PERSONALITY SUBTYPES OF INDIVIDUALS WITH TRAUMATIC CHILDHOOD SEPARATIONS FROM ATTACHMENT FIGURES

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ABSTRACT

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The goal of this research (composed of three studies) was to examine personality characteristics and identify personality subtypes of adolescents and adults with childhood histories of traumatic separations from a parent. Previous work from attachment theory and developmental psychopathology suggest that distinct developmental trajectories may lead to different styles of personality adaptation in both adults and adolescents with a history of attachment disruption. Randomly selected psychologists and psychiatrists provided data on 236 adolescents and 201 adults with histories of traumatic separations using a personality pathology instrument designed for use by clinically experienced observers, the Shedler-Westen Assessment Procedure (SWAP-II and SWAP-II-A). Using a Q factor analysis, five distinct personality subtypes were identified in both the adolescent and adult sample (Studies 1 and 2). Subtypes common to both adults and adolescents included: *internalizing/avoidant, psychopathic*, and *resilient*. The adult sample included an *emotionally dysregulated* subtype, while within the adolescent sample two subtypes characterized by emotional dysregulation emerged: *impulsive dysregulated* and *immature dysregulated.* Finally, within the adult sample, a *hostile/paranoid* subtype was identified. In Study 3, initial support for the validity of the subtypes was established based on Axis I and Axis II pathology, adaptive functioning, developmental history, and family history variables. The clinical implications of these findings are discussed in terms of treatment and case formulation.

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TABLE OF CONTENTS

LIST OF TABLES

Review of the Literature

Introduction

During childhood, a traumatic separation from an attachment figure (i.e., primary caregiver) can leave a child feeling frightened, helpless, and without the physical and emotional resources to care for him or herself. The study of traumatic separations as a form of attachment disruption has been of heightened interest during periods of pervasive societal crisis. For example, during World War II, Anna Freud and Dorothy Burlingham documented the "despair" of children separated from their parents (Freud & Burlingham, 1943, 1974). Later in the twentieth century, researchers began studying the developmental trajectories of children placed in Romanian orphanages under the Ceaucesku regime (O'Connor, Bredenkamp, Rutter, & The English and Romanian Adoptees Study Team, 1999; Zeanah, Smyke, Koga, & Carlson, 2005). More recently, research has focused on children growing up in the American foster care system with regards to biopsychosocial functioning (Dozier, Lindhiem, & Ackerman, 2005; Dozier et al., 2006; Stovall & Dozier, 1998).

Findings across these studies reveal a diversity of outcomes following the experience of a traumatic separation. Research suggests that the attachment disruption itself leads to a set of changes that may be independent or interrelated at different levels, including changes in the HPA axis (Dozier et al., 2006; Meinlschmidt & Heim, 2005), internalizing pathology (Heim & Nemeroff, 1999; Heim & Nemeroff, 2001; Vorria, Rutter, & Pickles, 1998a), externalizing pathology (Kendler et al., 1996; Kendler, Sheth, Gardner, & Prescott, 2002; Vorria et al., 1998a), and dissociative symptomatology (Kobak, Little, Race, & Acosta, 2001). In addition, attachment disruptions are associated

with indiscriminate affiliation in children and insecure and disorganized forms of attachment (Chisholm, 1998; Chisholm, Carter, Ames, & Morison, 1995; O'Connor, Rutter, & The English and Romanian Adoptees Study Team, 2000; O'Connor et al., 1999; Scharf, 2001; Zeanah, Smyke, & Dumitrescu, 2002; Zeanah et al., 2005).

It is likely that this wide range of biological, psychological, and social outcomes associated with traumatic separations are not associated with only one personality profile, particularly given that variables such as internalizing and externalizing pathology themselves are generally thought of as personality variables (often called negative affectivity or neuroticism, and low conscientiousness or constraint, respectively). The minimal amount of research assessing personality in this population suggests that traumatic separations are associated with Borderline and Avoidant personality disorders (PD) (Arbel & Stravynski, 1991; Bradley, 1979; Reich & Zanarini, 2001). Each of these studies considered just one PD, and thus did not account for the range of personality profiles that might be associated, in part, with the experience of the traumatic separation. In addition, research suggests that the PDs currently found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 2000) may not adequately represent a full range of personality pathology (i.e., disordered personality). A number of studies have found that personality pathology is often assessed in clinical settings but may or may not lead to a PD diagnosis for a variety of reasons, including the fact that most personality pathology is subthreshold and that most patients identified in research with a PD receive the nondescript diagnosis of PD Not Otherwise Specified (Morey et al., 2007; Westen & Arkowitz-Westen, 1998; Widiger & Trull, 2007).

Given the wide range of outcomes associated with traumatic childhood separations from attachment figures, the present study sought to identify personality subtypes, including, if present, both normal and pathological variants, of adult and adolescent patients who experienced traumatic separations in childhood. Knowledge of personality subtypes may be crucial in addressing the specific needs and experiences of such individuals within clinical setting.

Attachment theory and research provide an overarching framework for understanding the significance of traumatic separation for personality development. Therefore an overview of the attachment theory, its significance for the creation of persistent relational schemas (i.e., Internal Working Models), and the role of attachment in regulating affect is provided. However, traumatic separations have ramifications not only for attachment classification but also for personality as a whole. They lead to a range of developmental pathways likely due to genes, environments, and gene environment interactions (Caspi, Roberts, & Shiner, 2005). While the extant research suggests that there is heterogeneity in the way people's personality is affected by disrupted attachment, that heterogeneity is likely to be patterned, not random, because there are going to be some characteristic ways (e.g., turning into a psychopath, becoming self-loathing and depressed, or somehow managing to be resilient despite it) that are common to different groups of survivors. It was expected that some of these patterns would be common to adults, whereas some may be distinct to adolescents or adults.

In this research, personality was assessed using a psychometric instrument designed for clinically experienced observers, which encompasses both pathological and non-pathological personality characteristics and hence can identify both pathology and

resilience. After seeking to identify these subtypes empirically, external and predictive validity were considered using *a priori* hypotheses regarding psychopathology, adaptive functioning, developmental history, and family history variables that were expected to distinguish a valid classification (Robins and Guze, 1970).

Theoretical Background

Attachment theory emphasizes the importance of the parent child relationship for later healthy psychological development. Interactions between the attachment figure and infant result in the infant's development of Internal Working Models (IWMs) or representations of self and other relating to the expression of personality (Bowlby, 1969). Functioning as unconscious schemas, IWMs serve as relatively stable templates for expectations about relationships. Thus, an early caregiving relationship characterized by instability, neglect, or abuse could lead the child to develop negative feelings about him- or herself and to expect negative treatment from others (George, 1996; Lyons-Ruth & Jacobvitz, 1999).

Ethological and psychoanalytic theory influenced Bowlby's development of attachment theory (Bowlby, 1969, 1973, 1980). Bowlby was interested in substantiating his theory through the use of observable phenomena. Bowlby (1969) argued that natural selection favored proximity maintaining behaviors in young children that fostered both their survival and learning. In further work he chose to focus on separations, loss, and threats of abandonment because these events have readily observable effects, can be observed in other species, and are so pervasive that understanding their effects would be immediately useful in clinical settings (Bowlby, 1973).

Relevant to the study of traumatic separations, attachment theory has stressed the importance of both proximity and autonomy in development (Bowlby, 1988; Slade & Aber, 1992). As the child develops autonomy, he or she can use the parent as a "secure base" to return to after exploring the environment. Therefore the consistent presence of the parent grants opportunities for both exploration and reunion. This idea developed in part out of the psychoanalytic work of Margaret Mahler who theorized that as part of normative development children practice both pushing the parent away and pulling the parent close, in a sense rehearsing the experience of separation, which later develops into autonomy and individuation (Bretherton, 1987; Fonagy, 2001).

Ainsworth developed an observational lab paradigm called the Strange Situation and was able to identify three different attachment strategies utilized by children to connect with their attachment figures (Ainsworth, Blehar, Waters, & Wall, 1978). In the Strange Situation the child faces a series of separations and reunions with a caregiver. The behaviors that children display during these reunions represent their view or IWM of the relationship (Main, Kaplan, & Cassidy, 1985). *Securely* attached children show mutual responsiveness and pleasure with the caregiver, and effective use of proximity maintaining behaviors. *Insecure avoidant* children appear disinterested and exhibit neutral behavior towards the parent. The parent child interactions appear impersonal and unemotional. *Insecure ambivalent* children use whiny attempts to gain attention, reflecting resistance and fear. Patterns of interactions with the primary caregiver lead to expectations regarding both how they will be responded to, and how they will respond to others. IWMs of self and other serve as a mechanism for dealing with stress in the world,

whether through emotion, cognition, or behavior (Easterbrooks, Davidson, & Chazan, 1993).

The initial three classifications of the Strange Situation paradigm (Avoidant, Secure, and Ambivalent) were later expanded in order to explain contradictory behaviors that were seen in some infants indicating the absence of a coherent attachment strategy (e.g. running to a caregiver but then turning away when the caregiver approaches, freezing behaviors, or the mixing of different strategies) (Main & Solomon, 1990). These behaviors reflect what is now called *disorganized* attachment. Main and Hesse (1990) hypothesized that disorganized attachment originates in the frightening or frightened behavior of the primary caregiver. The presence of disorganized attachment reflects more than mere parental insensitivity, instead indicating either maltreatment or frightening behavior (e.g. traumatic separation or loss) (van Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). While the focus of this study is not on the classifications of attachment, researchers report that in response to an attachment disruption, a child will typically develop either an insecure or disorganized attachment pattern (Kobak, 1999; Nakash-Eisikovits, Dutra, & Westen, 2002; Solomon & George, 1999).

Research considering attachment in adults and adolescents often uses the Adult Attachment Interview (AAI). The AAI is used to classify four states of mind regarding attachment to early primary caregivers. It relies on outside coders to identify processes, which its developers believed to be outside of conscious awareness (Hesse, 1999). Narratives of *Secure/autonomous* individuals are coherent, demonstrating a balanced view of attachment experiences. The narratives of *Dismissing* individuals tend to be incoherent, contradictory, and overly normalize negative attachment experiences.

Narratives of *Preoccupied* individuals are characterized as incoherent with a view of the past that is angry, fearful, or passive. Finally, individuals given the qualifier *Unresolved* (which may be used with any of the primary three descriptors but is generally associated with insecure forms of attachment) demonstrate lapses of reasoning around experiences of loss or abuse (Hesse, 1999). Some researchers have found that adult attachment strategies may be relevant for understanding personality pathology (Fonagy et al., 1996; Westen, Nakash, Cannon, & Bradley, 2006). Importantly, the *Unresolved* classification relates specifically to the experience of attachment disruptions.

Developmental Pathways to Personality Subtypes: The Mediating Role of Internal Working Models

Bowlby (1973) himself emphasized the relevance of attachment disruptions to personality development. He described "homeorhetic pressures" (i.e., environmental and constitutional factors) that help maintain an expected developmental pathway even in the presence of minor disruptions. However, lengthy or recurring periods of separation, or the experience of loss may not only temporarily divert personality development from an optimal path, but may also lead to an entirely different path of development. Therefore Bowlby conceptualized traumatic separations as influencing not only IWMs but also having additional consequences for personality as a whole.

In addition, Bowlby (1973) noted that personality characteristics that are adaptive in one environment might be maladaptive in another. He even hypothesized that certain attachment strategies in early childhood would relate to certain personality styles later in life. He theorized that the anxious-ambivalent attachment strategy would relate to a personality style that was clingy, anxious, and demanding. In contrast, the anxious-

avoidant attachment strategy was hypothesized to relate to a personality style that lacked warmth and connectedness within interpersonal relationships. Research studying attachment and personality has largely borne out these hypotheses (Crawford et al., 2006; Kobak & Sceery, 1988; Nakash-Eisikovits et al., 2002; Westen, Nakash et al., 2006).

Personality pathology can also be viewed as a set of phenotypes resulting from environmental experiences (e.g., attachment disruptions) that moderate gene expression (Caspi et al., 2005). Individuals are born with temperamental traits influenced by their genotype, and the expression of these predispositions is modified by environmental factors (e.g., teratogens, relationships, poverty, etc.), which in turn produces behavior that creates different environmental experiences, such as exposure to delinquent peers. This widely held view is supported by research considering gene-environment interactions in which differences in sensitivity to environmental factors are based on allelic variation (Shiner & Caspi, 2003).

While some IWMs represent the overactivation of the attachment system (e.g., ambivalent or preoccupied IWMs), others suggest that the attachment system is down-regulated (e.g., avoidant or dismissing IWMs). Both of these responses may be adaptive to a given context in childhood but then become ineffective as the child develops into adolescence and adulthood, leaving their original family context (Fischer et al., 1997). For example, an overactivated attachment system develops when the infant learns that the caregiver responds most positively when he or she overuses normative proximity maintaining behaviors (e.g., crying, clinging, calling) (Mikulincer & Shaver, 2008). In contrast, the down-regulated attachment system develops when the infant learns that the caregiver is likely to respond negatively or even withdraw when he or she exhibits

normative proximity seeking behaviors. This results in the less frequent use of such behaviors, because they are ineffective and are associated with an undesired outcome. Emerging research suggests that the IWMs most chronically accessed across development are likely to form one of the stable aspects of personality (Mikulincer & Horesh, 1999; Mikulincer & Shaver, 2006; Shaver & Mikulincer, 2005). Therefore, IWMs likely mediate the experience of the traumatic separations and later outcomes of personality.

Understanding Personality Pathology: Moving towards a Dimensional Approach

With the understanding that traumatic separations have consequences for the developing personality, but that not all people respond to the experience in the same way due to genes, environments, and gene-environment interactions, personality outcomes were expected to be heterogeneous. Therefore, personality subtypes would be useful in organizing the diversity of clinical presentations. In order to assess personality, it was necessary to find an approach that would adequately represent the nuance of personality found in clinical practice. In addition, personality needed to be assessed in a way that was inclusive of resilient outcomes. Recent research has suggested that in clinical settings personality pathology may best be assessed using a dimensional approach, rather than the categorical approach found in the DSM-IV. Here, personality pathology refers to clinically relevant personality problems that may or may not result in a DSM-IV Axis II PD diagnosis. The necessity for personality pathology (i.e., disordered personality) to have a broader definition than the PDs listed in the DSM-IV will be described in the following section, which briefly reviews some of the identified shortcomings of the

categorical approach. This is followed by a brief description of two dimensional approaches to assessing personality and personality pathology: the Five Factor Model (FFM) and the Shedler Westen Assessment Procedure (SWAP).

A Categorical Approach: DSM-IV

The current method of diagnosing PDs found in the DSM-IV relies on a categorical approach in which individuals meet cut-offs for certain disorders. The DSM-IV is a multi-axial diagnostic system, on which PDs are listed on Axis II due to their more pervasive nature, as opposed to other forms of psychopathology, which are assumed to be more transient. The DSM-IV PDs are divided into three clusters: Cluster A (Paranoid, Schizoid, Schizotypal) refers to individuals who appear "odd or eccentric"; Cluster B (Antisocial, Borderline, Histrionic, and Narcissistic) refers to individuals who are "dramatic, emotional, and erratic"; Cluster C (Avoidant, Dependent, and Obsessive-Compulsive) refers to individuals who appear "anxious and fearful." The DSM-IV provides a syndromal approach to considering personality pathology, which means that each disorder is viewed as being composed of constellation of personality characteristics that are interrelated (Westen & Shedler, 2007).

