacceptable wishes or feelings by transforming them into their opposite (may express excessive concern or affection while showing signs of unacknowledged hostility; disgust about sexual matters while showing signs of unacknowledged interest or excitement; etc.). |
| **166** | 1 | 166. Tends to oscillate between undercontrol and overcontrol of needs and impulses (i.e., needs and wishes are expressed impulsively and with little regard for consequences, or else disavowed and permitted virtually no expression). |
| **167** | 7 | 167. Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered). |
| **168** | 0 | 168. Struggles with genuine wishes to kill him/herself. |
| **169** | 4 | 169. Fears becoming like a parent (or parent figure) about whom s/he has strong negative feelings; may go to lengths to avoid or reject attitudes or behaviors associated with that person. |
| **170** | 7 | 170. Tends to be oppositional, contrary, or quick to disagree. |
| **171** | 5 | 171. Appears to fear being alone; may go to great lengths to avoid being alone. |
| **172** | 0 | 172. Experiences a specific sexual dysfunction during sexual intercourse or attempts at intercourse (e.g., inhibited orgasm or vaginismus in females, impotence or premature ejaculation in males). |
| **173** | 0 | 173. Tends to become absorbed in details, often to the point that s/he misses what is significant in the situation. |
| **174** | 1 | 174. Expects self to be "perfect" (e.g., in appearance, achievements, performance, etc.). |
| **175** | 5 | 175. Tends to be conscientious and responsible. |
| **176** | 0 | 176. 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, treat the person as an "extension" of him/herself, etc.). |
| **177** | 0 | 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." |
| **178** | 5 | 178. Is preoccupied with the feeling that someone or something has been irretrievably lost (e.g., love, youth, the chance for happiness, etc.). |
| **179** | 1 | 179. Tends to be energetic and outgoing. |
| **180** | 0 | 180. Has trouble making decisions; tends to be indecisive or to vacillate when faced with choices. |
| **181** | 0 | 181. Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc. |

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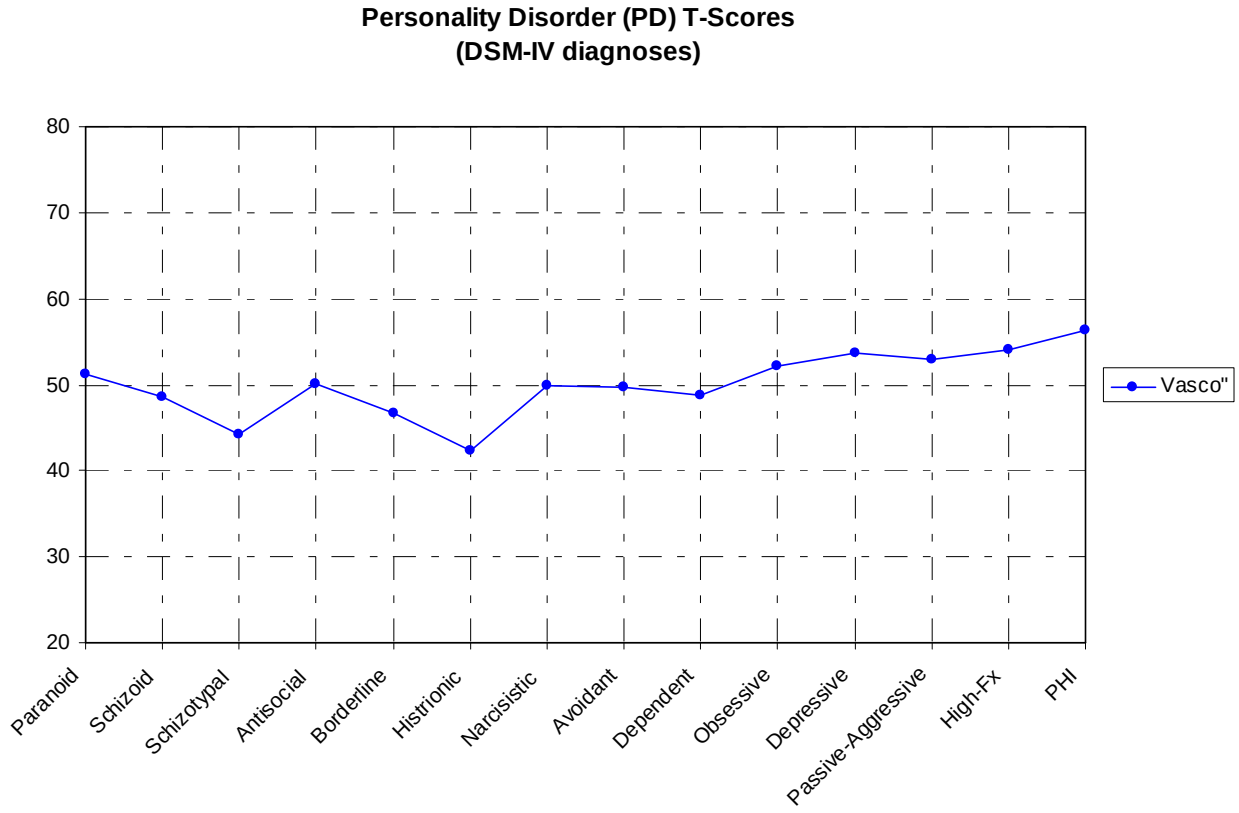
| **182** | 5 | | 182. Tends to be controlling. |
| **183** | 0 | | 183. Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways. |
| **184** | 0 | | 184. Verbal statements seem incongruous with accompanying affect, or incongruous with accompanying non-verbal messages. |
| **185** | 0 | | 185. Tends to express intense and inappropriate anger, out of proportion to the situation at hand. |
| **186** | 0 | | 186. 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). |
| **187** | 2 | | 187. Tends to feel guilty or ashamed about his/her sexual interests or activities (whether consciously or unconsciously). |
| **188** | 0 | | 188. Work life tends to be chaotic or unstable (e.g., working arrangements seem always temporary, transitional, or ill-defined). |
| **189** | 7 | | 189. Tends to feel unhappy, depressed, or despondent. |
| **190** | 0 | | 190. Appears to feel privileged and entitled; expects preferential treatment. |
| **191** | 3 | | 191. Emotions tend to change rapidly and unpredictably. |
| **192** | 2 | | 192. Tends to be overly concerned with rules, procedures, order, organization, schedules, etc. |
| **193** | 0 | | 193. Lacks social skills; tends to be socially awkward or inappropriate. |
| **194** | 3 | | 194. Tries to manipulate others' emotions to get what s/he wants. |
| **195** | 2 | | 195. Tends to be preoccupied with death and dying. |
| **196** | 2 | | 196. Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions. |
| **197** | 0 | | 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. |
| **198** | 0 | | 198. Is not verbally articulate; has limited ability to express self in words. |
| **199** | 4 | | 199. Tends to be passive and unassertive. |
| **200** | 0 | | 200. Is able to form close and lasting friendships characterized by mutual support and sharing of experiences. |

