Chapter 31
Empirically Informed Clinical Interviewing for Personality Disorders

Jared A. DeFife and Drew Westen

Keywords Case formulation • Diagnosis • Personality disorders • Shedler–Westen Assessment Procedure (SWAP) • Systematic interview

Introduction

Individuals with diagnosed personality disorders constitute a sizable proportion of patients receiving outpatient psychodynamic therapy [1, 2]. Beyond the DSM-IV diagnosable conditions, personality is still a significant diathesis for psychopathology [3] and plays a predominant role in how patients use and respond to psychotherapy [4, 5]. How can clinicians gather information about personality functioning and psychopathology in a way that is both empirically reliable and clinically sensible?

Here is where we run into the perpetual tension between clinical research and practice. To increase internal validity, researchers seek ways to standardize information under controlled conditions and using replicable protocols. To increase practical utility, practitioners must heed their unique interactions with uniquely individual patients. While researchers need to respect the fact that like snowflakes, no two patients are exactly alike, clinicians need to be aware that like discriminating between a light flurry and a blizzard, personality constellations can be usefully quantified and categorized.

In this chapter, we review the debate around the use of structured clinical diagnostic interviews and clinical observation for the diagnosis of personality disorders. We propose that a systematic clinical interview approach blending an organized approach to functional assessment with the observational methods that clinicians most commonly use in everyday practice can generate reliable and valid information about patient functioning. We start by looking at the costs and benefits of diagnosing personality. Then, we examine the arguments for using a structured diagnostic interview and some of its limitations. Finally, we review an alternative systematic clinical interview approach and demonstrate how it can be used to generate case formulation, facilitate clinical communication, and support the early therapeutic process.

J.A. DeFife, Ph.D. (✉)
Research Scientist, Department of Psychology, Emory University, Atlanta, Georgia, USA
e-mail: jdefife@emory.edu

D. Westen, Ph.D.
Departments of Psychology and Psychiatry and Behavioral Sciences, Emory University, Atlanta, Georgia, USA
e-mail: dwesten@emory.edu

R.A. Levy et al. (eds.), *Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence*, Current Clinical Psychiatry, DOI 10.1007/978-1-60761-792-1_31,

Why Diagnose?

Recently, a group of clinician researchers obtained pilot data from a medical chart review in their psychotherapy clinic. In contrast to research survey findings that Axis II disorders are "among the most frequent disorders treated by psychiatrists" [6, p. 1911] and despite a reasonable sample size, the researchers found zero personality disorder diagnoses recorded. They had stumbled upon a veritable Bermuda Triangle of personality pathology.

So where did all the Axis II patients go? Perhaps the clinic therapists were valiant vanquishers of all interpersonal problems, or, conversely, so poor at managing relational problems that all of their personality disordered patients quickly left treatment. May be selection bias was the culprit, either due to some thorough and draconian clinical screening process or because only the "healthy" patients agreed to participate in the research protocol. Any of these explanations were possible, albeit unlikely. The clinicians were gifted, to be sure, but hardly divine healers. The clinic catered to numerous patients with severe and long-standing social/occupational problems, and no diagnostic screening process was in place other than the weighing of typical factors such as therapist availability and clinical risk management negotiated at most every outpatient facility.

While Axis II pathology had been effectively ruled out in a number of the cases, it appeared that most patients at the clinic had been stricken with a particularly pernicious case of an Axis II disorder known as "deferred." A discussion with the clinicians quickly revealed four major concerns: (1) worries about labeling patients and how they would be treated by later therapists or other health care providers who might access the medical record, as if making an Axis II diagnosis were tantamount to branding one's patient with a diagnostic scarlet letter, (2) fears of a negative therapeutic reaction if a patient found out they had been assigned a personality diagnosis, (3) that not only are Axis II disorders not-billable to managed organization insurance payers, but also scary stories spread about how some patients were actually denied coverage of therapeutic services because their insurance providers deemed personality disorders as "untreatable," and (4) problems with the current DSM-IV diagnostic nosology which did not seem to quite "fit" their patients.

Each of the apprehensions mentioned previously are legitimate and also common [7, 8]. Stories abound of patients glibly dismissed or harshly condemned with diagnostic labels. One therapist was disturbed to receive a referral from a general practitioner rather indecorously describing the patient as a "prattling histrionic." Despite the fact that the wording probably reflected more poorly on the referring physician, the phrase left an indelible mark on the therapist who found it difficult to shake the thought before first meeting with the patient. "The abuse of psychodiagnostic language is thus easily demonstrated," writes McWilliams [7], "that something can be abused, however, is not a legitimate argument for discarding it" (p. 7).

Even put to the best of uses, psychiatric terminology can be inherently pathologizing. The level of visceral reaction to such labels varies by individual and also by certain diagnoses. Some individuals find it better to be labeled as "bipolar" than "borderline" and more people find it easier to see themselves as "avoidant" than "narcissistic." Even the term "personality disorder" seems to connote some archaic insinuations of moral turpitude or characterological weakness. On the other hand, diagnosis can have the opposite effect, normalizing thoughts and feelings that have been regarded as crazy or unusual. The term "borderline," for example, can be demonizing, but collaborative discussions of what borderline personality disorder actually means has left some individuals feeling like others have some framework for understanding their inner turmoil, that they are not alone in their struggles, and that hope exists in the availability of specialized treatments for the disorder.

One of the continuing controversies facing the framers of DSM-5 is in identifying what disorders to include in the revision, which leaves many falsely endowing the manual with special abilities to separate "normal" from "abnormal" behavior. The official naming of a disorder carries massive implications for guiding future research efforts, pharmaceutical development, and health care policy. The fact that some insurance companies discriminate based on the presence of certain diagnostic

conditions does not mean that the best answer to such abuses is to remain silent, acting as if personality disorders do not exist in common clinical practice. Without a standardized diagnostic system for personality disorders, clinicians would be left without a guiding light for treatment evaluation, coordination, and planning while researchers would have no common language for studying personality disorder etiology, impact, and treatment.

A Diagnostic System for Personality Diagnosis

Of course, we are already mostly wandering around in the dark when it comes to our current diagnostic system. Four major criticisms have been posited with the current Axis II model: arbitrary polythetic-categorical criterion sets, within category heterogeneity, co-morbidity, and failure to capture important sub-threshold information of clinical importance [9, 10].

A problem with polythetic-categorical criteria sets**,** where one has to cross an arbitrary threshold of symptom numbers**,** is that they falsely dichotomize a phenomenon that is not generally dichotomous in nature and give credence to quantity over quality of symptomatology. Furthermore, to truly adhere to the DSM-IV diagnostic system means individual decision markers and counting each of 79 distinct diagnostic items. Most therapists do not follow this model to the letter, instead implicitly matching their evaluation of the patient to an internalized model prototype or representation [10]. A dimensional approach to personality diagnosis is advocated for research [11–13] and clinical purposes [14–16], contributing to the likelihood that a dimensional approach will be employed in DSM-5 [17].

Another difficulty with polythetic-categorical criteria sets is the allowance for within-group heterogeneity. Where one person meets five criteria qualifying for diagnosis, another may meet that same diagnostic threshold by meeting criteria for a near entirely different subset of symptoms. For example, where one patient may match the more malignant/exploitative criteria for Narcissistic Personality Disorder without genuine care for others, another could exhibit patterns of grandiosity which serve as defensive protection against feelings of shame and inadequacy. Many personality disorders can be broken down into distinctly observable subtypes [18–21], and even amorphous individual diagnostic criteria such as "identity disturbance" can exhibit multidimensionality [22, 23].