Problems with the current DSM-IV approach to diagnosing PDs include the lack of adequate empirical support, arbitrary symptom cutoffs, and the use of a categorical approach that may insufficiently represent the construct of personality pathology, which might be better understood dimensionally (Leibing, Jamrozinski, Vormfelde, Stahl, & Doering, 2008; Morey et al., 2007; Widiger & Trull, 2007). Another problematic aspect of the current DSM-IV is that the categorical approach may fail to address personality attributes and psychopathology that are clinically relevant but not severe enough to result

in Axis II diagnosis. This problem would be better addressed with a dimensional approach to understanding personality pathology. Westen and Arkowitz-Westen (1998) found that of a sample of 714 patients who were being treated for personality problems (defined as "enduring maladaptive patterns of thought, feeling, motivation, and behavior"), only 34% actually met criteria for an actual PD, as outlined in the current DSM-IV. These problematic aspects with the current categorical approach have led to the investigation of dimensional approaches to assessing personality pathology in clinical settings.

Dimensional Approaches

The Five Factor Model. Originally developed to assess normative personality, the Five Factor Model (FFM) of personality has recently been utilized to assess personality pathology (Samuel & Widiger, 2006; Widiger & Trull, 2007). Such research suggests that the FFM and its facets would provide a dimensional approach to assessing personality pathology that would account for differences across PDs as well as reasons that the current PDs show high comorbidity (Lynam & Widiger, 2001). The five factors, including Extraversion, Agreeableness, Conscientiousness, Neuroticism, and Openness to new experiences, were derived from a lexical analysis without regard to theory or etiology. Some additional research has applied the FFM to understanding adolescent PDs with results indicating that the presence of PDs was associated with increased levels of Neuroticism and decreased levels of Agreeableness, Conscientiousness, Extraversion, and Openness (De Clercq & De Fruyt, 2003).

While the FFM has been identified as a potentially useful method of personality assessment in clinical settings, others have suggested that FFM alone may not be

sufficient in itself for understanding personality in such samples (Laverdière et al., 2007; Morey et al., 2007). For example, Laverdiére and colleagues (2007) suggest that trait approaches such as the FFM, and psychodynamic personality organization approaches such as that outlined by Kernberg, both make independent contributions to understanding mental health, and are in fact, interrelated. Morey and colleagues (2007) found that while the FFM provided information about stable personality characteristics, it may not provide adequate information about dysfunctional and maladaptive behaviors and compensatory strategies that are better represented in the current DSM-IV PD symptoms. Research from these studies is consistent with the findings of Shedler and Westen (2004) who found that the FFM sometimes did not always provide the nuanced view that may be needed for working within clinical populations (Shedler & Westen, 2004). They demonstrated ways in which the FFM groups together clinical phenomena that may in fact be discrete clinical constructs (e.g., dysphoria and emotional dysregulation are both represented by Neuroticism in clinical applications of the FFM). In addition, they found that the FFM failed to account for aspects of personality that are frequently assessed in clinical settings (e.g., thought disorder, sexual conflicts). Finally, several recent studies, found that clinicians had difficulty using the FFM trait approach in clinical practice and showed preference for a prototype matching approach (including one based on the SWAP) (Rottman, Ahn, Sanislow, & Kim, 2009; Spitzer, First, Shedler, Westen, & Skodol, 2008; Westen, Shedler, & Bradley, 2006). Prototype matching approaches (also dimensional) have clinicians rate how closely a patient matches a description of the "ideal" form of a syndrome. Overall, the FFM, has become increasingly recognized as

personality assessment tool, however, concerns about the measure's ability to fully capture the intricacies of personality and personality pathology, are still being evaluated.

The Shedler Westen Assessment Procedure (SWAP). Another dimensional approach to assessing both personality and personality pathology that was derived from work with clinical populations as well as empirical research is the Shedler Westen Assessment Procedure (SWAP). This measure was selected for use in the present research, because it was designed to utilize clinical experience and expertise when assessing patient personality. This method of assessment relies on a Q-sort procedure that is completed by a clinician or clinically trained interviewer using the Clinical Diagnostic Interview (Westen & Muderrisoglu, 2003). The advantages of using clinicians as informants include the ability to assess both explicitly and implicitly expressed information and the assessment of information that may not readily accessible to a patient completing self-report questionnaire. For example, some research suggests that self-reports are better at predicting internalizing outcomes, while informant reports are better predictors of externalizing outcomes or socially undesirable behaviors (Clifton, Turkheimer, & Oltmanns, 2005; Oltmanns, Feidler, & Turkheimer, 2004).

Westen and Shedler (2007) utilized SWAP data in multiple ways to dimensionally assess personality both in terms of syndromes and traits. A syndromal approach means that personality can be assessed in terms of a constellation of interrelated characteristics. This is consistent with the DSM-IV, which views personality pathology as made up of interdependent features. However, using a trait approach, the SWAP can also be used to assess separate characteristics (traits) that represent discrete aspects of personality (such as that found in the FFM). Most relevant to this study, the SWAP can also be used in

person-centered analyses to identify personality subtypes of certain psychological phenomena, consistent with a dimensional syndromal approach (i.e., one in which the patient is assessed for degree of match to a prototype of the syndrome, and given a dimensional score denoting degree of match).

Criticisms of the SWAP include issues related to the Q-Sort methodology such as the use of a fixed distribution and a lack of information regarding temporal stability (Wood, Nezworski, Garb, & Koren, 2007). Westen and Shedler (2007) state that the advantage of a fixed distribution is that it prevents patients who have different levels (e.g., mild and severe) of the same disorder from ending up with the same profile. In terms of temporal stability data, recent test-retest data using a 4-6 month interval found a reliability coefficient of .85, suggesting that this unlikely to be a valid criticism (Westen, Waller, Blagov, Shedler, & Bradley, 2007). Wood and colleagues (2007) also note that studies supporting the validity of the SWAP have generally obtained information all from a single reporter (e.g., the treating clinician). While this was true of most of the studies using the SWAP, more recent studies have used multiple informants (typically self-report and treating clinician) to further establish the validity of the SWAP (Bradley, Hilsenroth, Guarnaccia, & Westen, 2007; Westen et al., 2007). Finally, Mullins-Sweatt and Widiger (2007) also propose that the aspects of personality that are independent of the FFM may refer to clinical symptomatology rather than personality. Perhaps this refers to the fact that the SWAP items include personality functions (e.g., how a patient regulates emotions, etc) rather than only personality descriptors (Westen & Shedler, 2007). However, this broader view of personality may be essential in clinical settings.

Overall, current research suggests that personality may be better represented in clinical settings through the use of dimensional assessment measures. A number of dimensional approaches are currently under development, two of which are described here. In the current study, the SWAP will be utilized because of several potential strengths that may provide a nuanced view of personality in the individuals with histories of attachment disruptions. These include personality assessment that results in dimensional scores, the possibility of creating dimensional syndromal descriptions or prototypes, and the reliance on data aggregated from clinically sophisticated informants that does not presuppose the validity of patient self-reports.

Personality Pathology in Adolescence

One unique aspect of the current research was the consideration of personality subtypes of individuals with traumatic separations in both adult and adolescent samples. The importance of considering adolescent personality was to provide continuity across development in the study of attachment disruptions. Most studies related to attachment focus on early childhood or infancy (using the Strange Situation) or adulthood (using the AAI). However, given the extant research on temperament and IWMs, it was likely that personality and personality pathology begin taking shape in the years prior to adulthood.

The DSM-IV indicates that PDs are very unusual in adolescent patients, and, if present, would likely persist into adulthood. In order to diagnose adolescent PDs, the symptoms must be present for at least one year, and not attributable to the developmental stage. However, recent research has demonstrated that personality pathology is highly prevalent in adolescent samples (Cohen, Crawford, Johnson, & Kasen, 2005; Grilo et al., 1998; Westen, Dutra, & Shedler, 2005). Traditionally, adolescence is viewed as a time of

"storm and stress," (Arnett, 1999; Hall, 1904), leaving some to suggest it may be a developmentally inappropriate time in which to diagnose personality pathology. However, others argue that adolescents show similar levels of affective lability and dysregulation when compared to adults (Baird, Veague, & Rabbitt, 2005).

There is consensus regarding concurrent validity and similarities between the presentations of adolescent personality pathology with that of adult personality pathology. Levy et al. (1999) found strong concurrent validity with adolescent personality pathology relating to impairment on a range of clinical and global assessment of functioning scales. In addition to concurrent validity, adolescent personality pathology occurs at a relatively equal rate to adult personality pathology among psychiatric inpatients (Grilo et al., 1998). Durrett and Westen (2005), using an exploratory factor analysis, found that the structure of personality pathology among adolescents was similar to that of adults.

The current study sought to establish personality subtypes in adolescent and adult samples both of whom had experienced traumatic caregiver separations, to determine whether similar subtypes emerge at the two developmental stages. While this study did not longitudinally follow individuals from adolescence into adulthood, it did yield a cross-sectional portrait of the differences and similarities between adult and adolescent personality presentations within clinical settings.

Attachment and Personality Pathology

Some research has explored the relationship of attachment strategies to outcomes of personality pathology in both adult and adolescent samples. While attachment strategies are not entirely contingent on experiences of separation and loss, they are a

reflection of the accessibility, reliability, and quality of care in an individual's early caregiving environments (Ainsworth, 1969). Using the AAI in a sample of adolescents, Kobak and Sceery (1988) found that secure attachment was associated with ego-resilience and the ability to regulate emotions, preoccupied attachment was related to higher levels of anxiety, and dismissing attachment was related to increased levels of hostility and a maladaptive self-reliant style. Other research using clinician reports and self report measures has found that in adolescent samples, avoidant attachment styles are most related to cluster A PDs (Crawford et al., 2006; Nakash-Eisikovits et al., 2002). Anxious attachment was positively associated in one study with cluster A and C PDs (Crawford et al., 2006), while in another study anxious attachment was more specifically associated with PDs related to neediness and dependency (e.g., Borderline, Histrionic, and Dependent PD) (Nakash-Eisikovits et al., 2002). Interestingly, Nakash-Eisikovits et al. (2002) also found a negative correlation between secure attachment in adolescents and all types of DSM-IV PD diagnoses. After controlling for gender and PD diagnosis, Westen et al. (2006) found that certain types of PDs in adolescents remained significantly associated with certain attachment strategies. For example, Borderline PD was associated with both preoccupied and disorganized attachment, and Schizoid PD was associated with dismissing attachment. These studies all relied on a single reporter and, with the exception of Kobak et al., did not use the AAI, which is the standard narrative assessment measure of adult attachment.

Within adult samples, attachment classifications also relate to certain patterns of personality pathology. Using a self-report measure of attachment, Crawford and colleagues (2006) found that when co-occurring PD symptoms were controlled for,

Cluster A PDs were associated with high attachment avoidance (and low attachment anxiety), while both Clusters B and C showed the opposite pattern. Interestingly, Clusters B and C were differentiated by interpersonal aggression scale (similar to low agreeableness in the FFM), such that Cluster B was associated with elevated aggression, while Cluster C showed low interpersonal aggression. Some of these results are similar to that of Westen and colleagues (2006), who, using a clinician report measure, found that after controlling for gender and other PDs, preoccupied attachment was associated with Borderline, Histrionic PD, and Dependent PD. However, Westen et al (2006) also found that disorganized attachment (which was not included in Crawford's scale) was associated with Borderline PD and Paranoid PD, and dismissing attachment was associated with Narcissistic PD and Schizoid PD. Differences across studies may reflect the measure of assessment (i.e., they use of different attachment scales) and the different types of reporters (i.e., clinician vs. self-report). Interestingly, both studies make note that avoidant attachment is not related to Avoidant PD. Crawford et al. suggest, that although individuals with Avoidant PD have difficulty forming relationships, unlike individuals with avoidant attachment, they tend to hold on to the few relationships that they do have in a clingy and perhaps preoccupied way.

The adolescent and adult research assessing personality pathology and attachment here reviewed focused primarily at the correlations certain DSM PDs and attachment strategies. The current study proposes to extend this past research in a number of ways. First, rather than considering the association between attachment "states of mind" and DSM PD diagnoses, the current study instead identifies personality subtypes of individuals who have had a traumatic attachment experience (i.e., the traumatic

separation from an attachment figure). Personality can thus be assessed more broadly, and can be representative of subtypes of personality that are more associated with the common experience of a traumatic separation. Next, the current study did not intend to assess attachment states of mind. Instead, this study focused on a particular type of environmental event of significance to attachment (attachment disruption) and then set out to identify personality styles in individuals who have experienced this type of attachment disruption.

Assessing Personality Subtypes

The wide range of outcomes found among individuals with traumatic childhood separations suggests the need for assessing whether these individuals may be best understood as belonging to personality subtypes. The heterogeneous presentation of such individuals is evidenced in a number of ways.

First, attachment experiences lead to specific types of IWMs, which are central to the development of relationships, affect regulation, self-esteem, etc. The experience of a traumatic separation will have consequences not only for IWMs but also for the entirety of personality development. In addition, the experience of a traumatic separation for the individual with an ambivalent attachment strategy may differ from those with an avoidant, disorganized, or secure strategy. Therefore, the distinct IWMs may be influential in the outcomes of various personality profiles.

Next, attachment disruptions are associated with a wide range of Axis I and Axis II psychopathology, as well as dysregulation of the HPA axis. These outcomes do not represent a single profile that can easily be recognized and treated within clinical settings. A person-centered assessment of personality profiles identifies whether this wide range

of clinical phenomena, that currently provides a non-descript conglomerate of symptoms and features, may actually be better understood as prototypes of individuals who share the experience of a traumatic separation, yet differ on variables of Axis I and II psychopathology, developmental history variables, and even family history variables. The Q-sort analysis provides opportunity for a person centered approach because it identifies different sub-groups of people that have similar personality profiles, while a traditional factor analysis, a variable-centered approach, would identify groups of items that are indicative of certain factors. Person-centered analyses attempt to study individuals as indivisible units, rather than separating variables and studying them without regard to their original context (Bergman, von Eye, & Magnusson, 2006).

Finally, the significance of assessing personality subtypes embraces the concept of multifinality, which is central to the study of developmental psychopathology. In this case, multifinality suggests the possibility that the experience of a traumatic separation from a caregiver can lead to a number of different developmental trajectories, based on both the individual's biological, psychological, and social resources. The concept of multifinality helps explain why individuals with childhood traumatic separations may belong may have a wide range of personality pathology, as well as a resilient personality structure.

Aims of the Current Study

The goals of this research were threefold. First was to provide a comprehensive portrait of the personality characteristics (pathological and non-pathological) of both adults and adolescents with histories of traumatic separations from childhood attachment figures, including patterns of Axis II psychopathology. Second was to discover whether

clinically and empirically meaningful subtypes of these individuals could be identified. Given that attachment disruptions or traumatic separations from caregivers are associated with a range of outcomes in the areas of biological, psychological, and social functioning, the current study will seek to organize these outcomes according to personality subtypes using a personality pathology Q-sort and a cluster-analytic procedure widely used with Q-sort data, Q-factor analysis. It was expected that some core similar personality subtypes would emerge in the adolescent and adult samples, although exact correspondence was unlikely given the developmental fluidity of adolescence. The first two goals were addressed in studies 1 and 2.

The third goal (addressed in study 3) was to provide initial validity data for the subtypes that emerge in both samples, using criteria such as those outlined by Robins and Guze (1970) to assess the validity of any taxonomic distinctions. Specific hypotheses regarding DSM psychopathology as well as developmental and family histories related to each subtype were developed, based on theoretical and empirical literature. These hypotheses were developed following the identification of the subtypes but prior to examining their external correlates. Thus, the subtypes were identified through exploratory analyses, but the hypotheses were generated blind to the data associating subtypes and criterion variables.