| **Paranoid** | **Schizoid** | **Schizotypal** | **Antisocial** | **Borderline** | **Histrionic** | **Narcissistic** | **Avoidant** | **Dependent** | **Obsessive** | **Depressive** | **Passive-Aggressive** | **High-Fx** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

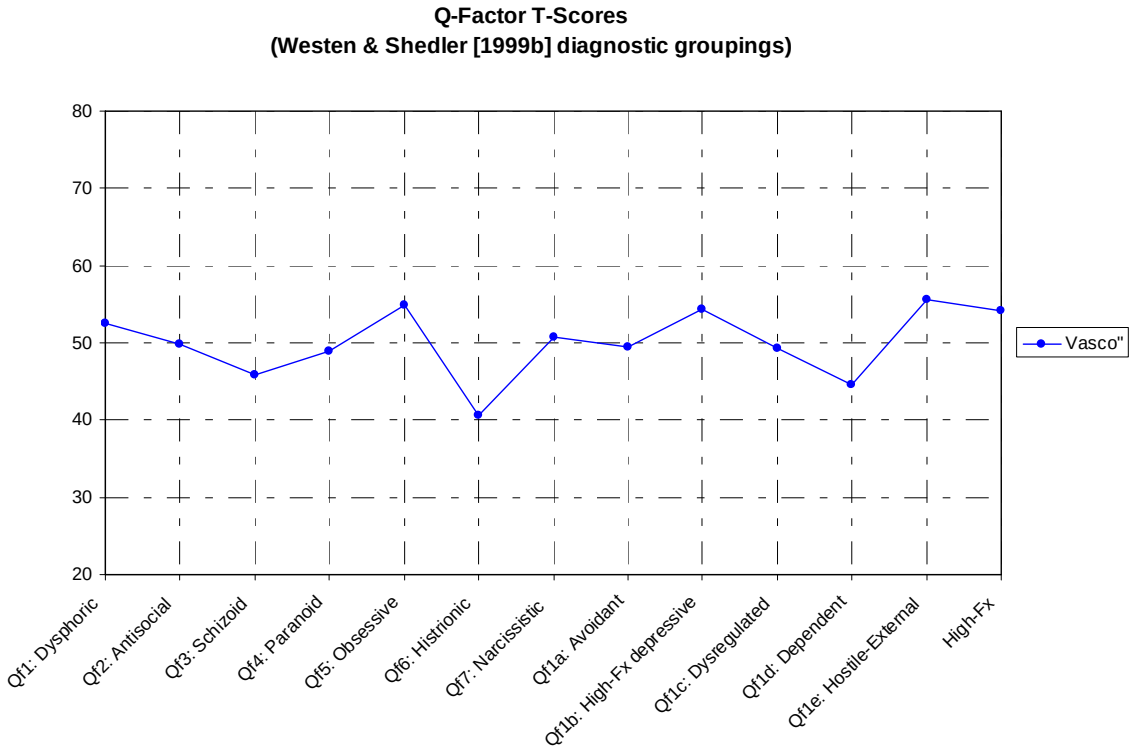
| F | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ACT | 51,2 | 48,6 | 44,2 | 50,0 | 46,8 | 42,4 | 49,8 | 49,8 | 48,7 | 52,1 | 53,7 | 52,9 | 54,1 |

OR T- SCORES




Q-FACTOR T- SCORES

| Psychological Health | Psychopathy | Hostility | Narcissism | Emotional Dysregulation | Dysphoria | Schizoid Orientation | Obsessionality | Thought Disorder | Oedipal Conflict | Dissociation | Sexual Conflict |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 57,6 | 46,8 | 54,7 | 44,5 | 42,8 | 62,6 | 48,1 | 41,9 | 44,6 | 55,1 | 49,6 | 43,5 |




## FACTOR SCORES

| Qf1: Dysphoric | Qf2: Antisocial | Qf3: Schizoid | Qf4: Paranoid | Qf5: Obsessive | Qf6: Histrionic | Qf7: Narcissistic | Qf1a: Avoidant | Qf1b: High-Fx depressive | Qf1c: Dysregulated | Qf1d: Dependent | Qf1e: Hostile-External | High-Fx |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 52,5 | 49,8 | 45,8 | 49,0 | 54,9 | 40,6 | 50,6 | 49,4 | 54,3 | 49,3 | 44,6 | 55,5 | 54,1 |

# APPENDIX B

TABLE 1 - DYSPHORIC (OPTIONAL*)

| *Item* | *Rank* |
|---|---|
| Tends to feel s/he is inadequate, inferior, or a failure. | 1 |
| Tends to feel unhappy, depressed, or despondent. | 2 |
| Tends to feel ashamed or embarrassed. | 3 |
| Tends to blame self or feel responsible for bad things that happen. | 4 |
| Tends to feel guilty. | 5 |
| Tends to fear s/he will be rejected or abandoned by those who are emotionally significant. | 6 |
| Tends to feel helpless, powerless, or at the mercy of forces outside his/her control. | 7 |
| Tends to be overly needy or dependent; requires excessive reassurance or approval. | 8 |
| Tends to be ingratiating or submissive (e.g., may consent to things s/he does not agree with or does not want to do, in the hope of getting support or approval). | 9 |
| Tends to be passive and unassertive. | 10 |
| Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects. | 11 |
| Tends to feel like an outcast or outsider; feels as if s/he does not truly belong. | 12 |
| Tends to be anxious. | 13 |
| Tends feel listless, fatigued, or lacking in energy. | 14 |
| Tends to feel empty or bored. | 15 |
| Appears to want to “punish” self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification. | 16 |
| Appears to find little or no pleasure, satisfaction, or enjoyment in life’s activities. | 17 |
| Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves. | 18 |
| Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect. | 19 |
| Lacks a stable image of who s/he is or would like to become (e.g., attitudes, values, goals, and feelings about self may be unstable and changing). | 20 |

*This prototype is optional, because more specific subtypes are rated.