Diagnostic co-morbidity across Axis II disorders is exceedingly high. Kreuger and Bezdjian [9] note that use of the term "co-morbidity" isn't even appropriate to capture the problem as it denotes overlap of two items; they suggest that use of the term "multi-morbidity" may actually be more accurate. A patient meeting diagnostic criteria for a single personality disorder often qualifies for about four to six and the Personality Disorder NOS is used with alarming frequency [2, 6, 24, 25]. At the same time, the majority of patients seen by therapists for personality problems warranting clinical attention are not captured by DSM-IV diagnostic categories [2]. For example, problems with intimacy, chronic fears of abandonment, and work inhibitions might not approach clinical levels of a personality disorder diagnosis, but may all be significant diatheses for depression which are left poorly accounted for in current diagnostic practices. The lack of specificity and comprehensiveness of the existing system muddies the diagnostic waters instead of clarifying them. Not surprising, then, that clinicians find little benefit in applying Axis II description for their patients.

The best current estimation is that DSM-5 will move to some form of dimensional diagnostic system [17]. What the actual content of that system will involve is still unclear, but appears likely to include some form of prototype diagnosis. A prototype matching system would resemble DSM-II's paragraph-long, narrative descriptions of disorders; would be developed through empirical selection of diagnostic criteria that was the goal of DSM-III through DSM-IV; and would involve a dimensional rating system not previously employed in DSM. Using this procedure, clinicians rate the overall similarity or "match" between a patient and the prototype using a 5-point scale, taking the prototype *as a whole* rather than counting a laundry list of individual symptoms (Box 31.1).

Box 31.1 Prototype Diagnosis of Antisocial-Psychopathic Personality Disorder

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

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

Prototype diagnosis is designed to maximize diagnostic accuracy while taking into consideration the cognitive characteristics of human clinicians [26–28]. Rather than memorize symptom lists with arbitrary and variable cutoffs across disorders, diagnosticians can form mental representations of coherent syndromes, in which signs and symptoms may be linked by meaningful functional relations [29]. A prototype diagnostic system demonstrates significant levels of reliability, shows convergent and discriminant validity, and is preferred by clinicians over alternative systems [28, 30–33].

How to Diagnose?

To be useful for clinical practice, diagnostic assessment procedures need to yield information that is reliable across raters, stable (yet sensitive to change), valid, pragmatic, and clinically meaningful. Structured diagnostic interviews such as the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II [34]) or the ICD-10 International Personality Disorders Examination (IPDE [35]) involve asking patients or research participants direct questions about specific diagnostic criteria. While some interviews allow for brief open-ended follow-up questions, these interviews rely on the examinee's explicit endorsement for scoring each criterion.

Structured diagnostic interviews have made possible tremendous advances for systematizing research since their emergence around DSM-III [36–41]. The standardization of the diagnostic process from these interviews is proposed to increase reliability of diagnostic categorization, improve comprehensiveness of clinical assessment, and remove biases from clinicians' judgments. Some suggest that these interviews should be more extensively employed in clinical practice and training [42, 43].

On the other hand, structured interview methods exhibit a number of particular shortcomings when applied to personality disorder diagnosis. While these interviews do purportedly improve reliability issues [43–46], they also demonstrate lower than ideal validity, clinician preference, and clinical utility ratings.

Concordance of structured clinical interviews with other diagnostic standards is modest. Some researchers have compared interview diagnoses against the LEAD-standard (longitudinal expert evaluation using all available data; [47]) for which multiple members of a clinical team with knowledge of the patient from different settings meet to arrive at a consensus diagnosis. Like other methods, the LEAD-standard has limitations, but its advantages are that it assesses behaviors and traits characteristic of patients over time and in various contexts and can reduce the effects of state-dependent responding evident in questionnaire responses on one particular occasion. Comparisons between structured interview and LEAD diagnoses show weak concordance [48, 49]. The two most widely used structured interviews (the SCID-II and the IPDE) show moderate convergence to each other (kappas from 0.14 to 0.66), but less of a relationship with LEAD diagnosis (kappas 0.03–0.60 for the SCID-II, −0.01 to 0.41 for the IPDE, and a median kappa of 0.25 for both measures). Across studies, the median kappa tends to be closer to 0.30 with the median *r* assessing convergence of dimensional diagnoses around 0.40 [50].

Structured personality disorder interviews also show particularly low associations with self-report personality disorder measures [50–54], a finding particularly unusual given that structured interviews ultimately rely on patient reports of their own symptoms and relational patterns. Validity evidence on structured interviews for Axis I and Axis II disorders differs substantially in this respect. SCID diagnoses for Axis I tend to be strongly associated with other interview and self-report measurements [46].

The process by which clinicians actually make personality diagnoses differs substantially from the methods used in structured interviews [55]. Regardless of theoretical orientation, clinicians report that they do not exclusively or even primarily rely on asking direct questions about specific diagnostic criteria (although they certainly do not discount such a method). Table 31.1 illustrates clinicians' perceived importance and reliance on five different methods for diagnosing personality disorders. Instead, clinicians primarily rely on and value their direct observations of the patient both in terms of listening to their patients' narratives of relationships with significant others and observing in-session behaviors and interactions.

Some might suggest that clinicians' preference for and reliance on such unstandardized observations only strengthens the argument for increased implementation of structured diagnostic methods. A recent monograph which drew a significant amount of popular media attention suggested that clinicians are so faulty in their thinking, so caught up in their own biases, and so unscientific in their outlook that only programs with extensive research training should be accredited for practice and that clinicians should be mandated to practice only from detailed treatment manuals that restrict use of

Table 31.1 Clinician ratings of importance and reliance on five methods for diagnosing personality disorders

	Importance rank ($N=30$)		Reliance rating ($N=51$)	
	Mean	SD	Mean	SD
Listening to the way patient describes interactions with significant others	1.20	0.48	1.10	0.41
Observing patient's behavior	1.87	0.57	1.22	0.50
Speaking with significant others	3.63	0.89	5.20	1.52
Asking direct questions derived from DSM-IV	3.37	0.93	5.31	1.71
Administering questionnaires	4.67	0.48	6.51	0.86

Importance ranking is on a 1–5 scale; lower scores indicate a higher ranking. Reliance rating is on a 1–7 scale; lower scores indicate a higher rating

Reproduced with permission from [55]

informed clinical judgment [56]. Clinicians are targeted for blame when moderate statistical relationships between clinician diagnoses and structured interviewer diagnoses appear, although clinicians have paradoxically been implicated for both underdiagnosing a host of disorders while at the same time overpathologizing their patients [43, 57–59]. Most of the findings discussed previously, however, point to significant problems with our current diagnostic system for personality disorders and limitations in the commonly used methods for diagnosing personality disorders. In contrast to the moderate relationships observed between structured diagnostic assessments and patient-report measurements, therapist assessments of adaptive functioning, developmental relationship quality, and social/occupational performance are highly related to patients' ratings of the same variables [60–62].