Overview of the Methods

The studies used data collected from two NIMH-funded projects on the nature and classification of adolescent and adult personality pathology. The present author actively participated in and oversaw many aspects of the data collection for both projects. Personality pathology was broadly defined in both projects in order to include the current

conceptualization of Axis II by the DSM-IV, as well as a much wider range of sub-threshold personality that may be less severe, or fail to fit into one of the current diagnostic categories. Clinicians were never asked to describe a patient with a specific Axis II PD. In the first study, 950 doctoral level clinicians described one of their adolescent patients (age 13-17), randomly selected, using a battery of psychometric instruments (see description below). Of these clinicians, 236 described a patient who they reported to have experienced a traumatic separation between the ages of 1-16. In the second study, 1201 doctoral level clinicians used a similar psychometric battery to describe one of their adult patients (age 18 and over), again randomly selected. Of these clinicians, 201 described an adult patient who they had strong reason to believe had experienced a traumatic separation between the ages of 1-16. Clinicians in both studies were directed to classify events such as childhood separations as absent unless they felt certain, based on data from the patient or collateral data, that the patient had actually experienced the event. This was done because the data not included are likely to include many false negatives when clinicians lacked enough knowledge of the patient's history but few false positives among patients included in this study. Neither study selected for patients with traumatic separations; thus, the study is not vulnerable to biases in subject ascertainment or likely clinician biases based on a single developmental history variable, given that they provided data on thousands of variables, of which separations in childhood were just one. In both studies clinicians completed a personality Q-sort and completed measures of psychopathology (including DSM-IV Axis I and Axis II diagnoses), adaptive functioning, and developmental history.

Study 1: Identifying Personality Subtypes of Adolescents with Histories of Traumatic Separations from Attachment Figures

Method

Participants

Adolescent data were collected using a practice network approach to taxonomy in which clinicians were asked to describe a current patient (see Morey, 1988; Shedler & Westen, 2007; Westen & Chang, 2000; Westen & Harnden-Fischer, 2001; Westen & Shedler, 1999a, 1999b, 2000; Wilkinson-Ryan & Westen, 2000). A random national sample of psychiatrists and psychologists with at least five years post-licensure or post-residency was obtained from the membership rosters of the American Academy of Child and Adolescent Psychiatry and the American Psychological Association. Other research describes the rationale for using clinicians as informants in basic science research (see Dutra, Campbell, & Westen, 2004; Westen & Shedler, 1999a, 1999b; Westen & Weinberger, 2003). The advantage of this method is that clinicians are experienced observers who are able to make inferences and recognize subtle distinctions of psychopathology based on knowledge of what is considered normative. Unlike self-report measures and observation reports by significant others, clinician-report instruments are less vulnerable to defensive and self-presentational biases.

Procedures

Clinicians were sent letters inviting them to participate in an adolescent personality pathology study. Of those contacted, 950 clinicians, one-third of the total sample, participated in the study. These clinicians returned postcards indicating the age, race, and gender of their current adolescent patients. In order to obtain a representative

sample, gender, age, and race were used to stratify. There was an attempt to have an even distribution of males and females between the ages of 13-18 and to have a racial distribution consistent with the U.S. census. The only exclusion criteria were chronic psychosis and mental retardation. In the second wave of data collection, there was over-sampling for ethnic and racial minority patients because clinicians described a low number of such patients during the first wave of data collection.

The clinicians in this study were asked to provide data on a current adolescent patient who was in treatment for "enduring maladaptive patterns of thought, feeling, motivation, or behavior—that is personality." To ensure a random sample, the clinicians were asked to describe "the last patient you saw last week before completing this form who meets study criteria." It was requested that clinicians describe a patient whose personality they knew, with a guideline of ≥ 6 clinical contact hours but ≤ 2 years (to minimize personality change that may have occurred over the course of treatment). Clinicians were not asked to describe a patient with a particular diagnosis, nor did patients need to meet criteria for a PD. The clinicians were also asked to disregard the caveats in the DSM regarding the application of Axis II psychopathology to adolescent populations. Instead, it was emphasized that the adolescent patient only needed to display problematic personality characteristics, as defined above.

Each clinician in the study described just one patient so that rater dependence variance would be minimized. Patient confidentiality was not compromised because no identifying information was collected. Clinicians completed a number of questionnaires and a Q-sort measure using only the information from their interactions with their patient. Measures could be completed either through a mail packet that could be returned in a

provided postage-paid envelope, or alternatively could be completed using a secure web-based data submission program (www.psychsystems.net). Clinicians received a $200 honorarium for their participation, which took approximately two hours.

Measures

Clinicians who participated in the current study completed a core battery of questionnaires related to their patient's demographics, personality, psychopathology, developmental history, and relationships. However, only the measures relevant to the current study are described below.

Shedler-Westen Assessment Procedure 200-item Q-sort for Adolescents (SWAP-II-A). This Q-sort instrument assesses adolescent personality by relying on the skills of an experienced clinician who has observed a patient over an extended period of time, or who has administered an extensive, systematic, narrative interview to the adolescent and his or her parents (see, e.g., Westen & Muderrisoglu, 2003). Clinicians sort (rank-order) 200 statements describing adolescent personality characteristics into eight categories based on applicability to the patient, from those that are not descriptive (assigned a value of 0) to those which are highly descriptive (assigned a value of 7). Following the suggestion by Block (1978; 2008), the SWAP-II-A items were written in "standard language," in this case, the kind of language experienced clinicians would use to describe a patient but without any use of jargon. This allowed for the collection of observational data from clinicians representing diverse theoretical backgrounds.

The SWAP-II-A is an adaptation of its progenitor the SWAP-200, a Q-Sort designed for assessing adult personality pathology. Westen and Shedler (2007) describe in great detail the process used to develop the SWAP item sets. SWAP Item content is

intended to reflect Axis II criteria from the DSM III and IV, Axis I criteria associated with personality disturbance (e.g., anxiety), both clinical and research literature on PDs, and research on child and adolescent psychopathology and personality. In addition, SWAP items reflect normal personality traits, psychological health (Block, 1978; Livesley, 1995; McCrae & Costa, 1997) and a model of functional diagnosis describing the range of personality functions used in case formulation (Westen, 1998). Finally, the items were developed using videotaped clinical interviews, the clinical experience of both the investigators, and through gathering feedback from over 1000 experienced clinicians. The adapted adolescent version was created with additional consultation with senior adolescent clinicians and through review of adolescent theoretical literature and empirical research. Research using a previous version of the instrument, the SWAP-200-A, provided support for the SWAP-II-A as an instrument for assessing personality pathology in adolescents (see Westen, Shedler, Durrett, Glass, & Martens, 2003). In this earlier study, dimensional PD scores created using the SWAP-200-A correlated in expected and meaningful ways with alternative methods of assessing Axis II, multiple measures of adaptive functioning (e.g., school and peer functioning; history of hospitalizations, suicide attempts, and arrests); and with Child Behavior Checklist scores. For example, using SWAP dimensions for each PD, Borderline PD positively correlated with history of suicide attempts (r=.46) and Schizotypal PD was negatively correlated with a scale of peer functioning (r=-.65).

Initial evidence of validity, reliability, and utility of the SWAP-II and II-A have also been shown in taxonomic research (Westen & Harnden-Fischer, 2001; Westen & Shedler, 1999a, 1999b, 2000). Using the SWAP, interrater reliability has been established

between a treating clinician and independent rater with the median correlation on SWAP dimensional personality traits being .82. Bradley and colleagues (2007) have found moderate correlations between self-report PD diagnoses made with the Personality Assessment Instrument and clinician diagnoses made with the SWAP for the same disorder (e.g., Borderline r=.31; Antisocial r=.35).

Clinical Data Form for Adolescent (CDF-A). The CDF-A is the adolescent version of the adult CDF which assesses a range of patient variables including demographics, diagnoses, and etiology (e.g., Westen & Shedler, 1999a; Westen et al., 2003). The first set of questions provides information about the treating clinician including their age, sex, treatment setting, discipline, and theoretical orientation. The remainder of the CDF-A asks questions regarding the patient, including basic demographics, diagnostic features, adaptive functioning, and family and developmental history. Clinicians rate the patient's adaptive functioning using indices such as school functioning and peer relationships. Further objective information, such as history of arrests, traumatic caregiver separations, psychiatric hospitalizations, and suicide attempts are also obtained. Clinician's ratings of adaptive functioning variables are highly correlated with the same data obtained through independent interview, thus demonstrating interrater reliability and validity (Hilsenroth et al., 2000; Westen, Muderrisoglu, Fowler, Shedler, & Koren, 1997). The next section of the CDF-A assesses family history of psychiatric disorders and developmental history variables with potential relevance to etiology including history of physical and sexual abuse, and family stability. Clinicians working with adolescents typically have this information from both the patient and collateral sources such as parents or teachers. Previous research indicates that clinicians' ratings of developmental and family history

variables predict criterion variables that are theoretically relevant (e.g., Dutra et al., 2004; Nakash, Dutra, & Westen, 2002). For example, Dutra et al. (2004) found that CDF adaptive functioning scales correlated in expected ways with CBCL scales (e.g., as expected school functioning was significantly negatively correlated with the CBCL subscales of attention problems (r=-.51), delinquent behavior (r=-.50), social problems (r=-.27) and aggressive behavior (r=-.48)). The CDF ratings of the patient's relationship with their parent also correlate strongly with scores on a clinician-report Parental Bonding Inventory and have a similar factor structure as that found using the self-report version of the measure (PBI; Parker, Tupling, & Brown, 1979; Russ, Heim, & Westen, 2003).

Axis II Checklist: The Axis II checklist is a randomly ordered checklist of all the criteria for the DSM-IV PD diagnoses that was completed by each clinician in regards to their patient. The measure is used to create both categorical and dimensional DSM-IV PD diagnoses. To create categorical diagnoses, the DSM-IV decision rules were applied to determine whether the disorder was either present or absent. Summing the number of endorsed symptoms for each disorder created dimensional scores. This method of assessing Axis II psychopathology produces patterns of comorbidity similar to those that are found using structured clinical interviews (Westen et al., 2003).

Results

The aim of the Study 1 was to identify personality subtypes of adolescents with traumatic caregiver separations. Initial exploratory analyses were completed in order to describe the adolescent patients and identify the existing personality subtypes using a Q-factor analysis. The initial results and subtypes are described below.

Characteristics of Participating Clinicians in the Overall Sample (N=950)

Of the 950 clinicians participating in the larger study, 57.3% were male and 71.6% were psychologists. These clinicians represented a range of theoretical orientations including 3.4% biological, 20.5% cognitive-behavioral, 18.7% psychodynamic, 52.1% eclectic, and 5.3% other. On average, the clinicians in the overall study were highly experienced with 18.49 years (SD=8.63) post-residency or post-licensure. The participating clinicians endorsed working in a range of settings including: 80.6% private practice, 26.1% clinic or outpatient hospital setting, 10.6% school, 13.2% inpatient or partial program setting, 8.7% residential facility, 15.9% forensic or other setting. Clinicians often worked in more than one setting. Finally, the clinicians worked with their identified patient for a mean of 12.36 months (SD=10.11) prior to completing the questionnaire for this study.

Characteristics of the Adolescent Patients in the Overall Sample (N=950)

The overall sample of 950 adolescent patients (50.7% female) was on average 15.57 years old (SD= 1.60, range 13-18). These adolescents were 78.7% Caucasian, 7.8% African American, 7.2% Hispanic, 2.6% Asian, and 3.7% biracial or other. The adolescents ranged in their socioeconomic status, with majority being middle class (40.7%) or upper-middle class (28.1%). The remaining sample was described as poor (5.9%), working class (19.2%), and upper class (6%).

Characteristics of Clinicians Describing Adolescent Patients with Histories of Traumatic Separations

Of the 950 participating clinicians, 236 described an adolescent with a history of traumatic separation(s) from attachment figures prior to the age of 16. Clinicians

identified whether to their knowledge the patient experienced any "lengthy traumatic separations from primary caregiver for more than 6 weeks." Separate questions assessed separations variables such as duration and frequency of separations and separations resulting from divorce or parental death. (Divorces did not automatically constitute traumatic separations; most patients with a positive history for divorce were not also coded positive for separations.) Clinicians (61.1% male, 66.8% psychologists) who described an adolescent with a traumatic caregiver separation were similar to the overall sample in terms of theoretical orientation: 5.9% biological, 20.8% cognitive behavioral, 18.2% psychodynamic, 49.2% eclectic, 5.9% other. On average, these clinicians were also highly experienced with 18.17 years (SD= 8.47) post-residency or post-licensure. Finally, the clinicians describing an adolescent patient with a traumatic caregiving separation knew their patients well (M= 12.48 months, SD=10.83).

Characteristics of Adolescent Patients with Histories of Traumatic Separations (N=236)

The adolescents with histories of traumatic separations were 49.4% female. Table 1 compares the adolescents with traumatic caregiving separations to the adolescent patients without traumatic caregiving separations across a number of domains.

As can be seen in Table 1, African American and Hispanic adolescents were more highly represented in the adolescent sample with traumatic separations than the sample of adolescents without. It is also notable that the sample adolescents with traumatic caregiving separations showed higher rates of adolescents from lower socioeconomic groups than the comparison group. In terms of treatment setting, the adolescents with a history of separations were seen less often in private practice and more often in clinic or

hospital outpatient settings and Inpatient setting. They were almost thirteen times more likely to be seen in a residential facility than the comparison sample. This is not surprising given that many were no longer living with their parents or had been removed from their homes. Differences in Axis I functioning are also presented in Table 1.

Differences in personality pathology between the adolescents with and without traumatic separations were assessed using an aggregated dimensional measure of each Axis II PD, constructed by standardizing and averaging the number of symptom criteria met for each disorder and a five point construct rating scale for how well a given PD described the patient. Adolescents with traumatic caregiver separations had significantly higher dimensional scores on Paranoid PD (t [944] = -2.53, p = .01); all cluster B PDs, including Antisocial PD (t [944] = -6.08, p = .001), Borderline PD (t [944] = -4.58, p = .001), Narcissistic PD (t [944] = -3.03, p = .003), and Histrionic PD, which was marginally significant (t [944] = -1.96, p = .05). Adolescents with traumatic separations had significantly lower rates of Avoidant PD (t [944] = 3.47, p = .001) and Obsessive Compulsive PD (t [944] = 2.64, p = .008). These are two PDs that tend to be healthier both in this sample and in others (Hopwood et al., 2006), and may suggest more severity in the group with separations.

A Composite Portrait of Adolescents with Histories of Traumatic Separations

To obtain a composite portrait of the personalities of adolescents with traumatic caregiver separations, the SWAP-II-A profiles of the 236 adolescents with such separations were averaged, and items were arranged in order from highest to lowest (i.e., most descriptive to least descriptive). Table 2 presents the 18 most descriptive items, which were selected because they represent the number of items that can be placed in the

two "most descriptive" categories of the fixed distribution (piles 6 and 7) of the SWAP-II-A Q-sort. The mean rankings in Table 2 reflect the average score of a particular SWAP item across all of the participants who experienced separations. The 18 SWAP items represent the "average" personality of adolescent who has experienced a traumatic separation. The composite portrait in Table 2 depicts an adolescent who is emotionally dysregulated, angry, and unhappy. Interpersonal relationships with peers and authority figures are a struggle for these adolescents, and they tend to feel like "outsiders" who are misunderstood. Within relationships they tend towards having unstable representations and vacillate in their perceptions of others. They are also likely to project their own negative qualities on to others. These adolescents may also lack insight regarding their own behavior.

This composite portrait is striking, and provides insight into a broad conceptualization of the adolescents with traumatic separations. However, it may mask differences that might relate to more specific subtypes of such adolescents. For example, some adolescents may be characteristically emotionally dysregulated, while others may be angry and impulsive. To consider this possibility, the next part of the exploratory analyses involved identifying personality subtypes of adolescents with histories of traumatic caregiver separations.

Q-analysis and Personality Subtypes with Adolescent Personality Constellations.