TABLE 2 -ANTISOCIAL-PSYCHOPATHIC

| *Item* | *Rank* |
|---|---|
| Tends to be deceitful; tends to lie or mislead. | 1 |
| Takes advantage of others; is out for number one; has minimal investment in moral values. | 2 |
| Appears to experience no remorse for harm or injury caused to others. | 3 |
| Tends to be angry or hostile (whether consciously or unconsciously). | 4 |
| Tends to act impulsively, without regard for consequences. | 5 |
| Tries to manipulate others' emotions to get what s/he wants. | 6 |
| Tends to be unreliable and irresponsible (e.g., may fail to meet work obligations or honor financial commitments). | 7 |
| Tends to engage in unlawful or criminal behavior. | 8 |
| Has little empathy; seems unable to understand or respond to others' needs and feelings unless they coincide with his/her own. | 9 |
| Tends to be unconcerned with the consequences of his/her actions; appears to feel immune or invulnerable. | 10 |
| Tends to show reckless disregard for the rights, property, or safety of others. | 11 |
| Tends to abuse alcohol. | 12 |
| Tends to blame others for own failures or shortcomings; tends to believe his/her problems are caused by external factors. | 13 |
| Tends to get into power struggles. | 14 |
| Appears to gain pleasure or satisfaction by being sadistic or aggressive toward others (whether consciously or unconsciously). | 15 |
| Has little psychological insight into own motives, behavior, etc.; is unable to consider alternate interpretations of his/her experiences. | 16 |
| 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." | 17 |
| Tends to seek power or influence over others (whether in beneficial or destructive ways). | 18 |
| Tends to be conflicted about authority (e.g., may feel s/he must submit, rebel against, win over, defeat, etc.). | 19 |
| Seeks to dominate an important other (e.g., spouse, lover, family member) through violence or intimidation. | 20 |
| Tends to react to criticism with feelings of rage or humiliation. | 21 |
| Tends to abuse illicit drugs. | 22 |
| Tends to break things or become physically assaultive when angry. | 23 |

TABLE 3- SCHIZOID

| *Item* | *Rank* |
|---|---|
| Lacks close friendships and relationships. | 1 |
| Appears to have a limited or constricted range of emotions. | 2 |
| Lacks social skills; tends to be socially awkward or inappropriate. | 3 |
| Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or "off"). | 4 |
| Tends to be shy or reserved in social situations. | 5 |
| Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses. | 6 |
| Has difficulty making sense of other people's behavior; often misunderstands, misinterprets, or is confused by others' actions and reactions. | 7 |
| 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. | 8 |
| Has little psychological insight into own motives, behavior, etc.; is unable to consider alternate interpretations of his/her experiences. | 9 |
| Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance. | 10 |
| Appears to have little need for human company or contact; is genuinely indifferent to the presence of others. | 11 |
| Perception of reality can become *grossly* impaired under stress (e.g., may become delusional). | 12 |
| Tends to avoid social situations because of fear of embarrassment or humiliation. | 13 |
| 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). | 14 |
| Tends to elicit boredom in others (e.g., may talk incessantly, without feeling, or about inconsequential matters). | 15 |
| Has difficulty acknowledging or expressing anger. | 16 |
| Has difficulty allowing self to experience strong pleasurable emotions (e.g., excitement, joy, pride). | 17 |
| Tends to be passive and unassertive. | 18 |
| Tends to feel like an outcast or outsider; feels as if s/he does not truly belong. | 19 |
| Has little empathy; seems unable to understand or respond to others' needs and feelings unless they coincide with his/her own. | 20 |
| Seems to know less about the ways of the world than might be expected, given his/her intelligence, background, etc.; appears naive or innocent. | 21 |
| Speech tends to be circumstantial, vague, rambling, digressive, etc. | 22 |
| Tends to describe experiences in generalities; is unwilling or unable to offer specific details. | 23 |
| Verbal statements seem incongruous with accompanying affect, or incongruous with accompanying non-verbal messages. | 24 |

TABLE 4 - PARANOID

| *Item* | *Rank* |
|---|---|
| Tends to hold grudges; may dwell on insults or slights for long periods. | 1 |
| Tends to feel misunderstood, mistreated, or victimized. | 2 |
| Is quick to assume that others wish to harm or take advantage of him/her; tends to perceive malevolent intentions in others' words and actions. | 3 |
| Tends to express intense and inappropriate anger, out of proportion to the situation at hand. | 4 |
| Tends to be critical of others. | 5 |
| Tends to get into power struggles. | 6 |
| Tends to be angry or hostile (whether consciously or unconsciously). | 7 |
| Tends to see certain others as "all bad," and loses the capacity to perceive any positive qualities the person may have. | 8 |
| Tends to be self-righteous or moralistic. | 9 |
| Tends to react to criticism with feelings of rage or humiliation. | 10 |
| Tends to blame others for own failures or shortcomings; tends to believe his/her problems are caused by external factors. | 11 |
| Tends to be oppositional, contrary, or quick to disagree. | 12 |
| Tends to see own unacceptable feelings or impulses in other people instead of in him/herself. | 13 |
| Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning. | 14 |
| Tends to "catastrophize"; is prone to see problems as disastrous, unsolvable, etc. | 15 |
| Tends to elicit dislike or animosity in others. | 16 |
| Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc. | 17 |
| Has difficulty making sense of other people's behavior; often misunderstands, misinterprets, or is confused by others' actions and reactions. | 18 |