A further benchmark for evaluating a diagnostic approach involves evaluating its ability to offer clinically meaningful information. Marshall et al. [63] and Suppiger et al. [42] investigated clinician and patient reactions toward implementing structured diagnostic interviews. Both studies found that clinicians rate the interviews as more detrimental to the therapeutic process than do patients, but that structured interviews are actually both acceptable to patients and non-intrusive to the therapeutic process. What the two studies failed to highlight from their findings was how *useful* and *facilitating* the interviews were for patients and therapists. In the Marshall et al. [63] study, patients and therapists rated structured interviews as only "slightly" helpful and facilitative of the therapeutic process. Patients in the Suppiger et al. [42] study rated the structured interviews as highly satisfying and agreed with statements that their interviewers took them seriously and were helpful. However, patients less than slightly agreed that the interviews helped them achieve a better understanding of themselves, and interviewers almost completely agreed that patients saw their problems as more differentiated than the interviews accounted for.

When it comes to the assessment of personality disorders, the most commonly used structured diagnostic interviews fail to demonstrate adequate validity with other measurements of the same constructs, are widely disparate with clinicians' typical and preferred practice methods, and are experienced by patients and therapists as only slightly improving clinical understanding and facilitating therapeutic process. Ironically, a push toward rigidly standardized methods of "evidence-based personality assessment" may have the unintended consequence of moving clinicians further away from effective clinical practice.

Diagnosis Versus Clinical Formulation

The greatest shortcoming in contemporary personality diagnosis is how far removed the process has become from clinical formulation. Whether a diagnostic system is categorical or dimensional, multimorbid or discriminately distinctive, it ultimately offers only a static snapshot of observable behavior.

Diagnostic classification fails to capture a dynamic understanding of how characteristic personality patterns emerge, under which conditions, for what purposes, and to what degree they are employed effectively. In an effort to address shortcomings of existing diagnostic classification systems, psychodynamic researchers and clinicians developed the *Psychodynamic Diagnostic Manual* (PDM [64]) "that attempts to characterize an individual's full range of functioning – the depth as well as the surface of emotional, cognitive, and social patterns" (p. 1). The manual offers a multidimensional approach to nosology assessing for manifest symptom presentation, personality patterns, and level of mental functioning (encompassing capacities such as affect regulation, defensive processes, and the ability to form and maintain interpersonal relationships).

Westen [65, 66] offers an outline of variables essential to measure in a comprehensive formulation of the cognitive, affective, interpersonal, motivational, and behavioral aspects of personality. Presented in Table 31.2, the model is both idiographic and nomothetic, as it identifies individual difference variables and organizes them theoretically, providing a concept of personality structure that accounts for both individual processes as well as it applies across diagnostic groupings of people.

Table 31.2 Domains of personality functioning in a comprehensive personality assessment

I. Psychological resources
   a. Cognitive functions
      1. Intellectual functioning; verbal and nonverbal skills; memory
      2. Cognitive style
      3. Coherence or disorder of thought processes
      4. Expectancies and belief systems
   b. Affective experience
      1. Intensity of affective experience
      2. Variability or lability of affect
      3. Tendency to experience positive and negative affect
      4. Tendency to experience particular affects
      5. Consciousness of affective experience
      6. Capacity for experiencing ambivalent emotions
   c. Affect regulation
      1. Conscious coping strategies
      2. Defenses
      3. Repertoire of affect-regulatory behavior
   d. Behavioral resources
      1. Behavioral skills
      2. Behavioral style

II. Motives
   a. Fears
   b. Wishes
   c. Values
   d. Conflicts among fears, wishes, and values
   e. Consciousness of dominant motives
   f. Notable compromise formations

III. Experience of the self and others and capacity for relatedness
   a. Cognitive structure of representations of self and others
      1. Complexity
      2. Differentiation of different representations from each other
      3. Integration of diverse elements
   b. Affect-tone of relationship schemas; expectations in different types of relationships
   c. Capacity for emotional investment in relationships
      1. Developmental level
      2. Style (e.g., attachment status)
   d. Capacity for investment in values and moral standards
   e. Understanding of social causality
      1. Logic and accuracy
      2. Level of inference (internal motives or external behavior)
   f. Dominant interpersonal concerns: chronically activated interpersonal wishes, fears, and schemas
   g. Management of aggressive impulses
   h. Self-structure
      1. Sense of self-continuity or coherence; sense of self as thinker, feeler, and agent; experience of self as continuous over time
      2. Conscious and unconscious representations
      3. Self-with-other schemas
      4. Self-esteem
      5. Feared, wished-for, ought, and ideal self- representations
      6. Self-presentation
      7. Identity
   i. Social skills and interpersonal behavior

Reproduced with permission of Elsevier from [65]

The model points to three questions to be considered for a comprehensive assessment of an individual's personality. *First, what cognitive, affective, and behavioral resources does the person have at his or her disposal to meet internal and external demands?*

In the cognitive domain, people differ in their intellectual skills, the extent to which they think in global or specific ways, the accuracy and intactness of their thought processes, and the schemas they use to process information. Affectively, people vary in the intensity and lability of their affect states, their tendency to experience various affect states, their consciousness of their emotional experience, and the processes they use to regulate their emotions (notably their conscious coping strategies and unconscious defensive processes). People also differ in their behavioral resources, that is, the skills they possess (such as athletic ability) and their behavioral style (such as extroversion or impulsivity), which is one of the aspects of personality most adequately assessed by self-report trait measures. *The second question regards what motivates the person: What does the person wish for, fear, and value, and to what extent are these motives conscious and mutually compatible?*

Humans differ from many animal species whose actions are rigidly controlled by hypothalamic drive states and midbrain mechanisms that automatically produce behavior under certain eliciting conditions. In humans, instead, the driving forces are more likely to be affects and the cognitive-affective representations that encode feared, wished-for, and valued states (such as those associated with moral or esthetic values) along associative networks. Thus, when a person finds herself in a situation reminiscent of a previously anxiety provoking event, he or she may begin to become anxious, whether or not she is aware of the cause (because associative thought is a form of implicit memory), and try to escape the anxiety by leaving, distracting, etc.

Similarly, a person pursues a romantic relationship with someone because he imagines doing so will feel gratifying in various ways, terminating it when he or she no longer feels that way unless other countervailing motives (such as guilt or fear of aloneness) intervene. Because these motivational processes typically arise in an environment that is only partially planned (for example, by socialization agents in childhood), and because some motives inherently conflict with others (such as wishes to become sexually involved with a friend's spouse if the spouse is attractive and willing – Moses could have saved himself the trouble of picking up the tablets if intrapsychic conflict were avoidable), people will experience conflicts among hundreds or thousands of quasi-independent motivational dynamisms.

Since empirical data have now confirmed Freud's most fundamental hypothesis, that much of mental life is unconscious and that this extends to motivational processes [67–70], the assessment of motives requires a dual assessment of those motives that are conscious and those that are not, as well as of the ways people forge compromises among competing and collaborative motives to maximize their satisfaction (called compromise formations; [71]). *The third question is more interpersonal: What is the person's experience of the self and others and capacity to relate to others in fulfilling and intimate ways?*

For example, how complexly does the person view the self and others, and does the degree of complexity vary under different circumstances [72, 73]? Does the person expect relationships with others to be enriching or dangerous, and does this vary under different circumstances or with different categories of people? To what extent does the person view others as tools to be used for gratification or self-soothing, or as independent others with their own needs and subjectivities with whom one can develop deep intimacy, commitment, and interdependence? (In some respects, this third set of variables is simply a more fine-grained examination of variables addressed in the first two questions as applied to the interpersonal domain, but distinguishing them seems useful, as this domain is so central to human experience and personality).