A Q-factor analysis was applied in order to examine the possibility of clinically meaningful personality subtypes of adolescents with traumatic caregiver separations. Q-factor analysis is a statistical procedure for grouping together cases whose profiles are similar; in this study, it identifies adolescent patients who have a similar personality

profile across the 200 items. This method has proven useful in the study of normal and pathological personality, in part because it does not require the assumption of mutually exclusive types (Block, 1978, 2008; Caspi, 1998; Robins, John, Caspi, Moffitt, & Stouthamer-Loeber, 1996). Thus, a patient can resemble one or more subtypes (prototypes) to varying degrees. This results in each subject having a score on every subtype indicating the extent to which he or she resembles the prototypical group. In addition, Q factor analysis, like conventional factor analysis, does not assume the presence of subgroups and therefore can result in unidimensional or multidimensional constructs. When applied to personality data, a conventional factor analysis identifies common underlying dimensions (e.g., such as those found in the Five Factor Model); in contrast, a Q-analysis identifies patients who have similar profiles across items and thus share a core personality style.

Using standard factor-analytic procedures, the data were first entered into a principal components analysis, specifying eigenvalues ≥ 1 (Kaiser's criteria). The scree plot, percent of variance accounted for, and parallel analysis (Horn, 1965; O'Connor, 2000) were used to determine the number of Q-factors to rotate. Q-factor analyses using Unweighted Least Squares (ULS) with a Promax (oblique) rotation were conducted for 5, 6, and 7 factor solutions. The 6 factor solution yielded 5 coherent personality subgroups, accounting for 38.08% of the variance (17.92%, 9.17%, 4.80%, 3.40%, 2.80% for each Q-factor, respectively), although multiple solutions and algorithms were tested to identify the most robust Q-factors (in this case, retaining 5 of 6 Q-factors from the 6-Q-factor solution). The median correlation among factors was .05, suggesting that they are not only distinct but fairly dissimilar. Correlations are presented in Table 3. Based on the

items within the factors, the personality subtypes were labeled "psychopathic," "internalizing/avoidant," "impulsive dysregulated," "resilient," and "immature dysregulated."

Table 4 shows the 18 items that best characterized each subtype. The items with the highest factor scores on each prototype are arranged in descending order, expressed in standard deviation units. (In Q-factor analysis, because cases are factored over items, instead of items over cases, patients receive factor loadings indexing their degree or match to the construct, and items receive factor scores. Those factors scores reflect the number of standard deviations each item differed from the other items in the Q-sort in defining the construct, i.e., how central each item was to the construct, where items with high scores are most central to the construct.) A brief description of each subtype follows.

Psychopathic. These adolescents are angry, manipulative, impulsive, and arrogant. They lack empathy, are critical of others, yet feel misunderstood themselves. They tend to be "defiant toward authority figures" and lack close friendships or relationships. They show "little or no remorse for harm or injury caused to others," are "impervious to consequences," and they "have little investment in moral values."

Internalizing/avoidant. These adolescents have feelings of unhappiness, emptiness, inadequacy, anxiety, and helplessness. They fear rejection and abandonment and tend to "feel like an outcast or outsider." They avoid social situations, are self-conscious, and "tend to feel ashamed or embarrassed." They are also characterized by lack of "satisfaction or enjoyment" and the tendency to feel that "life has no meaning."

Impulsive dysregulated. These adolescents have the tendency to engage in a number of risky behaviors including abusing alcohol or drugs, sexual promiscuity, self-mutilation, and running away from home. They "tend to act impulsively," "seek thrills, novelty, and excitement," and have emotions that "spiral out of control, leading to extremes." Within relationships, they tend to surround themselves with "peers who are delinquent"; their "relationships tend to be unstable"; they tend to "become attached quickly or intensely." Finally, they tend to be unable to soothe themselves without the help of another person.

Resilient. These adolescents are articulate, assertive, conscientious, and energetic. They enjoy challenges and gain recognition for accomplishments. At times they have the tendency to be anxious. Within relationships they are well liked, empathic, capable of intimacy, and can "recognize alternative viewpoints." These teenagers may have the tendency to express anger indirectly or passively (e.g., procrastinate).

Immature dysregulated. These adolescents appear childish for their age and when upset they become "irrational" and "tend to revert to earlier, less mature ways of coping. They tend to have emotions "that spiral out of control" and "change rapidly and unpredictably." They are prone to intense anger and extreme reactions to slight criticism. These adolescents have little psychological insight, are needy and dependent, and think in concrete terms. Within their relationships, they lack social skills, feel misunderstood, and have difficulty making sense of others' behavior. They fear rejection and abandonment, and are unable to soothe themselves without the help of another person.

Study 2: Identifying Personality Subtypes of Adults with Histories of Traumatic Separations from Attachment Figures in Childhood

Method

Participants and procedures for Study 2 were almost identical to those in Study 1, with the exceptions being that clinicians were asked to describe a randomly selected adult patient and that there was no stratification based on age or gender.

Participants

Participants were again a random national sample of psychologists and psychiatrists with over five years experience post licensure or residency whose names were obtained through the membership rosters of the American Psychiatric and American Psychological Associations. Of the clinicians contacted, over one-third (N=1201) participated in the study. The clinicians were asked to describe "an adult patient you are currently treating or evaluating who has enduring pattern of thoughts, feeling, motivation or behavior—that is, personality problems—that cause distress or dysfunction." Just as in Study 1, it was emphasized to clinicians that the patient did not have to meet criteria for an Axis II PD. It was required that the patient be at least 18 years of age and be well known to the clinician as indicated by the guideline of $\geq$ 6 clinical contact hours but $\leq$ 2 years. In efforts to minimize selection bias, clinicians were asked to describe the last patient they saw in the last week in any clinical setting who met study criteria.

Procedure & Measures

The procedures were almost identical to those described in study with the following exceptions: 1) clinicians were asked to describe a randomly selected adult patient, 2) there was no stratification based on age or gender, 3) clinicians used adult

versions of the measures described in Study 1 including the SWAP-II, CDF, and Axis II Checklist.

Results

The aim of Study 2 was to identify personality subtypes of adults with histories of traumatic separations from attachment figures in childhood. Initial exploratory analyses were completed in order to provide a description of the adult patients and identify the personality subtypes using a Q-sort analysis. The initial results and subtypes are described below.

Characteristics of Participating Clinicians

Of the 1201 clinicians participating in the larger study working with an adult patient, 54.3% were female and 70.7% were psychologists. These clinicians represented a range of theoretical orientations including 3.6% biological, 18.1% cognitive-behavioral, 25.7% psychodynamic, 46.3% eclectic, and 6.2% other. On average, the clinicians in the overall study were highly experienced with 19.80 years (SD=9.14) post-residency or post-licensure. The participating clinicians endorsed working in a range of settings including: 78.8% private practice, 24.7% clinic or out patient hospital setting, 4.9% school, 14.9% inpatient or partial program setting, 3.8% residential facility, 10.0% forensic, and 7% in some "other" setting. Clinicians often worked in more than one setting. Finally, the clinicians worked with their identified adult patient for a mean of 17.36 months (SD=20.57) prior to completing the questionnaire for this study.

Characteristics of the Adult Patients in the Overall Sample (N=1201)

The overall sample of 1201 adult patients (53.4% female) was on average 42.29 years old (SD= 12.35). These adults were 82.6% Caucasian, 6.6% African American,

6.0% Hispanic, 2.2% Asian, and 2.7% biracial or other. The adults ranged in their socioeconomic status, with majority being middle class (39.1%) or working class (27.2%). The remaining adult patients were described as poor (5.8%), upper middle class (23.8%), and upper class (4.1%).

Characteristics of Clinicians Describing Adult Patients with Histories of Traumatic Separations (N=203)

Of the 1201 participating clinicians, 203 described an adult with a history of a traumatic separation. Data regarding separations was missing for 10 clinicians. Clinicians identified whether to their knowledge there had been "lengthy traumatic separations from primary caregiver for more than 6 weeks." Separate questions assessed separations that were permanent, due to divorce, or parental death. Clinicians (55.5% female, 63.1% psychologists) who described an adult with a traumatic caregiver separation were similar to the overall sample in terms of theoretical orientation: 3.0% biological, 17.2% cognitive behavioral, 21.7% psychodynamic, 50.2% eclectic, 5.9% other. On average, these clinicians were also highly experienced with 20.26 years (*SD*=9.22) post-residency or post-licensure. Finally, the clinicians describing an adult patient with a traumatic caregiving separation knew their patients well (*M*= 17.99 months, *SD*=24.31).

Characteristics of Adult Patients with Histories of Traumatic Separations (N=203)

The 203 adults with a history of traumatic separations were 52.7% female. Table 5 compares the adults with traumatic separations to the adult patients without traumatic separations across a number of domains.

In terms of demographics, a similar pattern emerged as in the adolescent sample. As can be seen from Table 5, African Americans were more highly represented in the

adults with traumatic separations than the sample of adults without. It is also notable that the sample adults with traumatic separations consisted of higher rates of adults were poor and who had less than a high school education than the comparison group. In terms of treatment setting, the adults with a history of separations were seen less often in private practice. Table 5 also presents rates of Axis I psychopathology.

Differences in personality pathology between the adults with and without traumatic caregiving separations were assessed using the same aggregated dimensional PD scales as in Study 1, comprised of two variables after standardization: number of symptom criteria met for the given PD and a five point construct rating scale. Adults with traumatic caregiver separations had significantly higher rates of Paranoid PD (t [1184] = -2.53, p = .01); all cluster B PDs, including Antisocial PD (t [1184] = -4.12, p = .001), Borderline PD (t [1184] = -2.32, p = .02), Narcissistic PD (t [1184] = -3.32, p = .001), with the exception of Histrionic PD (t [1184] = -.255, p = .80). Unlike in the adolescent sample, there were no significant differences for cluster C PDs.

A Composite Portrait of Adults with Histories of Traumatic Separations

In order to obtain a composite portrait of the personalities of adults with traumatic caregiver separations, the SWAP-II profiles of the 203 adults with such separations were aggregated, and items were arranged in order from highest to lowest (i.e., most descriptive to least descriptive). Table 6 presents the 18 most descriptive items, which were selected because they represent the number of items that can be placed in the two "most descriptive" categories of the fixed distribution (piles 6 and 7) of the SWAP-II Q-sort. The 18 SWAP items represent the "average" personality of adult who has experienced a traumatic caregiving separation.

The composite portrait in Table 6 depicts an adult who is unhappy, anxious, and angry. Interpersonally these individuals fear abandonment, but also tend to feel like "outsiders" who are misunderstood. Within relationships they tend to be needy or dependent and unable to tolerate criticism but are themselves critical of others. These adults also tend to feel helpless, experience feelings of emptiness, and to ruminate or dwell on problems. This portrait also indicates, however, that these individuals tend to have a number of strengths including being articulate, conscientious, and striving to meet moral and ethical standards.

This composite portrait provides a broad picture of adults with traumatic separations, but like the adolescent composite, it may mask differences that relate to more specific subtypes. For example, some adults may be more hostile and angry while others may be more emotionally dysregulated. To consider this possibility, the next part of the exploratory analyses identified possible personality subtypes of adults with histories of traumatic caregiver separations.

Q-analysis and Personality Subtypes with Adult Personality Constellations

Just as with the adolescent sample, a Q-factor analysis was applied in order to examine the possibility of clinically meaningful personality subtypes of adults with traumatic caregiver separations. Using standard factor-analytic procedures, the data were entered into a principal components analysis, specifying eigenvalues ≥ 1 (Kaiser's criteria), and using the scree plot, percent of variance accounted for, and parallel analysis (Horn, 1965; O'Connor, 2000) to determine the number of Q-factors to rotate. These procedures suggested a 4 or 5 factor solution. Q-factor analysis using Unweighted Least Squares (ULS) with a Promax (oblique) rotation were conducted for 4, 5, and 6 factor

solutions. The 6 factor solution yielded 5 coherent personality subgroups, accounting for 39.71% of the variance (17.23%, 11.31%, 5.43%, 3.53%, 2.20% for each Q-factor, respectively). The median correlation among factors was .05, suggesting that they are not only distinct but fairly dissimilar. Correlations are presented in Table 7. Based on the items within the factors, the personality subtypes were labeled "internalizing/avoidant," "emotionally dysregulated," "resilient," "hostile/paranoid," and "psychopathic."

Table 8 shows the 18 items that best characterized each subtype. The items with the highest factor scores on each prototype are arranged in descending order, expressed in standard deviation units. (In Q-factor analysis, because cases are factored over items, instead of items over cases, patients receive factor loadings indexing their degree or match to the construct, and items receive factor scores.) The factor scores indicate the item's centrality to the construct in relation to the other items in the item set. The following paragraphs give a brief description of each personality subtype based on the representative SWAP-II items.

Internalizing/avoidant. These adults are characterized by feelings of inadequacy, guilt, anxiety, and unhappiness. They tend to be constricted and unassertive, with the tendency to turn anger against themselves rather than expressing it outwardly. These adults fear rejection and abandonment and tend to "feel like an outcast or outsider." They avoid social situations, are self-conscious, and "tend to feel ashamed or embarrassed." Strengths include being conscientious and striving for moral and ethical standards. However, their standards are often unrealistic, leading to increased self-criticism.

Emotionally dysregulated. Adults in this subtype tend to have emotions "that spiral out of control," "change rapidly and unpredictably," and become irrational when

stressed. These adults tend to be angry, unhappy, and impulsive. Within their relationships, they fear abandonment and have trouble seeing positive and negative characteristics of individuals simultaneously. Their relationships tend to be unstable and they tend to become attached too quickly. Finally, they are unable to soothe themselves without the help of another person.

Resilient. These adults with traumatic caregiver separations tend to be articulate, conscientious, creative, and insightful. They enjoy challenges and use talents effectively and productively. Interpersonally, they are able to sustain meaningful relationships, tend to be well liked, and are comfortable in social situations. These individuals tend to find meaning both in nurturing or mentoring others and also belonging to a greater community. They also have the tendency to be competitive and controlling.

Hostile/paranoid. Adults with traumatic caregiver separations within the hostile/paranoid subtype tend to be self-righteous, angry, arrogant, and unhappy. Interpersonally, they lack close friendships, are critical, suspicious, with the tendency to blame others for their own shortcomings. At the same time, these individuals tend to feel like outsiders and feel misunderstood and/or mistreated.

Psychopathic. This final subtype of adults tends to be deceitful, impulsive, angry, and manipulative. They lack empathy and have little psychological insight. They take advantage of others and show little or no remorse for harm that they inflict. They tend to abuse drugs and alcohol and engage in unlawful behavior, but they are "impervious to consequences." Their lives tend to be unstable in terms of work and/or living arrangements that are identity defining. They tend to "con" others, repeatedly convincing them that they intend on changing (e.g., "This time it is really different").

Study 3. Validating the Identified Personality Subtypes of Adolescents and Adults with Traumatic Separations

After identifying the personality subtypes of adults and adolescents with histories of traumatic separations from attachment figures in childhood, the next study sought to validate the personality subtypes using criterion variables. *A priori* hypotheses regarding associated psychopathology (Axis I and Axis II), developmental history, and family history variables were developed based on theory and prior empirical data.

The following section reviews the literature that supported specific hypotheses for each of the identified subtypes.

Personality as an Organizational Framework

Internalizing/Avoidant Personality Subtype

In both the adult and adolescent samples an internalizing/avoidant subtype of individuals with traumatic separations emerged. The DSM-IV characterizes Avoidant PD as "a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluations" (p. 721). As mentioned, Avoidant PD is not associated with avoidant attachment strategies and instead has been more strongly associated with anxious attachment (Crawford et al., 2007). Meyer and Pilkonis (2005) suggest that the avoidance of intimate relationships in individuals with Avoidant PD is fueled by attachment anxiety in which they fear rejection even though they deeply desire relationships. This is supported by research, which found that individuals with Avoidant PD remembered their parents as more rejecting (Stravynski, Elie, & Franche, 1989). Riggs and colleagues (2007) found that Avoidant personality pathology was associated with a fearful attachment style, defined as having a negative view of both self and other.