TABLE 5 - OBSESSIONAL

| *Item* | *Rank* |
|---|---|
| Tends to be conscientious and responsible. | 1 |
| Is articulate; can express self well in words. | 2 |
| Has moral and ethical standards and strives to live up to them. | 3 |
| Is able to use his/her talents, abilities, and energy effectively and productively. | 4 |
| Enjoys challenges; takes pleasure in accomplishing things. | 5 |
| Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential. | 6 |
| Is excessively devoted to work and productivity, to the detriment of leisure and relationships. | 7 |
| Tends to be controlling. | 8 |
| Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions. | 9 |
| Appreciates and responds to humor. | 10 |
| Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses. | 11 |
| Is able to assert him/herself effectively and appropriately when necessary. | 12 |
| Tends to think in abstract and intellectualized terms, even in matters of personal import. | 13 |
| Has difficulty acknowledging or expressing anger. | 14 |
| Tends to be competitive with others (whether consciously or unconsciously). | 15 |
| Expects self to be “perfect” (e.g., in appearance, achievements, performance, etc.). | 16 |
| Tends to elicit liking in others. | 17 |
| Tends to be overly concerned with rules, procedures, order, organization, schedules, etc. | 18 |
| Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings. | 19 |
| Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways. | 20 |
| Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects. | 21 |
| Has difficulty allowing self to experience strong pleasurable emotions (e.g., excitement, joy, pride). | 22 |

TABLE 6 - HISTRIONIC

| *Item* | *Rank* |
|---|---|
| Tends to be overly needy or dependent; requires excessive reassurance or approval. | 1 |
| Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship. | 2 |
| Tends to become attached to, or romantically interested in, people who are emotionally unavailable. | 3 |
| Tends to be suggestible or easily influenced. | 4 |
| 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.). | 5 |
| Expresses emotion in exaggerated and theatrical ways. | 6 |
| Fantasizes about finding ideal, perfect love. | 7 |
| Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect. | 8 |
| Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc. | 9 |
| Tends to fear s/he will be rejected or abandoned by those who are emotionally significant. | 10 |
| Tends to use his/her physical attractiveness to an excessive degree to gain attention or notice. | 11 |
| Tends to be anxious. | 12 |
| Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc. | 13 |
| Tends to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.). | 14 |
| Perceptions seem glib, global, and impressionistic; has difficulty focusing on specific details. | 15 |
| Seeks to be the center of attention. | 16 |
| Emotions tend to change rapidly and unpredictably. | 17 |
| Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning. | 18 |

TABLE 7 - NARCISSISTIC

| *Item* | *Rank* |
|---|---|
| Has fantasies of unlimited success, power, beauty, talent, brilliance, etc. | 1 |
| Appears to feel privileged and entitled; expects preferential treatment. | 2 |
| Has an exaggerated sense of self-importance. | 3 |
| Seems to treat others primarily as an audience to witness own importance, brilliance, beauty, etc. | 4 |
| Seeks to be the center of attention. | 5 |
| Expects self to be “perfect” (e.g., in appearance, achievements, performance, etc.). | 6 |
| Tends to be arrogant, haughty, or dismissive. | 7 |
| Fantasizes about finding ideal, perfect love. | 8 |
| Tends to think others are envious of him/her. | 9 |
| Tends to feel envious. | 10 |
| Tends to be competitive with others (whether consciously or unconsciously). | 11 |
| Tends to believe s/he can only be appreciated by, or should only associate with, people who are high-status, superior, or otherwise “special.” | 12 |
| Lacks close friendships and relationships. | 13 |
| Tends to feel s/he is not his/her true self with others; tends to feel false or fraudulent. | 14 |
| Tends to use his/her physical attractiveness to an excessive degree to gain attention or notice. | 15 |
| Tends to feel life has no meaning. | 16 |

TABLE 1.A - AVOIDANT-DYSPHORIC

| *Item* | *Rank* |
|---|---|
| Tends to be shy or reserved in social situations. | 1 |
| Tends to avoid social situations because of fear of embarrassment or humiliation. | 2 |
| Lacks social skills; tends to be socially awkward or inappropriate. | 3 |
| Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses. | 4 |
| Tends to be passive and unassertive. | 5 |
| Lacks close friendships and relationships. | 6 |
| Tends to feel like an outcast or outsider; feels as if s/he does not truly belong. | 7 |
| Has difficulty allowing self to experience strong pleasurable emotions (e.g., excitement, joy, pride). | 8 |
| Tends to feel s/he is inadequate, inferior, or a failure. | 9 |
| Tends to feel ashamed or embarrassed. | 10 |
| Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential. | 11 |
| Appears to have a limited or constricted range of emotions. | 12 |
| Has difficulty acknowledging or expressing anger. | 13 |
| Seems to know less about the ways of the world than might be expected, given his/her intelligence, background, etc.; appears naive or innocent. | 14 |
| Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects. | 15 |
| Tends to be anxious. | 16 |
| Tends to blame self or feel responsible for bad things that happen. | 17 |
| Appears to find little or no pleasure, satisfaction, or enjoyment in life’s activities. | 18 |

TABLE 1.B. HIGH FUNCTIONING DEPRESSIVE-DYSPHORIC

| *Item* | *Rank* |
|---|---|
| Is articulate; can express self well in words. | 1 |
| Has moral and ethical standards and strives to live up to them. | 2 |
| Is empathic; is sensitive and responsive to other peoples' needs and feelings. | 3 |
| Appreciates and responds to humor. | 4 |
| Tends to be conscientious and responsible. | 5 |
| Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways. | 6 |
| Tends to elicit liking in others. | 7 |
| Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings. | 8 |
| Tends to blame self or feel responsible for bad things that happen. | 9 |
| 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. | 10 |
| Tends to feel guilty. | 11 |
| Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring. | 12 |
| Is creative; is able to see things or approach problems in novel ways. | 13 |
| Tends to seek out or create interpersonal relationships in which s/he is in the role of caring for, rescuing, or protecting the other. | 14 |
| Is able to form close and lasting friendships characterized by mutual support and sharing of experiences. | 15 |
| Tends to feel unhappy, depressed, or despondent. | 16 |
| Enjoys challenges; takes pleasure in accomplishing things. | 17 |
| Is able to use his/her talents, abilities, and energy effectively and productively. | 18 |
| Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others. | 19 |
| Tends to fear s/he will be rejected or abandoned by those who are emotionally significant. | 20 |
| Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects. | 21 |
| Tends feel listless, fatigued, or lacking in energy. | 22 |