A fourth question one might add pertains to how each of the variables defined by these questions developed in a given individual; that is, *how specific developmental experiences interacted with temperamental proclivities at different points in the lifespan to create, maintain, or alter personality processes.*

Systematic Clinical Interview

Reframing the diagnostic *process* so that it is maximally useful remains an issue. Because clinician diagnoses are themselves often unreliable, reverting to unstructured clinical observation is not a recommended solution. The diagnostic process needs to retain maximal clinical utility and flexibility while also maintaining degrees of standardization and empirical sensibility. In contrast to a structured diagnostic interview, a *systematic clinical interview* is designed to blend the methods on which clinicians typically rely and value, including observing patients' interactions in the consulting room and listening to their narratives about their lives, while offering a systematic guideline for obtaining information from which to draw inferences about their characteristic behaviors, affective states, conscious coping strategies, emotional regulation processes, cognitive patterns, and implicit/explicit motivations as outlined earlier.

Arguably, the pioneer of this format was Karl Menninger, who stated that the primary task of the examiner is to "collect observations…in some systematic way that will insure orderliness on the one hand, and thoroughness on the other" and that a "psychological examination report (of personality) is made up of a combination of raw data obtained by the examiner, inferences and conclusions from those data, and inferences and conclusions from other data reported either by the patient or by others who have observed him" [74, p. 600]. He believed that the systematic organization of those data relies on either an implicit or explicit theory of personality.

Examples of the theory-driven systematic clinical interview include ones offered in Saul's "The Psychoanalytic Interview" [75] and Anna Freud et al.'s "Metapsychological Assessment of the Adult Personality" [76]. Their models suggested systematic assessment of presenting problems, description of the patient as observed directly by the clinician during the interview, family background, and possible environmental stressors. Their main approaches to the interview, however, focused on theory-driven assessments of drives, ego capacities, regressions and fixations, incompatible drive conflicts, and suitability for analytic process. Harry Stack Sullivan [77] presented the process of detailed inquiry and also highlighted the interpersonal factors present in the psychiatric interview. Nancy McWilliams [7] offers a contemporary example of this diagnostic outline highlighting demographics, presentation, mental status, developmental milestones, current adaptive functioning, and inferences about self and other representations. Similar themes and organization appear across these various forms of psychodynamically informed interviews, and they offer great clinical utility.

We present a similar evaluation format in the Clinical Diagnostic Interview (CDI [78]), available at www.psychsystems.net. Although the CDI includes some direct questions (e.g., about characteristic moods: "Do you often feel sad?"; subclinical thinking disturbances: "Do you ever have strange thoughts or feelings that come into your head, like sensing that another person is in the room, or suddenly seeing images or hearing voices?"; etc.), it does not primarily ask individuals to simply describe their personality characteristics and traits. Rather, it asks them to tell narratives about their lives and relationships which allow for systematic clinical judgments about their characteristic ways of thinking, feeling, regulating emotions, self/other representations, etc. For example, the interview asks "to describe a specific encounter with your mother, something that stands out. It can be an incident that's typical of your relationship, really meaningful, really good, really bad – whatever comes to mind." It is largely a narrative-based interview, eliciting relational narratives that involve family, friends, lovers and co-workers and which requires clinical inferences based on what subjects say, the way they say it, and what they do not say that seems implicit. Furthermore, the systematic interview questions are not organized around the specific diagnostic criteria of the DSM-IV PDs (e.g., direct questions asking whether the patient feels entitled or likes to be the center of attention). Table 31.3 presents the synopsis of CDI queries, forming the basic skeleton of the interview and the script around which interviewers can improvise.

The CDI is available in forms tailored for adult patient, non-patient, adolescent, and forensic populations. In addition to its utility across populations, the interview is designed for clinical or

Table 31.3 Synopsis of questions from the clinical diagnostic interview

1. Could you tell me about yourself and what brought you here?
2. Can you tell me about your childhood – what was it like growing up?
3. Can you tell me about your relationship with your mother? What was (is) she like as a person, and what was she like as a parent? Now I'd like you to describe a specific encounter with your mother, something that stands out. It can be an incident that's typical of your relationship, really meaningful, really good, really bad – whatever comes to mind
4. Could you tell me about your relationship with your father?
5. Do you have brothers and sisters? Could you tell me a little bit about them and your relationships with them? Was there anyone else who was really important to you as a child or teenager?
6. What was school like for you?
7. What were your friendships like when you were a kid, and what are they like now? Who are your closest friends now? Could you tell me about your relationship with one of them – what is it like?
8. Can you tell me about your romantic relationships – what have they been like? Are you currently married or involved with someone? Could you tell me about the relationship? How is your sex life? Are there things that make you uncomfortable sexually, or have led to friction in your relationships? Is there anything about your sexual attitudes or behavior that other people might consider unusual?
9. Could you tell me about your work history? What do you do now, and what have you done before?
10. Do you have children? Can you tell me a little bit about them, and about your relationships with them?
11. Now I'd like you to think of a really difficult, stressful, or upsetting time in the last year or two, and tell me about it
12. Can you tell me about your relationship with your therapist?
13. Now I'd like to finish up with a few more questions about your mental and physical health, and the ways you feel, think, and see yourself
    - (A) Do you often feel sad? Anxious? Ashamed or embarrassed? Guilty? Angry?
    - (B) How about positive feelings, like happiness or pride?
    - (C) Do you ever get overwhelmed by your feelings?
    - (D) Are there times when you try to shut off your feelings entirely, or when you just feel numb?
    - (E) Have you ever had trouble with alcohol or drugs?
    - (F) How does your body hold up under stress? Do you often get sick or have headaches, stomach problems, backaches, etc.? How is your health in general?
    - (G) How do you usually feel about yourself? Do your feelings about yourself change a lot? What do you most like and dislike about yourself?
    - (H) Have you ever hurt yourself, tried to kill yourself, or thought seriously about suicide?
    - (I) Do you ever feel like you don't know who you are, or like the different sides of you don't fit together?
    - (J) Do you ever feel like you're outside your body, or that you're somehow separate from the things around you, like you're looking at them through a pane of glass?
    - (K) Are you a superstitious person? Do you have any beliefs that other people would find unusual? Do you believe in ESP, or believe that people can read other people's minds? Do you ever have strange thoughts or feelings that come into your head, like sensing that another person is in the room, or suddenly seeing images or hearing voices?
15. I've asked you a lot of questions. How has this been? Is there anything we haven't covered that's really important in understanding you as a person? Is there anything else you'd like to add, or anything you'd like to ask?

Reproduced with permission from [78]

research purposes, and can be used to assess both Axis I and Axis II syndromes by applying specific instruments to it such as the SWAP-II [79] or diagnostic prototypes [26, 30, 32, 80].[1] The interview is *systematic* without being clinically *binding*, with open areas for probing as appropriate based on the interviewer's clinical skill, empathy, and hypotheses that emerge over the course of the interview. Also, while the instrument is not theory *neutral*, it is not theory *specific*. By evaluating the

[1] While the CDI offers direct questions about pertinent symptoms and personality problems, it cannot be used to apply DSM-IV diagnostic algorithms for each disorder, which require direct inquiry about the nature, length, and duration of hundreds of symptoms for disorders that may or may not be clinically relevant.

range of cognitive, affective, interpersonal, motivational, and behavioral aspects of personality free of clinical jargon, the interview can be accepted across brands of theoretical orientation. Finally, our lab has conducted empirical reliability and validity evaluations of information obtained from the interview and developed a process for generating detailed clinical case conceptualizations, both of which we detail later in the chapter.