The individual with this object representational style feels as though not only are others unavailable to provide care, but the individual himself perceives himself as unworthy of such care. This generalizes to later relationships, as individuals who experience attachment disruptions often have difficulty forming confiding relationships with peers (O'Connor et al., 1999; Vorria et al., 1998a; Vorria, Rutter, & Pickles, 1998b).

Bowlby (1973) suggested that attachment disruptions cause the child to experience the sequence of *protest, despair, and detachment*. Research with non-human primates may explain the pattern of avoidance and internalizing personality that may relate in part to traumatic caregiver separation. Following a traumatic separation, most studies found that over time, protests and cries decreased (Coe, Glass, Wiener, & Levine, 1983; Erickson et al., 2005; Suomi, Mineka, & DeLizio, 1983). Protests may decrease because of the onset of *despair*, which may be related to depressive symptomatology (Coe et al., 1983). Suomi et al. (1983) found that the experience of the separation has persistent effects, such that compare to controls, monkeys with traumatic caregiver separations actively avoided contact with their mothers when reunited at a later point and overall showed less developmentally expected infantile dependency behaviors. This finding may generalize to humans since at an early age a child's representations of the caregiver are shaped by the ability of the caregiver to meet the child's needs. It may be an adaptive, although avoidant strategy, for infants exposed to early separations to become independent and disconnected from a caregiver. In contrast, infants without separations may engage in infantile and dependent behaviors longer to ensure a connection with a stable provider.

It was expected that unlike some of the other identified personality subtypes, the internalizing/avoidant personality subtype will be characterized by internalizing features due to genetic predisposition and the impact of the separation on neurobiological functioning, specifically the HPA axis. Kendler et al. (2002) found that maternal separation led to a prolonged elevated risk for depression. They speculate that separations may be associated with other environmental risk factors and that results may be mediated by genetic factors. Relatedly, Heim and Nemeroff (1999) proposed a pathophysiological model in which the combination of a genetic disposition and an early adverse experience that occurs during a critical period leads to the expression of a phenotype that has an increased neurobiological vulnerability to stress. In considering the neurobiological impact of early adverse experiences, Heim and Nemeroff (1999; 2001) identified corticotropin releasing factor in the HPA axis as the mediator between early stressful life events and anxious and depressive outcomes. Specifically, they proposed that early stress leads to persistent sensitization of the Central Nervous System, long-lasting hyperactivity of the stress response, and resulting difficulties in the regulation of stress and emotion and ultimately higher anxiety.

Overall, it was expected that the internalizing/avoidant subtype would be associated with Avoidant personality pathology and internalizing features including anxiety and depression. These individuals were expected to have a low number of confidants due to their view of others as unavailable and rejecting and themselves as unworthy. Finally, given that genetic factors likely contribute to the development of this profile, it was anticipated that these individuals will have higher rates of anxiety disorders within their families.

Psychopathic Personality Subtype

Within this study a psychopathic personality subtype characterized by empathic deficits, anger, and manipulative behavior was identified in both the adult and adolescent sample. This subtype is consistent with clinical observations of Cleckley (1941) that were then studied empirically by Hare (1991; 2003). The DSM-IV describes Antisocial PD as "a pattern of disregard for, and violation of, the rights of others" (American Psychiatric Association, 2000, p. 685). However, numerous researchers have questioned whether antisocial features in adults and adolescents may in fact be combination of several clinical phenomena, one of which may be psychopathy.

Blair (2006) indicates that psychopathy is characterized not only by behavioral components (impulsive acts and delinquent or criminal activity) common to antisocial diagnoses, but also to an emotional and interpersonal component characterized by a lack of empathy and guilt. He views psychopathic aggression to be *instrumental*, as opposed to other aggressive behavior, which is *reactive* to threatening stimuli. This is consistent with the research of Frick and colleagues (2003) who identified "callous-unemotional" (CU) traits (i.e., low emotional reactivity to aversive stimuli and an absence of guilt regarding their actions) as differentiating to groups of children with Conduct Disorder. Nigg (2006) summarizes these findings stating that CU relates to low negative emotionality, high positive affectivity, and is unrelated to constraint, while Conduct Disorder or antisocial behaviors (without CU) relate to high negative affect, low constraint, and low affiliation. Others have identified differences between those who commit antisocial acts and feel remorse from those who do not feel remorse, perhaps indicative of a psychopathic subtype of Antisocial personality (Goldstein et al., 2006).

Psychopathy is viewed as highly heritable and relatively consistent across the lifespan (Blair, Peschardt, Budhani, & Pine, 2006; Lynam, Caspi, Moffitt, Loeber, & Stouthamer-Loeber, 2007). Wootton and colleagues (1997) found that child Conduct Disorder without the presence of CU was associated with parenting and environmental factors, while Conduct Disorder with the presence of the CU was unrelated to ineffective parenting. This finding does not rule out the impact of attachment disruptions on the development of CU in children with Conduct Disorder, because ineffective parenting is different than loss or separation. In fact, Wootton et al. excluded children from their study who had recently faced a separation from their caregiver.

IWMs have generally been studied in relation to a broader Antisocial domain rather than specifically to psychopathy. This research suggests that Antisocial personality pathology reflects an unresolved and dismissing state of mind using the AAI in adult and adolescent samples (Allen, Hauser, & Borman-Spurrell, 1996; Rosenstein & Horowitz, 1996; Timmerman & Emmelkamp, 2006). This is conceptualized as an deactivation of the attachment system in which the IWM works to reduce distressing thoughts that may be associated with adverse early child caregiving experiences such as attachment disruptions (Riggs et al., 2007). Allen and colleagues (1996) also found that the dismissing and unresolved state of mind on the AAI predicted criminality in a ten-year follow-up assessment, indicating the persistent effect of the IWM on behavior, even into young adulthood. Interestingly, the dismissing state of mind particular to the young adults with criminal behaviors was a specific subtype called 'derogation of attachment.' Theoretically, this may reflect deficits in empathy and anger towards the caregiver that also extend beyond the family to other relationships and other behaviors that show

disregard for the rights of others. As this IWM is chronically accessed across the course of development it becomes incorporated as a more stable aspect of personality (Shaver & Mikulincer, 2005).

Weinfield et al. (1999) describe the development of empathy as the complementary process of aggression by saying, "where aggression often reflects an alienation from others, empathy reflects an amplified connectedness, and whereas aggression reflects the breakdown or warping of dyadic regulation, empathy reflects heightened affective coordination." (p. 78). The necessity of the attachment relationship for the development of empathy was supported by Kestenbaum and colleagues (1989), who found that preschool children with avoidant attachment classification had significantly lower levels of empathy than children with secure attachment. Lyons-Ruth, Alpern, and Repacholi (1993) found that children classified as disorganized on the Strange Situation were more likely to show hostile aggressive behavior with their peers. The early experiences of maternal rejection, low parental nurturing and affection are linked to antisocial behavior in adolescence (Johnson, Cohen, Chen, Kasen, & Brook, 2006; Trentacosta & Shaw, 2008). Johnson et al. (2006) reported that this finding remained even when controlling for parental psychiatric illness and childhood behavior and emotional difficulties. This research lends supports to the idea that aggressive, unempathic behaviors can result in part from chronic rejection and insensitivity from caregivers (Weinfield et al., 1999).

In sum, a psychopathic subtype was identified in the adult and adolescent sample of individuals with attachment disruptions. It was expected that the psychopathic subtype would be associated with conduct disorder, Antisocial PD, and with having a low number

of close meaningful relationships. It was anticipated that these individuals would be more likely to have histories of physical abuse than the other subtypes. Because there is evidence for the high heritability of psychopathy ,it was anticipated that this subtype would be associated with a family history of criminality in addition to a personal history of criminal behavior.

Emotionally Dysregulated Subtypes

Within the adult sample, an emotionally dysregulated subtype with many features of Borderline personality pathology emerged. In the adolescent sample, two emotionally dysregulated subtypes emerged. The first was characterized by impulsive behavior, and the second was characterized by immaturity in both behavior and ways of relating to others. Because both of these adolescent subtypes have a core feature of affect dysregulation, it is likely that they would share features of Borderline personality pathology while still being distinct from one another.

A number of studies indicate that attachment disruptions are associated with Borderline personality pathology (Bradley, 1979; Paris, Nowlis, & Brown, 1988; Reich & Zanarini, 2001; Soloff & Millward, 1983). However, this experience is seen as neither necessary nor solely sufficient for the development of the disorder (Levy, 2005). For example, Torgersen et al. (2000) found evidence for the heritability of BPD in a twin study, in which monozygotic twins displayed a 35% concordance rate, compared to the 7% concordance rate in dizygotic twins.

The IWMs of individuals who develop Borderline personality pathology have been described as predominantly unresolved with a preoccupied trauma when measured by the AAI (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004). This is conceptualized

as an overactivation of the attachment system (Riggs et al., 2007). The IWM of the individual with Borderline features is reflected in the inability to represent the thoughts and feelings of others, originating in the early caregiving relationship. The DSM-IV describes BPD as "a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity" (American Psychiatric Association, 2000, p. 685). The disorder may be applied to adolescents and children if symptoms have been present for more than a year, are considered persistent and pervasive, and are not limited to a single developmental stage.

Borderline personality pathology may be related to the experience of a traumatic caregiver separation as well as other adverse developmental history variables such as childhood sexual and physical abuse (Bradley, Jenei, & Westen, 2005; Golier et al., 2003; Westen, Ludolph, Misle, Ruffins, & Block, 1990). However, results have not always been consistent suggesting that a range of factors contribute to Borderline pathology. One possibility is that the attachment relationship provides the child with the tools for affect regulation, a quality that is often dysregulated in Borderline patients. The caregiver attenuates negative affectivity and reinforces positive affectivity in order to facilitate this process (Levy, 2005). The experience of the early caregiving relationship leads to the development of mentalization, the individual's ability to understand the interpersonal acts of self and other by reflecting on mental states (Fonagy, Gergely, Jurist, & Target, 2002).

In the case of an attachment disruption, a child who is separated from a consistent and affectively attuned caregiver will struggle to develop the capacity for mentalization. Fonagy and colleagues (2002) theorize that the absence of parental mirroring leads to undifferentiated internal affective states, impoverished awareness of emotional states, and

the tendency to confuse one's own thoughts or internal mind states with external reality. This theory of mentalization is supported by research finding that maternal inconsistency (Bezirganian, Cohen, & Brook, 1993), low parental affection and nurturing (Johnson et al., 2006), verbal abuse (Johnson et al., 2001), and invalidation (Young & Gunderson, 1995) are all related to Borderline personality pathology in adolescence or adulthood.

Within both of the adolescent dysregulated subtypes there is evidence of mentalization difficulties. The immature dysregulated subtype has difficulty understanding both his own and others' behaviors. One possibility is that the absence or unavailability of the caregiver did not lead to the ability to self-regulate or learn how to interact with others and imagine their minds. This may contribute to the characteristic of under-developed social skills. Their emotional dysregulation is presented in the context of needy and childish ways of behaving. This contrasts with the impulsive dysregulated subtype, which is more characterized by impulsive and delinquent behaviors. Their mentalization difficulties are more in the context of unstable and fluctuating views of self other such that they quickly attach to others but then have rapidly changing relationships. They also have a similarly unstable view of the self. The adult emotionally dysregulated subtype resembles more closely the impulsive dysregulated subtype in terms of mentalization style, and of the three, most closely resembles Borderline PD. It may be that the two emotionally dysregulated adolescent subtypes (immature and impulsive) are indicative of a more complex representation of the ways in which individuals classically lumped together under a Borderline PD diagnosis may be understood.

Individuals with Borderline PD manage their affective dysregulation with maladaptive coping mechanisms (e.g., drugs, self-injury) (Bradley & Westen, 2005).

Borderline personality pathology is also associated with higher rates of suicidality and parasuicidal behavior, which has been linked to dysregulated affect (Foote, Smolin, Neft, & Lipschitz, 2008; Grilo et al., 2007). These types of responses were most evident within the personality descriptions of the impulsive dysregulated adolescents.

Neuroendocrinal research suggesting that the affective dysregulation seen in Borderline personality pathology may be related to HPA responses. Lieb and colleagues (2004) found that adults with BPD showed higher levels of cortisol both at the time of awakening and over the course of the day. Levy (2005) suggests that when a child is faced with stressors, secure attachment may moderate the effects of temperament and protect against elevated cortisol. Higher cortisol levels are linked to increased anxiety, depression and externalizing behaviors (Gunnar, Morison, Chisholm, & Schuder, 2001; Heim & Nemeroff, 1999; Heim & Nemeroff, 2001). These may be precursors to the development of personality pathology related to emotional dysregulation.

In sum, based on the extant research it was anticipated that all of the emotionally dysregulated individuals with traumatic separations would have higher rates of Borderline personality pathology, depression, and some features of anxiety and substance abuse. However, the immature dysregulated adolescents were expected to have less substance use and lower rates of Borderline PD than the impulsive dysregulated adolescent subtype. All emotionally dysregulated subtypes were anticipated to have developmental histories with higher rates of sexual abuse, suicidality, and poor global functioning. Physical abuse was also expected to be part of the developmental histories of these individuals. Given that Borderline PD has been found to be heritable, it was anticipated that individuals with traumatic caregiver separations and emotionally

dysregulated presentation will be more likely to have family members who also struggled with similar dysregulation as indicated by a higher rate of family suicidality.

Within the adolescent sample, the immature dysregulated subtype was expected to show more social impairment and dependency. Consistent with the research studying to deficits in mentalization, the immature dysregulated subtype was expected to have a wide range of problems relating to and understanding the thinking and behavior of others. As a result these adolescents would likely have fewer confidants than the other subtypes. When upset, individuals in the immature dysregulated subtype were expected to respond by affective dysregulation characterized by becoming increasingly more childish (as opposed to impulsive acting out behavior). The immature dysregulated adolescents were expected to be less consistent with the prototypical Borderline PD diagnosis and some of their emotional dysregulation and immature appearance could be associated with the developmental stage of adolescence.

In contrast, the adolescent impulsive dysregulated subtype was expected to engage in more impulsive (e.g., substance use, sexual promiscuity, self-harm), delinquent (e.g., rule breaking), and age inappropriate behavior. From a mentalization perspective, these adolescents would experience chronic feelings of emptiness and unstable sense of self due in part to some disruption in the early attachment relationship. These characteristics are also part of the DSM-IV Borderline personality criteria. As a result, they have unstable relationships and become to quickly attached to other people who are similarly unstable. The dysregulation in these adolescents would likely lead to rule-breaking behaviors associated with high rates of oppositional defiant disorder, conduct disorder, and Antisocial personality pathology. These adolescents were expected to have

high rates of attention deficit disorder and substance abuse, which would be associated with their impulsivity. With regards to their developmental history impulsive dysregulated adolescents were expected to have high rates of both sexual abuse and physical abuse. Finally, these individuals were expected to have family histories of substance abuse and suicidality reflecting a likely heritable pattern of impulsivity, dysregulation, and need for external stimulation.

Hostile/Paranoid Subtype

Within the sample of adults with traumatic separations a hostile/paranoid subtype emerged. The relationship between Paranoid PD features and attachment has been explored in some of the psychoanalytic theoretical literature as the individual having experienced the early love object as both needed but also persecutory (Blum, 1981). The DSM-IV indicates that individuals with Paranoid PD have a "pervasive mistrust and suspiciousness of others such that their motives are interpreted as malevolent" (p. 694). These individuals develop the expectation that they will be mistreated (PDM Task Force, 2006). Interestingly, the interpersonal cues that are threatening to the individual with paranoid features are often unapparent to others.