TABLE 1.C -EMOTIONALLY DYSREGULATED-DYSPHORIC

| *Item* | *Rank* |
|---|---|
| Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc. | 1 |
| Struggles with genuine wishes to kill him/herself. | 2 |
| Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect. | 3 |
| Tends to feel life has no meaning. | 4 |
| Tends to make repeated suicidal threats or gestures, either as a “cry for help” or as an effort to manipulate others. | 5 |
| Tends to feel unhappy, depressed, or despondent. | 6 |
| Tends to “catastrophize”; is prone to see problems as disastrous, unsolvable, etc. | 7 |
| Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning. | 8 |
| Tends to be preoccupied with death and dying. | 9 |
| Tends to feel empty or bored. | 10 |
| Appears to find little or no pleasure, satisfaction, or enjoyment in life’s activities. | 11 |
| Tends to be overly needy or dependent; requires excessive reassurance or approval. | 12 |
| 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). | 13 |
| Tends to engage in self-mutilating behavior (e.g., self-cutting, self-burning, etc.). | 14 |
| Tends to be angry or hostile (whether consciously or unconsciously). | 15 |
| Tends to feel like an outcast or outsider; feels as if s/he does not truly belong. | 16 |
| Tends to feel misunderstood, mistreated, or victimized. | 17 |
| Tends to feel s/he is inadequate, inferior, or a failure. | 18 |
| Emotions tend to change rapidly and unpredictably. | 19 |

TABLE 1.D - DEPENDENT MASOCHISTIC-DYSPHORIC

| *Item* | *Rank* |
|---|---|
| Tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused. | 1 |
| Tends to be ingratiating or submissive (e.g., may consent to things s/he does not agree with or does not want to do, in the hope of getting support or approval). | 2 |
| Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship. | 3 |
| Tends to be suggestible or easily influenced. | 4 |
| Tends to become attached to, or romantically interested in, people who are emotionally unavailable. | 5 |
| Tends to be overly needy or dependent; requires excessive reassurance or approval. | 6 |
| Fantasizes about finding ideal, perfect love. | 7 |
| Appears to fear being alone; may go to great lengths to avoid being alone. | 8 |
| Tends to fear s/he will be rejected or abandoned by those who are emotionally significant. | 9 |
| Tends to express aggression in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.). | 10 |
| Lacks a stable image of who s/he is or would like to become (e.g., attitudes, values, goals, and feelings about self may be unstable and changing). | 11 |
| Tends to idealize certain others in unrealistic ways; sees them as “all good,” to the exclusion of commonplace human defects. | 12 |
| Has trouble making decisions; tends to be indecisive or to vacillate when faced with choices. | 13 |
| Tends to be passive and unassertive. | 14 |
| Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect. | 15 |
| Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc. | 16 |
| Has difficulty acknowledging or expressing anger. | 17 |
| 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.” | 18 |

TABLE 1.E - HOSTILE EXTERNALIZING-DYSPHORIC

| *Item* | *Rank* |
|---|---|
| Tends to get into power struggles. | 1 |
| Tends to be angry or hostile (whether consciously or unconsciously). | 2 |
| Tends to blame others for own failures or shortcomings; tends to believe his/her problems are caused by external factors. | 3 |
| Tends to feel misunderstood, mistreated, or victimized. | 4 |
| Tends to be critical of others. | 5 |
| Tends to be conflicted about authority (e.g., may feel s/he must submit, rebel against, win over, defeat, etc.). | 6 |
| Tends to hold grudges; may dwell on insults or slights for long periods. | 7 |
| Tends to express aggression in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.). | 8 |
| Tends to be oppositional, contrary, or quick to disagree. | 9 |
| Is quick to assume that others wish to harm or take advantage of him/her; tends to perceive malevolent intentions in others' words and actions. | 10 |
| Tends to feel helpless, powerless, or at the mercy of forces outside his/her control. | 11 |
| Tends to be hostile toward members of the opposite sex, whether consciously or unconsciously (e.g., may be disparaging, competitive, etc.). | 12 |
| Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential. | 13 |
| Tends to be controlling. | 14 |
| Tends to react to criticism with feelings of rage or humiliation. | 15 |
| Tends to see own unacceptable feelings or impulses in other people instead of in him/herself. | 16 |

# APPENDIX C

**1** ***SWAP-200***

Tends to blame self or feel responsible for bad things that happen.

**2** ***SWAP-200***

Is able to use his/her talents, abilities, and energy effectively and productively.



**3** ***SWAP-200***

Takes advantage of others; is out for number one; has minimal investment in moral values.

**4** ***SWAP-200***

Has an exaggerated sense of self-importance.

**5** ***SWAP-200***

Tends to be emotionally intrusive; tends not to respect others' needs for autonomy, privacy, etc.

**6** ***SWAP-200***

Is troubled by recurrent obsessional thoughts that s/he experiences as senseless and intrusive.

**7** ***SWAP-200***

Appears conflicted about his/her racial or ethnic identity (e.g., undervalues and rejects, or overvalues and is preoccupied with, own cultural heritage).

**8** ***SWAP-200***

Tends to get into power struggles.

**9** ***SWAP-200***

Tends to think others are envious of him/her.

**10** ***SWAP-200***

Feels some important other has a special, almost magical ability to understand his/her innermost thoughts and feelings (e.g., may imagine rapport is so perfect that ordinary efforts at communication are superfluous).

**11** ***SWAP-200***

Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.