A few studies have assessed the inter-rater reliability and interviewer–therapist validity coefficients on measures rated using information obtained from the CDI.[2] The first used the Affect Regulation and Experiences Q-Sort (AREQ; [81]). The average correlation of AREQ profiles obtained by two clinician-judges observing the same videotaped CDI interview was $r=0.64$ (Spearman–Brown corrected reliability for the average rating of the two raters was $r=0.78$). The average correlation for profiles between the CDI interviewer and the patient's therapist was $r=0.62$.

Two other studies used the CDI [82, 83] for rating the SWAP-200 personality assessment Q-sort [79, 84] and dimensional ratings of DSM-IV personality disorder criteria. 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). Because the items are written in clinical language and describe personality functions (e.g., ways in which the person regulates or fails to regulate impulses, emotions, self-esteem), they can be used to create narrative descriptions of patients in plain clinical language, allowing not only quantitative score profiles but also interpretive reports written in the language of the instrument itself (i.e., without the slippage of meaning that may occur when self-report items are translated into clinical diagnostic constructs; [66, 85, 86]).

Both SWAP ratings and DSM-IV scores from the CDI yielded median convergent inter-rater reliability coefficients at $r=0.81$. Furthermore, convergent validity coefficients between CDI interviewers and therapists were impressively high (SWAP median $r=0.82$; DSM-IV median $r=0.74$). The DSM-IV rating results were particularly telling, as agreement was substantially higher than that typically seen between structured clinical diagnostic interviewers and therapists. Furthermore, adaptive functioning measures such as the DSM-IV Global Assessment of Functioning Scale correlated highly among CDI interviewers and therapists ($rs>0.70$). These results provide convincing support for both the reliability and validity of personality disorder and adaptive functioning information obtained from a systematic clinical interview in contrast to existing structured diagnostic personality interviews.

Case Illustration

To illustrate the comparison of information obtained from a structured diagnostic and systematic clinical interview, we present a brief case illustration. The case is taken from an ongoing multisite investigation comparing alternative dimensional approaches for personality diagnosis. In this study, participants complete both the Structured Clinical Interview for DSM-IV disorders (SCID-I and II) and CDI with separate interviewers. Participants' outpatient psychotherapists also provide clinical data through survey questionnaires and the SWAP-II Q-sort (the latest edition of the SWAP instrument incorporating minor item-level revisions [79]).

[2] Reliability and validity coefficients depend on both the psychometric properties of the instrument used as well as the quality of information obtained from an interview. We present this information in support of the CDI and in the context of the other advantages already described for the systematic clinical interview process.

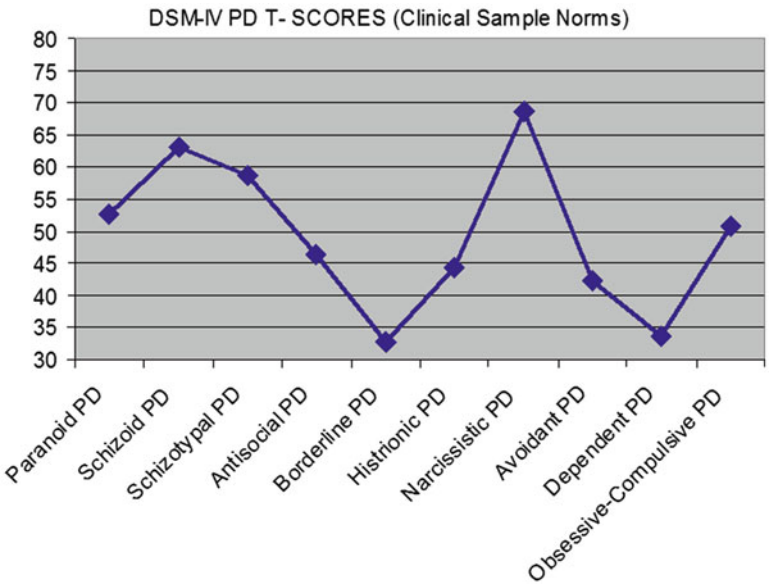

Fig. 31.1 Clinical diagnostic interviewer SWAP-II trait scores

Mr. Y is a 32-year-old single heterosexual Caucasian male seen in weekly individual psychotherapy for a little over 1 year. He has no history of psychiatric hospitalizations or suicide attempts. His therapist reported diagnoses of Adjustment Disorder and Narcissistic Personality Disorder with a GAF score of 55 (indicating moderate symptoms or difficulties in social/occupational functioning).

According to the SCID interviewer, the patient met criteria for Anxiety Disorder NOS and a lifetime history of Anorexia Nervosa (not current). According to the SCID-II, Mr. Y met no more than one criterion for any single Axis II disorder, though the interviewer scored him positively for Personality Disorder NOS.

Mr. Y's SCID-rated GAF score was 80 (indicating that where symptoms are present, they are transient and expectable reactions to interpersonal stressors, with no more than slight impairment in social/occupational functioning).

The Clinical Diagnostic Interviewer completed a SWAP-II scoring for Mr. Y. SWAP-II personality trait and personality disorder scorings are presented in Figs. 31.1 and 31.2. Mr. Y had clinically elevated levels of trait narcissism, emotional avoidance, and eating disturbance, with some prevalent features of psychological health. The SWAP-II's dimensional personality disorder scores indicate a prominent elevation for Narcissistic Personality Disorder, with Schizoid/Schizotypal features. The therapist's SWAP-II trait and personality disorder scores correlated with the CDI interviewer at $r = 0.76$. The CDI interviewer's scores appear to corroborate the therapist's diagnosis of Narcissistic Personality Disorder and indicate eating disturbance problems as reflected in the SCID-I's diagnosis of a prior history of Anorexia Nervosa. Note that both the therapist and CDI interviewer concordantly rate a much greater presence of personality disturbance than is apparent from the SCID-II interviewer. In terms of adaptive functioning, the CDI interviewer's GAF score rating of 62 (mild-to-moderate difficulties) was much closer to the therapist's rating of 55 than to the SCID-II interviewer's rating of 80.