There is limited empirical research studying the attachment experiences and developmental history of individuals with paranoid features. Rankin and colleagues (2005) found that both remitted and non-remitted paranoid patients reported a history of low parental care. Similarly, Kinderman and Bentall (1996) found that paranoid patients were more likely than non-paranoid patients to believe that their parents had negative views of them. Golier and colleagues (2003) found that individuals with Paranoid PD were more likely to have experienced physical abuse during childhood than those without

Paranoid PD. With regards to attachment classifications, Westen and colleagues (2006) found that after controlling for other PDs and gender, Paranoid PD was associated with incoherent/disorganized attachment in an adult sample but not in an adolescent sample. Within adolescent samples others have found associations between dismissing or avoidant attachment (Nakash-Eisikovits et al., 2002; Rosenstein & Horowitz, 1996) suggesting that such adolescents devalue attachment relationships.

Previous research has found that individuals with Paranoid personality pathology lack friendships, have difficulty understanding others, and often feel victimized (Shedler & Westen, 2006). With regards to psychopathology, there are reports of high comorbidity with Antisocial personality. For example, Fonagy and colleagues (1996) found that in an inpatient sample, two out of three of the individuals with Antisocial PD also met criteria for Paranoid PD, leading them to make a combined group. In terms of developmental history, Yang and colleagues (2007) found that Paranoid personality pathology in adults with histories of being institutionalized was associated with conduct disorder in childhood.

Based on the extant research, the hostile/paranoid subtype of adults with traumatic separations was expected to relate not only to Paranoid PD diagnoses but also to Antisocial PD. Individuals in this subtype were expected to have higher rates of a history of physical abuse compared with sexual abuse.

Resilient-High Functioning Personality

Within both adult and adolescent samples, a resilient subtype emerged. Many individuals who experience a traumatic caregiver separation overcome this experience to become high-functioning adults and adolescents. While separations and loss may lead to

increased rates of personality pathology, these are probabilistic, not deterministic associations. While some individuals have constitutional traits leading to an increased likelihood of personality pathology, others may have constitutional traits that are protective in the face of loss. This is consistent with the *resilience association* in which temperament protects children from the impact of adverse environmental stimuli and any associated psychopathology (Shiner & Caspi, 2003). In addition to constitutional traits, environmental factors can also be protective. Research examining attachment disruptions suggests that interpersonal relationships both before and after the separation can influence developmental pathways in human and non-human primate samples. Reite, Kaemingk, and Boccia (1989) found that Pig-tail monkeys, who were adopted by a surrogate, showed less agitation and depression following a separation from their biological mother. Interestingly, these Pig-tail infants were most able to use the adoptive mother to regulate their emotions when they had a positive relationship with their initial caregiver. Similarly, Vorria et al. (1998a) found that emotional and scholastic outcomes of children living in long-term residential group care were predicted by the situation that lead to their initial placement in the group home (e.g., abandonment, financial difficulties, loss). Children who came from harmonious homes were the highest functioning. This may represent the IWM serving as a mediator to a resilient outcome in the developmental pathway. Finally, just as the IWM may serve as mediator leading to personality pathology it may also protect a person from pathological outcomes, despite the experience of an attachment disruption. These findings also illustrate that protective factors derived from relationships both before and after attachment disruptions may have lasting effects of personality.

Therefore, it was expected that the resilient high-functioning subtype would have relatively low rates of Axis I and Axis II psychopathology. It was also anticipated that the developmental histories for these individuals would on average reflect low rates of abuse, low rates of antisocial behavior and suicidality, and families who had relatively lower rates of psychopathology. These individuals were expected to be the least impacted by a traumatic caregiver separation due to protective environmental and genetic factors.

Hypotheses Regarding Criterion Variables

Based on the extant theoretical and empirical literature, *a priori* hypotheses were made regarding the relationship between the subtypes and the criterion variables (see Tables 12-15). These hypotheses were focused on the relative ordering of group means (represented by contrast weights) on various Axis I and II disorders, adaptive functioning, developmental history, and family history variables. The data were analyzed with both contrast analyses and correlational analyses (treating the subtypes both categorically and dimensionally), which produced highly similar results. While results from both analyses were presented, the focus was on the contrast analyses, which had the capacity to test highly focused, specific, directional hypotheses.

The hypotheses regarding the different domains of criterion variables were presented in numeric form as contrast weights in Tables 12-15. For example, in Table 12, the contrast weights for adolescent Major Depressive Disorder (MDD) of 0, 2, 2, -6, 2 represent the *a priori* hypothesis that the two emotionally dysregulated subtypes and the internalizing/avoidant subtype would have the highest rates of MDD (2), followed by the psychopathic subtype (0), and then lastly the resilient subtypes (-6). This hypothesis was developed taking into account research studying outcomes of depression in individuals

with traumatic separations related to dysregulation of the HPA axis, seen in both internalizing and emotionally dysregulated personality research (Heim & Nemeroff, 1999; Heim & Nemeroff, 2001; Lieb et al., 2004).

In contrast, the contrast weights for adolescent Conduct Disorder (CD) of 3, -4, 3, -3, 1 indicated that the psychopathic and impulsive dysregulated subtypes were expected to have the highest rates of CD (3), followed by the immature dysregulated subtype (1), with the resilient (-3) and internalizing subtypes (-4) expected to have the lowest rates. This hypothesis was supported by data suggesting that antisocial behavior is associated with both deficits in empathy and impulsivity (Blair et al., 2006; Burt & Donnellan, 2008; Moffitt, 2006).

With regards to an adolescent development history variable (see Table 13), the contrast weights for childhood sexual abuse of 0, 0, 3, -5, 2 indicated that the impulsive dysregulated subtype would have the highest rates (3), followed by the immature dysregulated (2), then the psychopathic and internalizing/avoidant subtypes (0), and lastly the resilient (-5). This hypothesis reflects the research that has established a relationship between both emotional dysregulation and Borderline PD with childhood sexual abuse (Bradley, Jenei et al., 2005; Westen et al., 1990).

This same pattern of interpretation may be used to interpret the remaining hypotheses in Tables 12-15

In the final set of analyses, hierarchical linear regression was used to assess the incremental validity of the subtypes. Here, it was hypothesized that the personality subtypes would account for a significant portion of the variance in global adaptive functioning after controlling for demographic variables (race, age, gender, and

socioeconomic status) and other traumatic events in childhood (e.g., childhood abuse, witnessing violence). Thus, the goal was to examine whether, within a sample of adolescents and within a sample of adults with a history of traumatic separations, personality styles could predict functioning above and beyond other predictors (and essentially holding constant history of attachment disruptions, since all the subjects included in this analysis had suffered disrupted attachments).

Method: Participants, Procedures, and Measures

The goal of study 3 was to validate the personality subtypes using both external criteria and by considering the incremental validity of the subtypes. Participants included the clinicians who described adolescents and adults with traumatic childhood separations from attachment figures in study 1 and study 2. Procedures and Measures were already described in the preceding studies.

Results

Validating the Personality Subtypes

The goal of these analyses was to provide an initial test of the construct validity of the personality styles identified through Q-factor analysis by testing specific predictions about patterns of association with criterion variables that should distinguish them (Andreasen, Endicott, Spitzer, & Winokur, 1977; Westen & Muderrisoglu, 2003). This study utilized additional data reported by the clinician including Axis I and II psychopathology, individual history variables (e.g., history of physical abuse), and family history variables (e.g., substance abuse, criminality). These criteria are similar to those elaborated by Robins and Guze (1970) for validating diagnostic distinctions, particularly

comparing the subtypes on comorbid diagnoses, adaptive functioning, and etiologically relevant variables.

To test *a priori* hypotheses, the personality subtypes were treated categorically. Adults and Adolescents were assigned to the subtype on which they had the highest factor loading, presuming (1) the loading was $\geq .35$, which indicates considerable match to the diagnostic prototype; and (2) the primarily loading was $\geq .10$ higher than any secondary loading. Thus, patients who did not load highly on any factor or loaded highly on multiple factors were not included. Using this approach, 159 (67.4%) of the 236 adolescents and 154 (75.9%) of the 203 adults were classified[1]. Patients without histories of separations were also assigned categorically to a subtype using the same method to rule out the rival hypothesis that these subtypes represent characteristics of a clinical sample rather than of patients with a history of disrupted attachments.

Table 9 presents the distribution of patients with and without separations across the subtypes. Most notable was that within both the adult and adolescent samples, higher percentages of the psychopathic subtype occurred within the samples of individuals with traumatic separation histories as compared to those without separation histories. Treating the personality subtypes as continuous variables and using *t* tests yielded the same pattern of results. In the adolescent sample, the average factor loadings were significantly higher in the separations group than the non-separations group for the psychopathic ($t = -4.43$, *df*

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[1] Of the unassigned adolescents, 46% did not load at .35 or above on any subtype, 14% loaded highly on both the psychopathic and impulsive dysregulated subtypes, 10% loaded on the psychopathic, impulsive dysregulated, and immature dysregulated subtypes, 5% loaded on both the impulsive dysregulated and immature dysregulated and 5% loaded on both the internalizing/avoidant and immature dysregulated subtypes. Of the unassigned adults, 39% did not load at .35 or above on any subtype, 16% loaded on both the internalizing/avoidant and resilient subtypes, and 34% loaded on the emotionally dysregulated subtype and at least one other subtype.

= 943, p <.001) and impulsive dysregulated dimensions (t = -4.21, df = 943, p <.000), and significantly lower for the internalizing/avoidant (t = 3.91, df = 943, p <.001) and resilient (t = 3.77, df = 943, p <.001) dimensions. Within the adult sample these differences were significantly higher in the separations group than the non-separations group for the emotionally dysregulated (t = -2.40, df = 1189, p =.02), and psychopathic dimensions (t = -3.89, df = 1189, p <.001), and significantly lower than the non-separations group for the internalizing avoidant dimension (t = 3.33, df = 1189, p =.001).

Demographic Variables by Subtype

Analysis of variance (ANOVA) was used to identify any differences between the subtypes on age, sex, race, and socioeconomic status. In the adolescent sample, subtypes differed significantly by sex *(F* (4,154)= 5.70, *MSE*=.22, *p*=.000*)*, age *(F* (4,153)= 4.00, *MSE*=2.43, *p*=.004*)*, socioeconomic status *(F* (4,153)= 3.39, *MSE*=1.25, *p*=.03*)*, but not by race and ethnicity *(F* (4,154)= 4.00, *MSE*=1.06, *n.s.)*. The same pattern of results was found in the adult sample [sex *(F* (4,149)= 8.45, *MSE*=.21, *p*=.000*)*, age *(F* (4,148)= 5.33, *MSE*=152.54, *p*=.000*)*, socioeconomic status *(F* (4,149)= 4.24, *MSE*=1.11, *p*=.003*)*, race and ethnicity *(F* (4,148)= 2.18, *MSE*=.83,*n.s*)]. Tables 10 and 11 present demographic variables by subtype. Notable gender differences common to both samples were that psychopathic subtype was substantially male, while the emotionally dysregulated (or adolescent impulsive dysregulated) was substantially female.

Subtypes were also compared by characteristics of the traumatic separation. Neither the adolescent or adult subtypes differed significantly by age of separation *(*Adolescent *F* (4,154)= .59, *MSE*=.23, *n.s.*; Adult, *F* (4,149)= .72, *MSE*=.21, *n.s.)* or by the clinician's rating of the separation's traumatic impact on a scale of 1-5 *(*Adolescent, *F*

(4,153)= .40, *MSE*=1.15,*n.s.*; Adult, *F* (4,148)= 1.03, *MSE*=1.26, *n.s.)*. Means and standard deviations for these variables are presented in Tables 10 and 11.

Contrast Analyses

Contrast analyses were used to compare the groups on validity criteria and to test *a priori* hypotheses. Benefits of using contrast analysis include the maximizing of power and reducing the likelihood of spurious findings that occur when running multiple analyses. In addition, contrast analysis tests highly specific, focal, one-tailed hypotheses about the relative ordering of group means instead of more global questions that do not specify in advance *how* the groups may differ (Rosenthal, Rosnow, & Rubin, 1999). The *a priori* hypotheses for each sample were developed based on the previously reviewed theoretical and empirical literature and are presented along with the results in Tables 12-15. Axis I and II variables were dummy coded (0/1), resulting in means that correspond to percentages. All remaining variables were dummy coded with the exception of global adaptive functioning, criminality, and number of confidants, which were continuous variables. The global adaptive functioning composite variable was created by averaging the standardized ratings of GAF, level of personality functioning, quality of peer relationships, and work or school functioning. The early-onset delinquency variable in the adolescent sample was a composite variable created by averaging the standardized ratings of arrests, violence, torturing animals, stealing, and fire setting. In contrast, the adult criminality composite variable was created by averaging the standardized ratings of the arrests within the past five years, violent crime committed in the past five years, and having been a perpetrator in an adult abusive relationship. Number of confidants was coded on a 1 to 4 scale (1=none, 2= very few, 3= some, 4= many). Because the subtypes

in the adult and adolescent sample significantly differed on socioeconomic status, age, and gender, these variables were controlled for in secondary analyses, which yielded the same patterns of significant results.

The results of the contrasts analyses and corresponding effect sizes are presented in Tables 12-15. These effect sizes (*r)* are converted from the *t-scores* resulting from the contrast analyses[2]. With regard to Axis I psychopathology, there was support for the expected associations of Major Depression, Substance Use Disorder, Oppositional Defiant Disorder, and Conduct Disorder. Effect sizes for these analyses ranged from .39-.65. However, the expected findings regarding Generalized Anxiety Disorder were not supported in either sample. While rates of Generalized Anxiety Disorder were relatively low across all subtypes, it was notable that the resilient subtype seemed to have higher levels of the disorder than had been anticipated in relation to the other subtypes, suggesting that anxiety may be one of the residues of disrupted attachment in the resilient group. In addition, within the adolescent sample, rates of Attention Deficit Hyperactive Disorder did not differ across subtypes.

With regards to Axis II psychopathology, all hypotheses were supported using contrast analyses, with corresponding effect sizes ranging from .42-.60. The psychopathic subtypes had the highest rates of Antisocial PD (adolescent 67%; adult 90%), while the Adult Emotionally Dysregulated and Adolescent Impulsive Dysregulated had relatively high rates of both Antisocial PD (adolescent 63%; adult 43%) and Borderline PD (adolescent 67%; adult 75%). As expected, the Internalizing/Avoidant subtypes had the highest rates of Avoidant PD (adolescent 47%; adult 70%). With regards to adult

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[2] The formula for this conversion was: $r = \sqrt{(t^2 / [t^2 + df])}$

Paranoid PD, rates were relatively elevated in the Hostile/Paranoid subtype (55%), Psychopathic Subtype (54%), and the Emotionally Dysregulated subtype (50%).

A priori hypotheses regarding global adaptive functioning and developmental history were also supported by the findings (See Tables 13 and 15). The individuals with high loadings on the resilient subtypes had the highest global adaptive functioning. Within both the adult and adolescent samples the lowest functioning subtypes were the psychopathic and emotionally dysregulated (including both the adolescent immature and impulsive dysregulated subtypes). The subtypes characterized by having the lowest numbers of confidants were the psychopathic (both adult and adolescent), immature dysregulated, and hostile/paranoid. However, it is possible that the underlying reason for the low number of close confidants differs depending of the nature of the subtypes. The internalizing/avoidant subtypes had higher numbers of confidants, perhaps in part due to their higher levels of global adaptive functioning. History of criminal activity was highest among the psychopathic subtypes, and history of suicide attempts was higher among the emotionally dysregulated subtypes (adolescent impulsive 75%; adolescent immature 53%, adult 75%). With regards to physical and sexual abuse, rates were elevated across expected subtypes. It was notable, however, that within the adolescent sample, the highest rates of physical abuse occurred within the immature dysregulated (59%) and impulsive dysregulated (50%) subtypes.