**12** ***SWAP-200***

Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc.

**13** ***SWAP-200***

Tends to use his/her psychological or medical problems to avoid work or responsibility (whether consciously or unconsciously) .

**14** ***SWAP-200***

Tends to blame others for own failures or shortcomings; tends to believe his/her problems are caused by external factors.

**15** ***SWAP-200***

Lacks a stable image of who s/he is or would like to become (e.g., attitudes, values, goals, or feelings about self may be unstable and changing).

**16** ***SWAP-200***

Tends to be angry or hostile (whether consciously or unconsciously).

**17** ***SWAP-200***

Tends to be ingratiating or submissive (e.g., may consent to things s/he does not agree with or does not want to do, in the hope of getting support or approval).

**18** ***SWAP-200***

When romantically or sexually attracted, tends to lose interest if other person reciprocates.

**19** ***SWAP-200***

Enjoys challenges; takes pleasure in accomplishing things.

**20** ***SWAP-200***

Tends to be deceitful; tends to lie or mislead.

**21** ***SWAP-200***

Tends to be hostile toward members of the opposite sex, whether consciously or unconsciously (e.g., may be disparaging, competitive, etc.).

**22** ***SWAP-200***

Tends to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.).

**23** ***SWAP-200***

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.).

**24** ***SWAP-200***

Tends to be unreliable and irresponsible (e.g., may fail to meet work obligations or honor financial commitments).

**25** ***SWAP-200***

Has difficulty acknowledging or expressing anger.

**26** ***SWAP-200***

Tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused.

***27*** ***SWAP-200***

Has panic attacks lasting from a few minutes to a few hours, accompanied by strong physiological responses (e.g., racing heart, shortness of breath, feelings of choking, nausea, dizziness, etc.).

**28** ***SWAP-200***

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.).

***29*** ***SWAP-200***

Has difficulty making sense of other people’s behavior; often misunderstands, misinterprets, or is confused by others’ actions and reactions.

**30** ***SWAP-200***

Tends to feel listless, fatigued, or lacking in energy.

**31** ***SWAP-200***

Tends to show reckless disregard for the rights, property, or safety of others.

**32** ***SWAP-200***

Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring.

**33** ***SWAP-200***

Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential.

**34** ***SWAP-200***

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.).

**35** ***SWAP-200***

Tends to be anxious.

**36** ***SWAP-200***

Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.

**37** ***SWAP-200***

Finds meaning in belonging and contributing to a larger community (e.g., organization, church, neighborhood, etc.).

**38** ***SWAP-200***

Tends to feel s/he is not his/her true self with others; tends to feel false or fraudulent.

**39** ***SWAP-200***

Appears to gain pleasure or satisfaction by being sadistic or aggressive toward others (whether consciously or unconsciously).

**40** ***SWAP-200***

Tends to engage in unlawful or criminal behavior.

**41** ***SWAP-200***

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.

**42** ***SWAP-200***

Tends to feel envious.

**43** ***SWAP-200***

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

**44** ***SWAP-200***

Perception of reality can become grossly impaired under stress (e.g., may become delusional).

**45** ***SWAP-200***

Tends to idealize certain others in unrealistic ways; sees them as “all good,” to the exclusion of commonplace human defects.

**46** ***SWAP-200***

Tends to be suggestible or easily influenced.

**47** ***SWAP-200***

Is unsure whether s/he is heterosexual, homosexual, or bisexual.

**48** ***SWAP-200***

Seeks to be the center of attention.

**49** ***SWAP-200***

Has fantasies of unlimited success, power, beauty, talent, brilliance, etc.

**50** ***SWAP-200***

Tends to feel life has no meaning.

**51** ***SWAP-200***

Tends to elicit liking in others.

**52** ***SWAP-200***

Has little empathy; seems unable to understand or respond to others' needs and feelings unless they coincide with his/her own.

**53** ***SWAP-200***

Seems to treat others primarily as an audience to witness own importance, brilliance, beauty, etc.

**54** ***SWAP-200***

Tends to feel s/he is inadequate, inferior, or a failure.

**55** ***SWAP-200***

Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others.

**56** ***SWAP-200***

Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities.

**57** ***SWAP-200***

Tends to feel guilty.

**58** ***SWAP-200***

Has little or no interest in having sexual experiences with another person.

**59** ***SWAP-200***

Is empathic; is sensitive and responsive to other peoples' needs and feelings.

**60** ***SWAP-200***

Tends to be shy or reserved in social situations.

**61** ***SWAP-200***

Tends to disparage qualities traditionally associated with own sex while embracing qualities traditionally associated with opposite sex (e.g., a woman who devalues nurturance and emotional sensitivity while valuing achievement and independence).

**62** ***SWAP-200***

Tends to be preoccupied with food, diet, or eating.

**63** ***SWAP-200***

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

**64** ***SWAP-200***

Mood tends to cycle over intervals of weeks or months between excited and depressed states (high placement implies bipolar mood disorder).

**65** ***SWAP-200***

Seeks to dominate an important other (e.g., spouse, lover, family member) through violence or intimidation.

**66** ***SWAP-200***

Is excessively devoted to work and productivity, to the detriment of leisure and relationships.

**67** ***SWAP-200***

Tends to be stingy and withholding (whether of money, ideas, emotions, etc.)

**68** ***SWAP-200***

Appreciates and responds to humor.

**69** ***SWAP-200***

Has difficulty discarding things even when they are worn-out or worthless; tends to hoard, collect, or hold onto things.

**70** ***SWAP-200***

Has uncontrolled eating binges followed by “purges” (e.g., makes self vomit, abuses laxatives, fasts, etc.); has bulimic episodes.

**71** ***SWAP-200***

Tends to seek thrills, novelty, adventure, etc.

**72** ***SWAP-200***

Perceptions seem glib, global, and impressionistic; has difficulty focusing on specific details.

**73** ***SWAP-200***

Tends to "catastrophize"; is prone to see problems as disastrous, unsolvable, etc.

**74** ***SWAP-200***

Expresses emotion in exaggerated and theatrical ways.

**75** ***SWAP-200***

Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance.