Clearly, the CDI interviewer and therapist were picking up valuable clinical information about Mr. Y's characteristic modes of relating to others through his relational narratives and clinical interactions which were grossly overlooked by the direct questions probing for specific and self-reported symptoms posed in the SCID interview (e.g., "Are you NOT really interested in other people's problems

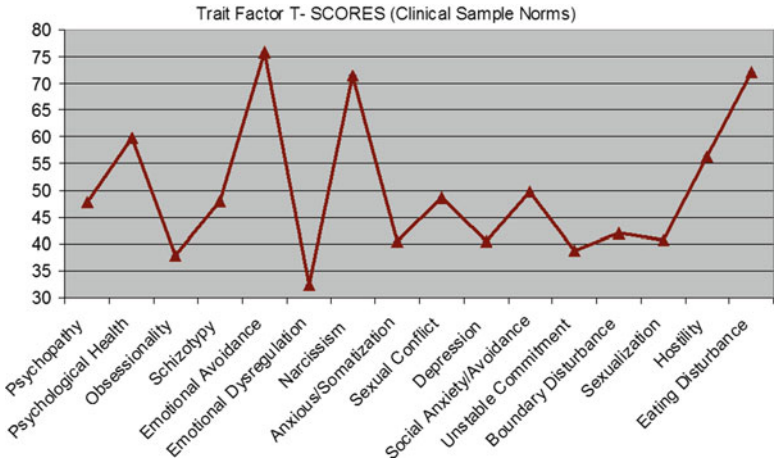

Fig. 31.2 Clinical diagnostic interviewer's SWAP-II ranked DSM-IV personality disorder scores

and feelings?"). The dimensional personality diagnostic system also accounted for gradations among personality disorder features (particularly narcissism and schizoid/emotional avoidance), whereas the SCID-II results in the sufficiently vague categorization of Personality Disorder NOS.

The following two case formulations for Mr. Y compiled from the contrasting interview methods should illustrate the paucity of clinical information obtained from the SCID-II compared to the rich narrative description afforded from the CDI and SWAP ratings.

A composite of all the positively rated SCID-II items shows only that Mr. Y is inhibited in new interpersonal situations because of feelings of inadequacy, complains of being misunderstood and unappreciated by others, shows arrogant or haughty behaviors or attitudes, deliberately destroyed someone else's property before the age of 15, perceives attacks on his character which are not readily apparent to others, and is quick to react angrily or counterattack.

Another narrative description was compiled by listing the SWAP-II items ranked by the Clinical Diagnostic Interviewer in the highest (most descriptive) three categories (categories 5, 6, and 7) of the Q-sort. The items are reprinted near verbatim, with only some minor grammatical changes to aid the flow of the narrative:

Mr. Y's sexual orientation is central to his identity or sense of self. While Mr. Y tends to repress or "forget" distressing events, or distort memories of distressing events beyond recognition, he appears to have come to terms with painful experiences from the past, has found meaning in, and grown from such experiences. He is articulate and is capable of using his talents, abilities, and energy effectively and productively.

He is occasionally liked by others, but lacks close friendships and relationships and assumes the role of an outcast or outsider. He is frequently angry or hostile and feels misunderstood, mistreated, or victimized. Feelings of unhappiness, depression, or despondency are prevalent, and his appearance or manner can seem "off," odd or peculiar.

He seeks to be the center of attention, but is critical of others and appears unable to describe important others in rich and three-dimensional ways. While he has the capacity to recognize alternative viewpoints of others, he seems to have little empathy, as if unable or unwilling to understand or respond to others' needs or feelings.

Mr. Y seems conflicted about authority (e.g., feeling he must submit, rebel against, win over, defeat, etc.) and believes he can only be appreciated by, or should only associate with, people who are high-status, superior, or otherwise "special." Dismissive, haughty, or arrogant, he has an exaggerated sense of self-importance (e.g., feels special, superior, grand, or envied). At times he is able to assert himself effectively and appropriately when necessary, but he frequently gets into power struggles.

Exhibiting a limited or constricted range of emotions, he prefers to see himself as logical, rational, and uninfluenced by emotion. He prefers to operate as if emotions were irrelevant or inconsequential. He tends to think in abstract and intellectualized terms, and is invested in seeing and portraying himself as emotionally strong, untroubled, and emotionally in control, despite clear evidence of underlying insecurity, anxiety, or distress. He appears to have a deep sense of inner badness; sees self as damaged, evil, or rotten to the core. Similarly, he has a disturbed or distorted body-image (e.g., may see self as unattractive, grotesque, disgusting, etc.) and tends to restrict food intake perhaps even to the point of being underweight and malnourished.

Mr. Y's case illustration vividly demonstrates the wealth of clinically useful information obtained from the systematic CDI. The CDI elicited a portrait of Mr. Y that much more closely matched up with the clinical picture observed by his therapist after over a year of their working together. Many of Mr. Y's characteristic modes of relating were overlooked by the SCID. Existing standardized and structured clinical interviews are constrained by their reliance on patient responses to direct questions assessing circumscribed symptoms.

Conclusion

Individuals with personality disorders and subclinical personality problems constitute a large portion of patients seeking psychotherapy. These maladaptive patterns of motivation, cognition, affect regulation, behavior and interpersonal relatedness are integrally related with the diathesis and maintenance of mood, anxiety, impulse, and somatic disorders. Unfortunately, personality conceptualization has been relegated to the backseat of clinical diagnosis (literally as an afterthought to "higher order" Axis I conditions). Clinicians are reluctant to implement the existing personality diagnostic system with its laundry list of symptoms, cumbersome algorithms, and limited clinical utility. Researchers are skeptical of the limitations in the reliability and specificity of Axis II.

Psychodynamic thinkers have a rich history for exploring the foundational roots of personality development and a unique appreciation for the role of personality features in the therapeutic process. However, psychodynamic clinicians and researchers are bereft not only of an empirically sound and clinically useful diagnostic system, but also of a systematic method for eliciting and organizing patient narratives. Structured clinical interviews such as the SCID and IPDE may be helpful for standardizing the diagnostic process, but are ill-favored by clinicians and may overlook a great deal of information about patient functioning which is valuable for informing therapeutic work.

We have presented three approaches to improve the reliability of the diagnostic process while preserving the clinical utility of an in-depth individual case formulation. The outline for a functional personality assessment offers a blueprint of the functional domains (such as cognition, motivation, behavioral controls, modes of relatedness, etc.) necessary to explore in completing a comprehensive and meaningful clinical conceptualization. The systematic CDI provides a roadmap for that exploration by focusing on eliciting an individual's detailed relational narratives, as opposed to the constraints imposed by the current standard structured interviews which focus on direct questioning of discrete psychiatric symptoms. Finally, information obtained from a systematic exploration of relational narratives can be reliably categorized with psychometrically sound methods such as prototype diagnosis and instruments such as the SWAP Q-sort; furthermore, this quantification of interview material need not be divorced from the development of a conceptually rich case formulation.

The use of the CDI embodies the ideals of clinically informed research contributing to empirically informed practice. By studying and incorporating the methods on which clinicians actually rely on everyday (i.e., attention to patient relational narratives and direct behavioral observations in the therapeutic process), the CDI yields information which is psychometrically sound for empirical investigation, diagnostically practical, and clinically meaningful.