Finally, results regarding family history variables were somewhat inconsistent. Consistent with the Axis I findings, family history of anxiety disorder did not differentiate the groups. The adolescent subtypes were differentiated by family history of criminality and suicidality but not family history of illicit drug use. The adult subtypes

were differentiated by family history of criminality and illicit drug use but not by suicidality.

The contrast analyses treated subtype assignment as a categorical variable. Results were replicated using correlations to treat the subtypes (or dimensions) as continuous variables (See Tables 16 and 17). This allowed for each individual with a traumatic separation to be included in the analyses. A similar pattern of results emerged. Notable differences will be highlighted here. A difference with regards to Axis I psychopathology included the absence of a significant positive correlation between the adolescent psychopathic dimension and substance use disorder (*r=.06)*. In terms of developmental history variables, there were no significant positive correlations between subtypes and physical abuse history within the adolescent sample. Within the adult sample, the emotionally dysregulated dimension (r=.45), but not the psychopathic dimension (r=.11) was significantly positively correlated with physical abuse history at the .05 level. With regards to family history of suicidality, the contrast analyses had found rates of 94% within the adolescent immature dysregulated subtype. However, using correlations to treat the subtypes dimensionally there was no significant positive correlation between the immature dysregulated dimension and family history of suicidality (r=.10).

Incremental Validity of the Traumatic Separation Personality Dimensions

The final set of analyses tested the incremental validity of these personality dimensions in predicting global adaptive functioning while holding constant demographic variables and a composite childhood trauma variable. The childhood trauma composite was created by averaging the standardized ratings of presence of childhood physical

abuse, childhood sexual abuse, witnessing violence between parents, involvement of state agencies charged with protection of children, and maternal history of sexual abuse. Personality dimensions were treated as continuous variables for these analyses. Using hierarchical multiple regression, demographic variables (age, sex, race, and socioeconomic status) were included in the first step of the model, the childhood trauma composite variable was included in the second step, and the personality dimensions were placed in the third step.

As can be seen in Table 18, within the adolescent sample, the demographic variables and the composite childhood trauma variable together accounted for a substantial amount of variance in functioning (18%). Of the demographic variables, socioeconomic status was the main predictor of functioning. However, in step 3 of the model, the personality dimensions added substantially to prediction, accounting for 36% more of the variance.

Within the adult sample, a similar pattern of results emerged (See Table 19). Once again, among the demographic variables, socioeconomic status was the greatest predictor of functioning. In contrast to the adult model, the childhood trauma composite variable in step 2 did not predict a significant portion of variance over and above the demographic variables. However, in the step 3 of the model, the personality dimensions once again added to substantially to the prediction of variance in global adaptive functioning accounting for an additional 36% of the variance.

General Discussion of the Three Studies

The aim of this research was to identify personality subtypes of adolescents and adults with traumatic attachment separations (Studies 1 and 2 respectively) using

exploratory Q analyses. Study 3 provided initial validity data for the identified personality subtypes using contrast analyses, correlational analyses, and hierarchical linear regression. The initial two studies produced strikingly similar findings: Both samples converged on *psychopathic, internalizing/avoidant, dysregulated,* and *resilient* subtypes. The sole difference was that the adolescent sample produced two types of dysregulated patients, one more impulsive and the other more immature, whereas the adult sample produced a single hostile/paranoid subtype. A review of the empirical literature suggested that these subtypes are both theoretically sound and clinically coherent.

The results showed that a composite description of the personalities among these individuals masks the patterned heterogeneity found in patients with histories of traumatic separations, which highlights the importance of using personality in clinical settings to better understand and organize the heterogeneous presentations of individuals with attachment disruptions. These results were consistent with additional research that used personality constellations to organize the diverse clinical presentations of people who share a common traumatic experience (Bradley, Heim, & Westen, 2005).

Adolescent and Adult Traumatic Separation Subtypes

The SWAP items provided a portrait of the prototypical patient from each subtype. In the adolescent sample, the psychopathic subtype was primarily male, these youths tended to rebellious, angry, and lacked empathy for others. The internalizing/avoidant subtype was characterized by depressed mood, low self-esteem, and feelings of being an "outsider". The impulsive dysregulated subtype was substantially female and was characterized by emotions that spiral out of control,

unstable relationships, and difficulty with self-soothing. Other behaviors for this subtype included substance abuse and sexual promiscuity. While the immature dysregulated group was also described as having "emotions that spiral out of control," these adolescents tended to be childish and have difficulty thinking in complex and insightful ways about their own mind and the minds of others. Finally the resilient adolescent subtype provided a portrait of a patient who would be likable, energetic, and articulate, with the capacity pursue goals and have meaningful relationships.

In the adult sample, many of the same subtypes emerged. The adult psychopathic subtype had little empathy for others, and was also characterized as manipulative and impulsive, with the tendency to engage in criminal acts. The internalizing/avoidant adult subtype was very similar to that found in the adolescent group. The adult emotionally dysregulated group most closely resembled the adolescent impulsive dysregulated group. This subtype appeared to be primarily female and have characteristics of emotional lability, intense anger, and fears of abandonment. Unique to the adult sample was the hostile/paranoid subtype, which created a portrait of a rigid, critical, and angry individual who lacks close relationships and is suspicious of others. Finally, the resilient adult subtype was characterized with many of the same descriptors as those found for the adolescent resilient subtype.

It should be noted that individuals without separations can also be classified with these subtypes, suggesting that the subtypes are unlikely unique to individuals with traumatic separations. However, it appears that separations may predispose individuals to certain forms of psychopathology. Specifically, the psychopathic subtype and the emotionally dysregulated adult/impulsive dysregulated adolescent subtypes were better

able to describe individuals with separations than those without. This would be consistent with previous attachment research, which has described affect regulation, interpersonal stability, and lack of empathy and the ability to reflect on the perspective of potential victims as consequences of traumatic attachment disruptions (Bezirganian et al., 1993; Fonagy, 1999; Fonagy & Bateman, 2008; Fonagy et al., 1997; Johnson et al., 2006; Kernberg & Caligor, 2005). All of these characteristics could be influenced by mentalization deficits, which are related, in part, to experiences within the parent-child relationship (Fonagy et al., 2002).

Interestingly, these two subtypes showed clear sex differences, perhaps indicating that certain developmental trajectories associated with traumatic separations are more common to males (psychopathic) and females (emotionally dysregulated). The extant research regarding sex differences across personality disorders reveals highly inconsistent results. Some research has found that Borderline personality pathology is more common in females (Ekselius, Bodlund, von Knorring, Lindström, & Kullgren, 1996; Grilo et al., 1996) or that Antisocial personality pathology is more common in males (Ekselius et al., 1996; Grilo, 2002; Lynam & Widiger, 2007). However, this is not the case across all studies (Golomb, Fava, Abraham, & Rosenbaum, 1995). Identifying personality subtypes that are primarily male or female raises questions about gender specific adaptation. In one study, Grilo and colleagues (1996) understood higher rates of Borderline PD in females and Narcissistic PD in males to be associated with differences in developmental biases. They suggest that females may be pushed to be more afilliative and interpersonally connected, while males may be more influenced to be powerful, independent, and controlling. If these developmental gender biases were overly utilized

following a traumatic attachment disruption, this may explain personality subtypes that are more male or female specific. Akhtar (1996) suggests the need not only to study gender differences in prevalence rates of personality disorders, but also to consider gender differences in etiology, symptomatology, broader social influences, and outcomes related to personality pathology. More research is needed to understand the way personality development is influenced by gender following a traumatic separation.

Personality Subtypes and Comorbid Psychopathology: Axis I and II Criterion Variables

The contrast analyses tested *a priori* focal hypotheses to provide support for the taxonomies. As expected, the profiles differed by DSM-IV diagnoses. The psychopathic subtype was associated with Antisocial PD in both the adults and adolescents, and with Conduct Disorder, and Oppositional Defiant Disorder in the adolescents. The internalizing/avoidant subtype was associated with Avoidant PD and Depression. The adult emotionally dysregulated and adolescent impulsive dysregulated subtypes were strongly associated with Borderline PD.

However, some results were different than expected. For example, the subtypes were not differentiated based on Generalized Anxiety Disorder (GAD) in the adult or adolescent sample. Interestingly, although not significant, in the adolescent sample the resilient subtype had the highest rates of GAD. It may be that, although resilient, these high functioning adolescents are predisposed to higher levels of stress and anxiety, which may in part be associated with the traumatic separation. Attachment theory suggests that anxiety is a key force in maintaining contact and safety in the face of threats to security (Bowlby, 1969). Resilient individuals with higher levels of anxiety may have attachment

systems that are overactivated due to a learned heightened sensitivity response. While in some cases this anxiety may be associated with Axis I pathology, at other times it may be an adaptive quality that once helped maintain contact in the face of an attachment disruption.

In the adolescent sample, the subtypes were also not significantly differentiated by ADHD. This suggests that the impulsivity that is a feature of some of the personality subtypes is unlikely to be attributable to an Axis I ADHD diagnosis but instead is a facet of personality. Another explanation for ADHD not differentiating the subtypes may include issues related to the diagnostic subtypes of the disorder, which include Inattentive, Hyperactive, and Combined subtypes. Previous research on children with different subtypes of ADHD suggests that aspects of child temperament and different types of parenting styles interact, resulting in either ambivalent or avoidant attachment (Finzi-Dottan, Manor, & Tyano, 2006). Research considering personality traits has found that inattentive symptoms are associated primarily with low conscientiousness and that the hyperactive-impulsive symptoms are associated with low agreeableness (Nigg et al., 2002; Parker, Majeski, & Collin, 2004). In a study of comorbid psychopathology, ADHD was significantly associated with both cluster B and cluster C DSM-IV PDs, without any differentiation by ADHD subtype (Miller, Nigg, & Faraone, 2007). Therefore, the previous research suggests that personality development in individuals with ADHD is likely a complex pattern that relates to both temperament traits and parenting responses. While personality traits may explain differences in subtypes, other studies of personality pathology have not found differences between ADHD subtypes in relation to different Axis II diagnoses. In the present study, ADHD does not significantly differ across

personality subtypes, but did show small significant associations with the adolescent impulsive dysregulated and psychopathic subtypes (Table 16).

One other finding that was somewhat different than expected was with regard to Paranoid PD. While the adult subtypes did differ significantly on rates of this disorder, it was notable that three of the subtypes had elevated rates of this PD (emotionally dysregulated 50%, psychopathic 54%, and hostile/paranoid 55%). While previous research has found that Paranoid PD and Antisocial PD are highly comorbid (Fonagy et al., 1996), another possible explanation for the elevated rates of paranoid symptomatology may be driven by the presence of traumatic separation. Future studies should assess whether the experience of the separation results in the child forming a belief that others will be inaccessible and unresponsive resulting in a schema that reflects others' untrustworthiness. Overall, the hostile/paranoid subtype is unlikely to be differentiated from the other subtypes simply by the presence or absence of the DSM-IV Paranoid PD diagnosis.

Personality Subtypes in Relation to Developmental History and Family History Criterion Variables

After considering rates of Axis I and II psychopathology, additional criterion variables related to adaptive functioning, developmental history, and family history were used to provide further support for the subtypes identified in each sample. As expected, the emotionally dysregulated subtypes and the psychopathic subtypes were characterized by the lowest global adaptive functioning, suggesting that these subtypes were most impaired. It was anticipated that these individuals would have the most difficulties in terms of their relationships and functioning at work or school. Interestingly, the

internalizing/avoidant subtypes had the highest global adaptive functioning after the resilient subtype, suggesting that this personality presentation interferes least with general functioning. Therefore, personality constellations dominated by dysregulation and deficits in empathy are associated with the greatest general impairment.

In terms of number of confidants, the resilient group, as expected, was characterized by a greater number of close relationships than the other subtypes. Within the adult sample, the hostile/paranoid subtype and psychopathic subtypes were most impaired in this area. The hostile/paranoid individuals appear to be outcasts who likely stay away from people, because of their suspicious, critical, and controlling styles. This contrasts with those in the psychopathic subtype who likely have a lower number of confidants due to their tendency to manipulate and exploit others without regard for their welfare. Interestingly, individuals in the psychopathic subtype appeared to seek out others to use for their own purposes, while the hostile/paranoid subtype's intense mistrust leads them to isolate themselves. Common to both is the intense anger that pervades their personalities. This corresponds to the theoretical work of Meyer and Pilkonis (2005) who suggest that those with Antisocial personality utilize a "dismissing" attachment style in which their sense of self as superior leads them to manipulate others, while those with Paranoid personality pathology use a mixed "fearful-dismissing" attachment style. For these individuals this mixed-style results in a primarily negative self-view that is beneath a façade of superiority and a general mistrust of others despite their desire for nurturance.

Within the adolescent sample, the psychopathic subtype also had fewer confidants; however, as expected, the lowest number of confidants was associated with the immature dysregulated group. The childishness and underdeveloped social skills

characteristic of the immature dysregulated group likely limits their capacity to form rich confiding mutual relationships, regardless of whether they desire them. The deficits in reflective functioning (i.e., thinking about others' mental states) within this subtype may relate to the longitudinal research following Romanian adoptees, which has identified a subgroup who have persistent underdeveloped abilities with both theory of mind and perceptions of emotional expression in others, which results in poor peer relationships (Rutter et al., 2007). More generally, attachment security in adolescents is correlated with better peer relationships (Allen, Porter, McFarland, McElhaney, & Marsh, 2007; Lieberman, Doyle, & Markiewicz, 1999). The number of confidants within the internalizing/avoidant subtypes was higher than expected, which perhaps is attributable to the lack of severity associated with the subtype. While socially avoidant and shy, these adolescents still are able to relate with others to form some meaningful relationships.

Rates of criminality and early-onset delinquency followed the expected patterns. Given the literature regarding the criminal activity of psychopaths, the high rates associated with this subtype were not surprising. Similarly, the impulsive behaviors associated with Borderline personality pathology suggest that these individuals would also be more likely to engage in illicit activity (Fonagy et al., 1997).

Histories of suicide attempts were most strongly associated with the adult emotionally dysregulated and adolescent impulsive dysregulated subtypes. A number of studies have previously documented the association between both suicide attempts and parasuicidal behavior with aspects of affective dysregulation common to Borderline personality pathology (Links et al., 2007; Yen et al., 2004).

Sexual abuse related most to the adult emotionally dysregulated and adolescent impulsive dysregulated subtypes. These results are consistent with previous research linking childhood sexual abuse to Borderline PD, which is characterized by dysregulated affect (Ogata et al., 1990; Westen et al., 1990; Zanarini, 1997). This finding has implications for understanding the ways in which multiple interpersonally traumatic developmental antecedents are associated with affective dysregulation. In childhood, these individuals faced multiple risk factors relating to being cared for and protected. In fact, factors such as family stability mediate these effects (Bradley, Jenei et al., 2005), and others have conceptualized childhood abuse as sometimes symptomatic of difficulties within the attachment relationship (Alexander, 1992). This is consistent with a mentalization perspective in which the absence of parental mirroring leads to affective states that are undifferentiated, outside of awareness, and dysregulated (Fonagy et al., 2002). Overall, developmental history variables were associated with the subtypes in ways that were consistent with previous theory and research.