**76** ***SWAP-200***

Manages to elicit in others feelings similar to those he or she 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).

**77** ***SWAP-200***

Tends to be overly needy or dependent; requires excessive reassurance or approval.

**78** ***SWAP-200***

Tends to express aggression in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).

**79** ***SWAP-200***

Tends to see certain others as "all bad," and loses the capacity to perceive any positive qualities the person may have.

**80** ***SWAP-200***

Tends to be sexually possessive or jealous; tends to be preoccupied with concerns about real or imagined infidelity.

**81** ***SWAP-200***

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).

**82** ***SWAP-200***

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.

**83** ***SWAP-200***

Beliefs and expectations seem cliché or stereotypical, as if taken from story-books or movies.

**84** ***SWAP-200***

Tends to be competitive with others (whether consciously or unconsciously).

**85** ***SWAP-200***

Has conscious homosexual interests (moderate placement implies bisexuality; high placement implies exclusive homosexuality).

**86** ***SWAP-200***

Tends to feel ashamed or embarrassed.

**87** ***SWAP-200***

Is quick to assume that others wish to harm or take advantage of him/her; tends to perceive malevolent intentions in others' words and actions.

**88** ***SWAP-200***

Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves.

**89** ***SWAP-200***

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

**90** ***SWAP-200***

Tends to feel empty or bored.

**91** ***SWAP-200***

Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects.

**92** ***SWAP-200***

Is articulate; can express self well in words.

**93** ***SWAP-200***

Seems to know less about the ways of the world than might be expected, given his/her intelligence, background, etc.; appears naive or innocent.

**94** ***SWAP-200***

Has an active and satisfying sex life.

**95** ***SWAP-200***

Appears comfortable and at ease in social situations.

**96** ***SWAP-200***

Tends to elicit dislike or animosity in others.

**97** ***SWAP-200***

Tends to use his/her physical attractiveness to an excessive degree to gain attention or notice.

**98** ***SWAP-200***

Tends to fear s/he will be rejected or abandoned by those who are emotionally significant.

**99** ***SWAP-200***

Appears to associate sexual activity with danger (e.g., injury, punishment, contamination, etc.), whether consciously or unconsciously.

**100** ***SWAP-200***

Tends to think in abstract and intellectualized terms, even in matters of personal import.

**101** ***SWAP-200***

Generally finds contentment and happiness in life's activities.

**102** ***SWAP-200***

Has a specific phobia (e.g., of snakes, spiders, dogs, airplanes, elevators, etc.).

**103** ***SWAP-200***

Tends to react to criticism with feelings of rage or humiliation.

**104** ***SWAP-200***

Appears to have little need for human company or contact; is genuinely indifferent to the presence of others.

**105** ***SWAP-200***

Tends to avoid confiding in others for fear of betrayal; expects things s/he says or does will be used against him/her.

**106** ***SWAP-200***

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

**107** ***SWAP-200***

Tends to express qualities or mannerisms traditionally associated with own sex to an exaggerated degree (i.e., a hyperfeminine woman or hypermasculine, "macho" man).

**108** ***SWAP-200***

Tends to restrict food intake to the point of being underweight and malnourished.

**109** ***SWAP-200***

Tends to engage in self-mutilating behavior (e.g., self-cutting, self-burning, etc.).

**110** ***SWAP-200***

Tends to become attached to, or romantically interested in, people who are emotionally unavailable.

**111** ***SWAP-200***

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

**112** ***SWAP-200***

Tends to be unconcerned with the consequences of his/her actions; appears to feel immune or invulnerable.

**113** ***SWAP-200***

Appears to experience no remorse for harm or injury caused to others.

**114** ***SWAP-200***

Tends to be critical of others.

**115** ***SWAP-200***

Tends to break things or become physically assaultive when angry.

**116** ***SWAP-200***

Tends to see own unacceptable feelings or impulses in other people instead of in him/herself.

**117** ***SWAP-200***

Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect.

**118** ***SWAP-200***

Tends to see sexual experiences as revolting or disgusting.

**119** ***SWAP-200***

Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.

**120** ***SWAP-200***

Has moral and ethical standards and strives to live up to them.

**121** ***SWAP-200***

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

**122** ***SWAP-200***

Living arrangements tend to be chaotic or unstable (e.g., living arrangements are temporary, transitional, or ill-defined; may have no telephone or permanent address).

**123** ***SWAP-200***

Tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered.

**124** ***SWAP-200***

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

**125** ***SWAP-200***

Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or “off”).

**126** ***SWAP-200***

Appears to have a limited or constricted range of emotions.

**127** ***SWAP-200***

Tends to feel misunderstood, mistreated, or victimized.

**128** ***SWAP-200***

Fantasizes about finding ideal, perfect love.

**129** ***SWAP-200***

Tends to be conflicted about authority (e.g., may feel s/he must submit, rebel against, win over, defeat, etc.).

**130** ***SWAP-200***

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).

**131** ***SWAP-200***

Has difficulty allowing self to experience strong pleasurable emotions (e.g., excitement, joy, pride).

**132** ***SWAP-200***

Tends to have numerous sexual involvements; is promiscuous.

**133** ***SWAP-200***

Tends to be arrogant, haughty, or dismissive.

**134** ***SWAP-200***

Tends to act impulsively, without regard for consequences.

**135** ***SWAP-200***

Has unfounded fears of contracting medical illness; tends to interpret normal aches and pains as symptomatic of illness; is hypochondriacal.

**136** ***SWAP-200***

Tends to be superstitious or believe in magical or supernatural phenomena (e.g., astrology, tarot, crystals, ESP, “auras,” etc.).

**137** ***SWAP-200***

Shows evidence of unconscious homosexual wishes or interests (e.g., may be excessively homophobic, or may show signs of unacknowledged attraction to a person of the same sex).

**138** ***SWAP-200***

Tends to enter altered, dissociated states of consciousness when distressed (e.g., the self or the world feels strange, unfamiliar, or unreal).

**139** ***SWAP-200***

Tends to hold grudges; may dwell on insults or slights for long periods.