References

1. Friedman RC, Bucci W, Christian C, Drucker P, Garrison III WB. Private psychotherapy patients of psychiatrist–psychoanalysts. Am J Psychiatry. 1988;155(12):1772–4.
2. Westen D, Arkowitz-Weste L. Limitations of Axis II in diagnosing personality pathology in clinical practice. Am J Psychiatry. 1998;155:1767–71.
3. Tackett JL, Balsis S, Oltmanns TF, Krueger RF. A unifying perspective on personality pathology across the life span: developmental considerations for the fifth edition of the diagnostic and statistical manual of mental disorders. Dev Psychopathol. 2009;21(Special Issue 03):687–713.
4. Cromer T, Hilsenroth M. Patient personality and outcome in short-term psychodynamic psychotherapy. J Nerv Ment Dis. 2010;198(1):59.
5. Wilczek A, Weinryb R, Gustavsson P, Barber J, Schubert J, Asberg M. Symptoms and character traits in patients selected for long-term psychodynamic psychotherapy. J Psychother Pract Res. 1998;7(1):23.
6. Zimmerman M, Rothschild L, Chelminski I. The prevalence of DSM-IV personality disorders in psychiatric outpatients. Am J Psychiatry. 2005;162(10):1911–8.
7. McWilliams N. Psychoanalytic diagnosis. New York: Guilford; 1994.
8. Westen D. Case formulation and personality diagnosis: two processes or one? In: Barron J, editor. Making diagnosis meaningful. Washington, DC: American Psychological Association; 1998. p. 111–38.
9. Krueger R, Bezdjian S. Enhancing research and treatment of mental disorders with dimensional concepts: toward DSM-V and ICD-11. World Psychiatry. 2009;8(1):3–6.
10. Shedler J, Westen D. Refining personality disorder diagnoses: integrating science and practice. Am J Psychiatry. 2004;161:1350–65.
11. Brown T, Barlow D. Dimensional versus categorical classification of mental disorders in the fifth edition of the diagnostic and statistical manual of mental disorders and beyond: comment on the special section. J Abnorm Psychol. 2005;114(4):551.
12. Krueger R, Skodol A, Livesley W, Shrout P, Huang Y. Synthesizing dimensional and categorical approaches to personality disorders: refining the research agenda for DSM-V Axis II. Int J Methods Psychiatr Res. 2007;16(1):65.
13. Kupfer DJ, First MB, Regier DA, editors. A research agenda for DSM-V. Washington, DC: American Psychiatric Association; 2002.
14. Rottman B, Ahn W, Sanislow C, Kim N. Can clinicians recognize DSM-IV personality disorders from five-factor model descriptions of patient cases? Am J Psychiatry. 2009;166(4):427.
15. Skodol AE, Oldham JM, Bender DS, Dyck IR, Stout RL, Morey LC, et al. Dimensional representations of DSM-IV personality disorders: relationships to functional impairment. Am J Psychiatry. 2005;162(10):1919–25.
16. Spitzer RL, First MB, Skodol AE. Clinical acceptability of five dimensional systems for personality diagnosis: a pilot study. Unpublished manuscript. Department of Psychiatry, Columbia University; 2006.
17. Skodol A, Bender D. The future of personality disorders in DSM-V? Am J Psychiatry. 2009;166(4):388–91.
18. Blagov P, Westen D. Questioning the coherence of histrionic personality disorder: borderline and hysterical personality subtypes in adults and adolescents. J Nerv Ment Dis. 2008;196(11):785.
19. Bradley R, Zittel C, Westen D. Borderline personality disorder in adolescence: phenomenology and subtypes. J Child Psychol Psychiatry. 2005;46:1006–19.
20. Hicks BM, Markon KE, Patrick CJ, Krueger RF, Newman JP. Identifying psychopathy subtypes on the basis of personality structure. Psychol Assess. 2004;16(3):276–88.
21. Russ E, Bradley R, Shedler J, Westen D. Refining the narcissistic diagnosis: defining criteria, subtypes, and endophenotypes. Unpublished manuscript. Emory University; 2005.
22. Westen D, Betan E, DeFife JA. Identity disturbance in adolescence: Associations with borderline personality disorder. Development and Psychopathology. 2011;23(1):305–13.
23. Wilkinson-Ryan T, Westen D. Identity disturbance in borderline personality disorder: an empirical investigation. Am J Psychiatry. 2000;157:528–41.
24. Amies P. Psychotherapy patients: are they“ the worried well”? Psychiatr Bull. 1996;20(3):153–6.
25. First M. Mutually exclusive versus co-occurring diagnostic categories: the challenge of diagnostic comorbidity. Psychopathology. 2005;38:206–10.
26. Westen D, Bradley R. Prototype diagnosis of personality. In: Strack S, editor. Handbook of personology and psychopathology. New York: Wiley; 2005. p. 238–56.
27. Westen D, Heim AK, Morrison K, Patterson M, Campbell L. Classifying and diagnosing psychopathology: a prototype matching approach. In: Beutler L, Malik M, editors. Rethinking the DSM: psychological perspectives. Washington, DC: APA; 2002. p. 221–50.
28. Westen D, Shedler J. A prototype matching approach to diagnosing personality disorders toward DSM-V. J Pers Disord. 2000;14:109–26.

29. Ahn W. Effect of causal structure on category construction. Mem Cognit. 1999;27(6):1008–23.
30. Ortigo KM, Bradley B, Westen D. An empirically based prototype diagnostic system for DSM-V and ICD-11. In: Millon T, Krueger R, Simonsen E, editors. Contemporary directions in psychopathology: scientific foundations of the DSM-V and ICD-11. New York: Guilford; 2010. p. 374–90.
31. Spitzer R, First M, Shedler J, Westen D, Skodol A. Clinical utility of five dimensional systems for personality diagnosis: a "consumer preference" study. J Nerv Ment Dis. 2008;196:356–74.
32. Westen D, DeFife JA, Bradley B, Hilsenroth MJ. Prototype personality diagnosis in clinical practice: A viable alternative for DSM-5 and ICD-11. Professional Psychology: Research and Practice. 2010;41(6):482–87.
33. Westen D, Heim A, Morrison K, Patterson M, Campbell L. Simplifying diagnosis using a prototype-matching approach: implications for the next edition of the DSM. In: Beutler LE, Malik ML, editors. Rethinking the DSM: a psychological perspective. Washington, DC: American Psychological Association; 2002. p. 221–50.
34. First MB, Spitzer RL, Gibbon M, Williams JBW. Structured clinical interview for DSM-IV personality disorders (SCID-II). Washington, DC: American Psychiatric; 1997.
35. Loranger AW, Janca A, Sartorius N, editors. Assessment and diagnosis of personality disorders: The ICD-10 international personality disorder examination (IPDE). Cambridge, UK: Cambridge University; 1997.
36. First MB, Spitzer RL, Gibbon M, Williams JBW, Davies M, Borus J, et al. The structured clinical interview for DSM-III-R (SCID). Part II: Multi-site test-retest reliability study. J Pers Disord. 1995;9:92–104.
37. Gibbon M, Spitzer R, Williams J, Benjamin L. Structured clinical interview for DSM-IV axis II personality disorders: SCID-II. Washington, DC: American Psychiatric Publishing; 1997.
38. Gunderson JG, Kolb JE, Austin V. The diagnostic interview for borderline patients. Am J Psychiatry. 1981;138:896–903.
39. Loranger A, Susman VL, Oldham JM, Russakoff M. Personality disorders examination (PDE) manual. Yonkers: DV Communications; 1998.
40. Pfohl B, Blum N, Zimmerman M. Structured interview for DSM-IV personality. Washington, DC: American Psychiatric Press; 1997.
41. Zanarini MC, Frankenberg F, Chauncey D, Gunderson JG. The diagnostic interview of personality disorders: interrater and test-retest reliability. Compr Psychiatry. 1987;28:467–80.
42. Suppiger A, In-Albon T, Hendriksen S, Hermann E, Margraf J, Schneider S. Acceptance of structured diagnostic interviews for mental disorders in clinical practice and research settings. Behav Ther. 2009;40(3):272–9.
43. Wood JM, Garb HN, Lilienfeld SO, Nezworski M. Clinical assessment. Annu Rev Psychol. 2002;53:519–43.
44. Farmer R, Chapman A. Evaluation of DSM-IV personality disorder criteria as assessed by the structured clinical interview for DSM-IV personality disorders. Compr Psychiatry. 2002;43(4):285–300.
45. Rogers R. Handbook of diagnostic and structured interviewing. New York: Guilford Press; 2001.
46. Rogers R. Standardizing DSM-IV diagnoses: the clinical applications of structured interviews. J Pers Assess. 2003;81(3):220–5.
47. Spitzer RL. Psychiatric diagnosis: are clinicians still necessary? Compr Psychiatry. 1983;24:399–411.
48. Pilkonis PA, Heape CL, Proietti JM, Clark SW, McDavid JD, Pitts TE. The reliability and validity of two structured diagnostic interviews for personality disorders. Arch Gen Psychiatry. 1995;52:1025–33.
49. Skodol AE, Oldham JM, Rosnick L, Kellman D, Hyler S. Diagnosis of DSM-III-R personality disorders: a comparison of two structured interviews. Int J Methods Psychiatr Res. 1991;1:13–26.
50. Clark LA, Livesley WJ, Morey L. Personality disorder assessment: the challenge of construct validity. J Pers Disord. 1997;11:205–31.
51. Barber JP, Morse JQ. Validation of the Wisconsin personality disorders inventory with the SCID-II and PDE. J Pers Disord. 1994;8:307–19.
52. Hills HA. Diagnosing personality disorders: an examination of the MMPI-2 and MCMI-II. J Pers Assess. 1995;65: 21–37.
53. Hyler SE, Skodol AE, Kellman HD, Oldham JM, Rosnick L. Validity of the personality diagnostic questionnaire-revised: comparison with two structured interviews. Am J Psychiatry. 1990;147:1043–8.
54. Renneberg B, Chambless DL, Dowdall DJ, Fauerbach JA, Gracely EJ. The structures clinical interview for DSM-III-R, Axis II and the Millon Clinical Multiaxial Inventory: a concurrent validity study of personality disorders among anxious outpatients. J Pers Disord. 1992;6:117–24.
55. Westen D. Divergences between clinical and research methods for assessing personality disorders; implications for research and the evolution of Axis II. Am J Psychiatry. 1997;154:895–903.
56. Baker TB, McFall RM, Shoham V. Current status and future prospects of clinical psychology: toward a scientifically principled approach to mental and behavioral health care. Psychol Sci Public Interest. 2009;9(2):67–103.
57. Garb HN. Studying the clinician: judgment research and psychological assessment. Washington, DC: American Psychological Association; 1998.
58. Hansen S, Munk-Jørgensen P, Guldbaek B, Solgård T, Lauszus K, Albrechtsen N, et al. Psychoactive substance use diagnoses among psychiatric in-patients. Acta Psychiatr Scand. 2000;102(6):432–8.

59. Zimmerman M, Mattia JI. Axis I diagnostic comorbidity and borderline personality disorder. Compr Psychiatry. 1999;40(4):245–52.
60. DeFife JA, Drill R, Nakash O, Westen D. Agreement between clinician and patient ratings of adaptive functioning and developmental history. American Journal of Psychiatry. 2010;167(12):1472–78.
61. Hilsenroth MJ, Ackerman SJ, Blagys MD, Baumann BD, Baity MR, Smith SR, et al. Reliability and validity of DSM-IV axis V. Am J Psychiatry. 2000;157(11):1858–63.
62. Hilsenroth MJ, Baity MR, Mooney MA, Meyer GJ. DSM-IV major depressive episode criteria: an evaluation of reliability and validity across three different rating methods. Int J Psychiatry Clin Pract. 2004;8(1):3–10.
63. Marshall R, Spitzer R, Vaughan S, Vaughan R, Mellman L, MacKinnon R, et al. Assessing the subjective experience of being a participant in psychiatric research. Am J Psychiatry. 2001;158(2):319.
64. Psychodynamic Diagnostic Manual Task Force, editor. Psychodynamic diagnostic manual. Silver Spring: Alliance of Psychoanalytic Organizations; 2006.
65. Westen D. A model and a method for uncovering the nomothetic from the idiographic: an alternative to the five-factor model? J Res Pers. 1996;30:400–13.
66. Westen D, Gabbard GO, Blagov P. Back to the future: personality structure as a context for psychopathology. In: Krueger RF, Tackett JL, editors. Personality and Psychopathology. New York: Guilford; 2006.
67. Bargh J, Chartrand T. The unbearable automaticity of being. Am Psychol. 1999;54(7):462–79.
68. McClelland DC, Koestner R, Weinberger J. How do self-attributed and implicit motives differ? Psychol Rev. 1989;96:690–702.
69. Shedler J, Mayman M, Manis M. The illusion of mental health. Am Psychol. 2003;48:1117–31.
70. Westen D. The scientific status of unconscious processes: is Freud really dead? J Am Psychoanal Assoc. 1999;47:1061–106.
71. Brenner C. The mind in conflict. New York: International Universities Press; 1982.
72. Leigh J, Westen D, Barends A, Mendel MJ, Byers S. The assessment of complexity of representations of people using TAT and interview data. J Pers. 1992;60(4):809–37.
73. Woike B, Aronoff J. Antecedents of complex social cognitions. J Pers Soc Psychol. 1992;63(1):97–104.
74. Menninger K. Recording the findings of the psychological examination ("mental status"). Am J Psychiatry. 1952;108(8):600–9.
75. Saul L. The psychoanalytic diagnostic interview. Psychoanal Q. 1957;26:76–90.
76. Freud A, Nagera H, Freud W. Metapsychological assessment of the adult personality – the adult profile. Psychoanal Study Child. 1965;20:9–41 [PEP Web].
77. Sullivan H, Perry H, Gawel M. The psychiatric interview. New York: WW Norton; 1970.
78. Westen D. Clinical diagnostic interview. Emory University. Unpublished manual. www.psychsystems.net/; 2004.
79. Westen D, Shedler J. Personality diagnosis with the Shedler–Westen assessment procedure (SWAP): integrating clinical and statistical measurement and prediction. J Abnorm Psychol. 2007;116:810–22.
80. Westen D, Shedler J, Bradley R. A prototype approach to personality diagnosis. Am J Psychiatry. 2006;163:838–48.
81. Westen D, Muderrisoglu S, Fowler C, Shedle J, Koren D. Affect regulation and affective experience: individual differences, group differences, and measurement using a Q-sort procedure. J Consult Clin Psychol. 1997;65:429–39.
82. Westen D, Muderrisoglu S. Reliability and validity of personality disorder assessment using a systematic clinical interview: evaluating an alternative to structured interviews. J Pers Disord. 2003;17:350–68.
83. Westen D, Muderrisoglu S. Clinical assessment of pathological personality traits. Am J Psychiatry. 2006;163:1285–7.
84. Shedler J, Westen D. Refining the measurement of Axis II: a Q-sort procedure for assessing personality pathology. Assessment. 1998;5:333–53.
85. Lingiardi V, Shedler J, Gazzillo F. Assessing personality change in psychotherapy with the SWAP–200: a case study. J Pers Assess. 2006;86(1):23–32.
86. Shedler J, Westen D. The Shedler–Westen assessment procedure (SWAP): making personality diagnosis clinically meaningful. J Pers Assess. 2007;89(1):41–55.