**140** ***SWAP-200***

Has a sexual perversion or fetish; rigidly-scripted or highly idiosyncratic conditions must be met before s/he can experience sexual gratification.

**141** ***SWAP-200***

Is extremely identified with a social or political “cause,” to a degree that seems excessive or fanatical.

**142** ***SWAP-200***

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

**143** ***SWAP-200***

Tends to believe s/he can only be appreciated by, or should only associate with, people who are high-status, superior, or otherwise “special.”

**144** ***SWAP-200***

Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential.

**145** ***SWAP-200***

Speech tends to be circumstantial, vague, rambling, digressive, etc.

**146** ***SWAP-200***

Tends to elicit boredom in others (e.g., may talk incessantly, without feeling, or about inconsequential matters).

**147** ***SWAP-200***

Tends to abuse alcohol.

**148** ***SWAP-200***

Has little psychological insight into own motives, behavior, etc.; is unable to consider alternate interpretations of his/her experiences.

**149** ***SWAP-200***

Tends to feel like an outcast or outsider; feels as if s/he does not truly belong.

**150** ***SWAP-200***

Tends to identify with admired others to an exaggerated degree; tends to become an admirer or “disciple” (e.g., may take on the other’s attitudes, beliefs, mannerisms, etc.).

**151** ***SWAP-200***

Appears to experience the past as a series of disjointed or disconnected events; has difficulty giving a coherent account of his/her life story.

**152** ***SWAP-200***

Tends to repress or “forget” distressing events, or to distort memories of distressing events beyond recognition.

**153** ***SWAP-200***

Interpersonal relationships tend to be unstable, chaotic, and rapidly changing.

**154** ***SWAP-200***

Tends to elicit extreme reactions or stir up strong feelings in others.

**155** ***SWAP-200***

Tends to describe experiences in generalities; is unwilling or unable to offer specific details.

**156** ***SWAP-200***

Has a disturbed or distorted body-image; sees self as unattractive, grotesque, disgusting, etc.

**157** ***SWAP-200***

Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning.

**158** ***SWAP-200***

Appears afraid of commitment to a long-term love relationship.

**159** ***SWAP-200***

Tends to deny or disavow own needs for caring, comfort, closeness, etc., or to consider such needs unacceptable.

**160** ***SWAP-200***

Lacks close friendships and relationships.

**161** ***SWAP-200***

Tends to abuse illicit drugs.

**162** ***SWAP-200***

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

**163** ***SWAP-200***

Appears to want to “punish” self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification.

**164** ***SWAP-200***

Tends to be self-righteous or moralistic.

**165** ***SWAP-200***

Tends to distort unacceptable wishes or feelings by transforming them into their opposite (may express excessive concern or affection while showing signs of unacknowledged hostility; disgust about sexual matters while showing signs of interest or exciteme

**166** ***SWAP-200***

Tends to oscillate between undercontrol and overcontrol of needs and impulses (i.e., needs and wishes are expressed impulsively and with little regard for consequences, or else disavowed and permitted virtually no expression).

**167** ***SWAP-200***

Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered).

**168** ***SWAP-200***

Struggles with genuine wishes to kill him/herself.

**169** ***SWAP-200***

Fears becoming like a parent (or parent figure) about whom s/he has strong negative feelings; may go to lengths to avoid or reject attitudes or behaviors associated with that person.

**170** ***SWAP-200***

Tends to be oppositional, contrary, or quick to disagree.

**171** ***SWAP-200***

Appears to fear being alone; may go to great lengths to avoid being alone.

**172** ***SWAP-200***

Experiences a specific sexual dysfunction during sexual intercourse or attempts at intercourse (e.g., inhibited orgasm or vaginismus in females, impotence or premature ejaculation in males).

**173** ***SWAP-200***

Tends to become absorbed in details, often to the point that s/he misses what is significant in the situation.

**174** ***SWAP-200***

Expects self to be “perfect” (e.g., in appearance, achievements, performance, etc.).

**175** ***SWAP-200***

Tends to be conscientious and responsible.

**176** ***SWAP-200***

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, treat the person as an “extension” of him/her

**177** ***SWAP-200***

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.”

**178** ***SWAP-200***

Is preoccupied with the feeling that someone or something has been irretrievably lost (e.g., love, youth, the chance for happiness, etc.).

**179** ***SWAP-200***

Tends to be energetic and outgoing.

**180** ***SWAP-200***

Has trouble making decisions; tends to be indecisive or to vacillate when faced with choices.

**181** ***SWAP-200***

Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.

**182** ***SWAP-200***

Tends to be controlling.

**183** ***SWAP-200***

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

**184** ***SWAP-200***

Verbal statements seem incongruous with accompanying affect, or incongruous with accompanying non-verbal messages.

**185** ***SWAP-200***

Tends to express intense and inappropriate anger, out of proportion to the situation at hand.

**186** ***SWAP-200***

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).

**187** ***SWAP-200***

Tends to feel guilty or ashamed about his/her sexual interests or activities (whether consciously or unconsciously).

**188** ***SWAP-200***

Work life tends to be chaotic or unstable (e.g., working arrangements seem always temporary, transitional, or ill-defined).

**189** ***SWAP-200***

Tends to feel unhappy, depressed, or despondent.

**190** ***SWAP-200***

Appears to feel privileged and entitled; expects preferential treatment.

**191** ***SWAP-200***

Emotions tend to change rapidly and unpredictably.

**192** ***SWAP-200***

Tends to be overly concerned with rules, procedures, order, organization, schedules, etc.

**193** ***SWAP-200***

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

**194** ***SWAP-200***

Tries to manipulate others' emotions to get what s/he wants.

**195** ***SWAP-200***

Tends to be preoccupied with death and dying.

**196** ***SWAP-200***

Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.

**197** ***SWAP-200***

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

**198** ***SWAP-200***

Is not verbally articulate; has limited ability to express self in words.

**199** ***SWAP-200***

Tends to be passive and unassertive.

**200** ***SWAP-200***

Is able to form close and lasting friendships characterized by mutual support and sharing of experiences.