In contrast to the developmental history variables, family history variables were less successful in differentiating the subtypes, perhaps because of lack of reliability, or simply because family history of a class of disorders is too blunt an instrument for detecting gene-environment interactions (especially when the disorders themselves include substantial psychosocial influences). A family history of an anxiety disorder did not differentiate the subtypes in either sample. This unexpected result was consistent with the earlier finding that GAD diagnosis did not significantly differentiate the subtypes.

Subtypes were, however, distinguished in both samples by family history of criminality, with the psychopathic subtypes showing the highest rates. This is consistent

with the literature identifying the heritability of both callous-unemotional traits and the absence of empathy common to psychopathy (Blair et al., 2006; Wootton et al., 1997). From a diathesis-stress perspective, it may be that individuals in this group who were already vulnerable to developing this personality style were at increased risk following the experience of traumatic separations and other correlated risk factors. In this case, a genetic predisposition for psychopathy may account for the covariance between temperament variables and variables affecting the family environment (e.g., parental consistency, warmth, and empathic responses) (Shiner, 2006). Alternatively, parents who pass on the genes that predispose their children to early-onset delinquency may be more likely to abandon their children.

Overall, the criterion variables were able to provide some initial validity for the distinct subtypes of individuals with traumatic separations. At times, the dimensional analyses were able to reveal some interesting findings that were unapparent when using an arbitrary cut-off to treat the subtypes categorically. For example, although the categorical results did not support differences between groups on GAD or family history of an anxiety disorder, in the adolescent sample the psychopathic personality dimension showed a significant negative correlation with both variables, which is consistent with both theoretical and more recent empirical perspectives of psychopathy (Frick, Lilienfeld, Ellis, Loney, & Silverthorn, 1999). While the contrast analyses allowed for the testing of *a priori* hypotheses, a dimensional view of the personality Q factors provided a rich perspective that incorporated all of the data.

In summary, using contrast analyses, Axis I and II psychopathology significantly differentiated the subtypes, with the exception of GAD and ADHD. The subtypes were

also well differentiated by both adaptive functioning and individual history variables. The emotionally dysregulated and psychopathic subtypes were associated with the lowest adaptive functioning and the greatest number of risk factors. The hostile/paranoid subtype in adulthood was most differentiated by having a combination of low confidants, Paranoid PD, and less antisocial activity than those in the psychopathic group. The resilient subtype was consistently associated with relatively low levels of psychopathology and the fewest developmental risk factors. Least successful in differentiating the subtypes were family history variables. This may suggest that for patients who have experienced traumatic attachment disruptions, certain genetic influences may be less useful in differentiating their overall personality profiles. The exception to this was criminality, which did differentiate the subtypes and was consistent with previous findings suggesting a strong heritable component to psychopathic tendencies.

Incremental Validity

In the final analyses, the incremental validity of the personality dimensions in predicting adaptive functioning, while controlling for demographic variables and histories of childhood trauma, was tested. Demographic variables, particularly socioeconomic status, predicted a substantial portion of the variance in global adaptive functioning. This suggests that for patients with separation histories, the correlates of having a low income greatly affect their functioning in the domains of psychological health, work or school, and relationships. It also indicates that factors related to socioeconomic status (e.g., the availability of resources) should be considered when working with such patients in clinical settings. However, even when controlling for these variables and childhood

trauma, the addition of the personality dimensions predicted a significant and substantial portion of incremental variance in adaptive functioning. These findings suggest that personality is an important predictor of functioning and should be considered along with developmental history variables and important demographic variables. The attention to personality dimensions may help clinicians in formulating their conceptualization of the presenting problem and plans for structuring treatment.

In the adolescent sample, impulsive dysregulated and psychopathic features were significant predictors of lower functioning, while the resilience dimension was a predictor of higher functioning. Within the adult sample, only the resilient dimension was predictive of higher global adaptive functioning. When considering the personality dimensions independently, the results draw attention in both samples to the role of resiliency in adaptive functioning. When controlling for demographic risk factors and trauma, those with traumatic separations whose personalities were characterized as articulate, likable, able to maintain caring relationships, energetic, driven, and responsible were likely to be adapting well to their worlds. This is consistent with longitudinal research from Hauser and Allen (2006) who studied the narratives of at-risk youth. They identified agency, persistence, self-esteem, complexity of thought, and narrative coherence as descriptive qualities of the adolescents who became higher functioning. The adolescents described relationships with narratives rich in reflective functioning. By knowing which qualities are not only characteristics of resilience but also predictive of adaptive functioning, clinicians will be able to have goals that are more clearly tied to empirical data, and better ways to assess therapeutic change.

Limitations

This research had several limitations. First, data in this study were cross-sectional. Without longitudinal prospective data it is impossible to make causal statements about the impact of the traumatic separation on personality development. While one possibility is that an attachment disruption has a lasting impact on personality, another possibility suggests that personality characteristics were already present prior to the separation. Additionally, other factors that are correlated with the presence of separations, rather than the separation itself, may have been more influential to the formation of different personality constellations. While attempts were made to account for some of these differences (e.g., controlling for socioeconomic status, education, gender, and age) it was not possible to fully account for confounding variables. In addition, it was notable that the personality dimensions did account for a significant amount of the variance in global adaptive functioning over and above childhood traumas and socioeconomic status.

Second, within this study a single informant (i.e., the treating clinician) described each patient. Future research should use multiple informants including the self-report of the patient. This would be beneficial both in terms of assessing personality, but also in terms of gathering information regarding the separation and the other criterion variables. Relatedly, this study had relatively little specific information regarding the nature of the separation. While exploratory analyses revealed that subtypes did not differ based on age of separation or trauma severity associated with the separation, it is possible that other factors related to the precise quality of the separation would have helped to further differentiate the subtypes. For example, prolonged traumatic separations due to a parent's illness, being placed in foster care, having a parent in the military who is deployed in

combat, or having a parent incarcerated are likely quite different experiences. In addition, this study suggested that certain aspects of the social environment were associated with different subtypes. The precise nature of the contribution of environmental risk and protective factors to personality development would be useful for understanding ways to assist patients who have experienced attachment disruptions.

Finally, this study utilized data from a clinical sample and may not reflect the more general population. While subjects were not initially recruited based on their patients' histories of separations, it is possible that psychopathology was overrepresented in the sample. The presence of a resilient subtype provides support for the need to consider aspects of personality strengths as part of personality assessment.

Directions for Future Research

As discussed in the limitations section, the results of this study should be extended using prospective longitudinal studies that rely on multiple informants. There are also some additional, broader domains that would benefit from future inquiry.

First, theoretically, IWMs should mediate the development of personality following traumatic separations. However, beyond looking at SWAP items that are reflective of qualities specific to IWMs, this study did not directly assess attachment style or IWMs. Future research should use a measure of attachment security to directly assess IWMs in relation to personality for those with traumatic separations. It may be that the individuals with more severe symptomatology and lower global adaptive functioning are most likely to have insecure or even disorganized attachment. In contrast, it is expected that the resilient subtypes would most likely display secure attachment strategies given the higher global adaptive functioning and greater number of confidants. It would be

useful to compare findings from the traditional measures of attachment to clinical rating scales of attachment (both clinician and patient self report), as these would be more easily utilized within clinical settings. Another issue to address is the specific relationship between the subset of items within the SWAP that are descriptive of relational dynamics and representations of self/other and scales from other measures assessing IWMs. This would further clarify the relationship between the domains of personality and attachment.

In addition to assessing the IWM of the individual who faced the separation, it would also be important to consider the role of IWM of the caregiver in relationship to child personality development. A growing body of research suggests that parents' own representations of relationships may influence aspects of the child's personality and IWMs (Abrams, Rifkin, & Hesse, 2006; Crowell & Feldman, 1988; Main & Hesse, 1990; Zeanah, Zeanah, & Stewart, 1990). For example, it would be interesting to see the ways in which caregivers utilize their own representations of relationships to help the child process and make meaning around the experience of the traumatic separation. Parents with their own histories of unresolved loss and trauma, may be less able to be affectively present and attentive to their children at such times, which may leave the child to utilize self-soothing or inconsistent strategies for emotional regulation. Similarly, researchers developing foster care interventions have emphasized the importance of caregivers reflecting and resolving relational issues from their own childhood that may prevent them from being fully emotionally available and attuned to their foster child, who very likely has suffered a traumatic separations (Dozier & Bick, 2007; Dozier et al., 2005). Therefore it may be that caregiver's IWMs play an important role in the developmental trajectories of personality following a traumatic separation.

Finally, the study of traumatic separations in relation to personality development needs to further untangle the role of genes, environment, and gene-environment interactions. One possible way to address these issues would be through the use of behavior genetic research designs such as adoption studies or those including families with half-siblings following a divorce. Interestingly, some of these research designs by their nature include the presence of a potentially traumatic separation. The results of previous behavior genetics studies suggest that when environment accounts for differences in the traits and behavior, it is generally non-shared environment (Plomin & Caspi, 1999; Scarr, 1996). However, more recently research has found substantial portions of the variance in infant attachment classifications are attributable to shared environment (Bokhorst et al., 2003). It would be interesting to assess the relationship between attachment classification and personality utilizing behavior genetics methodology. An ideal study would simultaneously be able to gather more specific data regarding the separation and the way the separation was experienced for the child. Therefore, a behavior genetics research design may provide an opportunity to both assess parent-child relationships, personality development, and the variance in personality outcomes attributable genes and environment.

Clinical Implications

The presence of personality subtypes among individuals with histories of traumatic separations has important clinical implications for both case formulation and intervention. In terms of case formulation, it provides support for both being thoroughly attentive to developmental history variables and also completing an assessment of personality characteristics. Traumatic separations do not result in a single patient

prototype or pattern of symptomatology. This study identified subgroups of people who differ in their developmental histories, relationships, global functioning, and co-occurring psychopathology. Therefore, a careful assessment of personality from the onset of treatment would likely assist clinicians formulate their understanding of the patient and plan a treatment that will be most appropriate for those with a particular constellation of personality characteristics. The data support the use of personality as an overarching framework for organizing more general symptomatology.

The results of this study suggest that patients with histories of attachment disruption will not be best served by treatments that try to address discrete Axis I disorder (Westen & Bradley, 2005). Instead, working with these patients requires understanding how personality informs their Axis I symptomatology. For example, in the adult sample, high rates of substance use disorders are common to both the emotionally dysregulated and psychopathic subtypes. It may be, however, that treating a substance disorder without considering the way that personality shapes the prognosis and both motivation and experience of the behavior ignores factors that will affect the treatment process.

Next, in working through and resolving issues related to the traumatic separation, treating clinicians need to consider how personality may be affecting clinical presentations. While attachment research has begun to inform adult psychotherapy (Slade, 2008), this study suggests that this work should be expanded to further understand the role of attachment disruptions in personality development. This would build upon the work of mentalization therapies (Bateman & Fonagy, 2004) and research considering therapeutic outcomes of those classified as Unresolved on the AAI.

Conclusion

In summary, this research identified personality subtypes within samples of adult and adolescent patients with histories of traumatic separations. Consistent with Bowlby's expectations, attachment disruptions are associated with a range of personality profiles that are likely related to genetic, environmental, and the gene-environment interactions. Initial support for the validity of the subtypes was established through the expected associated patterns of psychopathology and developmental history variables. Family history variables were less successful at differentiating the subtypes, with the exception of criminality, which was consistent with literature suggesting the heritability of psychopathic personality. Future research should address limitations of this research by using prospective longitudinal studies and data collected by multiple methods and from multiple reporters. There is also a need to further define the role of IWMs in relation to personality development. Finally, future studies assessing individuals with attachment disruptions should utilize a range of personality assessment measures in order to explore different representations of personality and personality pathology. Thus, the results of this research emphasize the value of utilizing personality subtypes within case formulation and treatment for individuals with histories of attachment disruptions.

APPENDIX A: TABLES

Table 1

*Characteristics of Adolescent Patients with and without Childhood Traumatic Separations from Attachment Figure**

	Adolescents with Traumatic Separations (N = 236)	Adolescents without Traumatic Separations (N=714)	*t (df)*	*Sig.*
Race[a]				*<.01*
Caucasian	66.0	82.9		
African American	13.6	5.9		
Hispanic	12.8	5.3		
Asian	3.0	2.5		
Biracial or Other	4.7	3.4		
SES[a]				*<.01*
Poor	17.5	2.1		
Working class	32.9	14.7		
Middle class	28.6	44.7		
Upper middle class	15	32.4		
Upper class	6	6		
Age[a]				.24
13	15.8	12.8		
14	16.2	14.7		
15	15.4	19.1		
16	17.9	22.9		
17	20.9	16.5		
18	13.7	14.0		
Setting[a]				<.01
Private practice	49.6	77.0		
Clinic/hospital outpatient	23.9	16.3		
School	3	2.5		

Table 1 (cont'd)

Inpatient/partial program	3.4	1.7		
Residential facility	12.8	1.1		
Forensic	5.1	1.1		
Other	2.1	.3		
Time in treatment (months) Mean (SD)	12.9 (10.8)	12.3 (9.9)	-.20 (934)	.84
GAF - Mean (SD)	54.9 (9.9)	57.4 (9.7)	3.39 (944)	.001
IQ	106.6 (14.2)	112.0 (14.3)	5.04 (935)	.000
Comorbid Axis I Disorders				
Major Depression	28	27	-.14 (947)	.89
Dysthymia	40	41	.34 (947)	.73
Bipolar	8	7	-.32 (947)	.75
Generalized Anxiety Disorder	8	16	3.8 (947)	.000
PTSD	25	8	-5.77 (947)	.000
Social Phobia	5	9	2.25 (947)	.025
Sexual Disorder	6	2	-2.16 (946)	.03
Substance Use Disorder	25	15	-3.22 (944)	.001
ADHD	31	27	-1.16 (947)	.24
Conduct Disorder	22	12	-3.49 (947)	.001
Oppositional Defiant Disorder	40	32	-2.29 (946)	.02

*Data are percentages unless otherwise specified; [a] Subscript a denotes significance from Chi-square test

Table 2

Composite SWAP-II-A Description of Adolescents with Traumatic Separations from Attachment Figure (N = 236)

SWAP Items	Mean ranking
Tends to feel unhappy, depressed, or despondent.	3.86
Tends to feel misunderstood, mistreated, or victimized.	3.81
Tends to be impulsive.	3.69*
Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, etc.	3.69
Is rebellious or defiant toward authority figures; tends to be oppositional, contrary, quick to disagree, etc.	3.67*
Tends to be angry or hostile (whether consciously or unconsciously).	3.64*
Tends to blame own failures or shortcomings on other people or circumstances; attributes his/her difficulties to external factors rather than accepting responsibility for own conduct or choices.	3.60*
Tends to fear s/he will be rejected or abandoned.	3.39
When upset has trouble perceiving the same qualities in the same person at the same time (e.g., may see others in black or white terms, shift suddenly from seeing someone as caring to seeing him/her as malevolent and intentionally hurtful, etc.)	3.33*
Tends to be manipulative.	3.28*
Attempts to avoid feeling helpless or depressed by becoming angry instead.	3.28*
Lacks close friendships and relationships.	3.15*
Is prone to intense anger, out of proportion to the situation at hand.	3.15*
Tends to be unreliable and irresponsible (e.g., may fail to meet school or work obligations).	3.13
Has little psychological insight into own motives, behavior, etc.	3.11
Tends to give up quickly when frustrated or challenged.	3.10
Is articulate; expresses self well in words.	3.00
Tends to feel like an outcast or outsider.	3.00

*indicates that the SWAP item mean was significantly higher ($p<.05$) in the separation group than the non-separation group

Table 3

Correlations among the 5 Adolescent Personality Subtypes

	Psychopathic	Internalizing/ Avoidant	Impulsive Dysregulated	Resilient	Immature Dysregulated
Psychopathic					
Internalizing/ Avoidant	-.06				
Impulsive Dysregulated	.25	.01			
Resilient	.05	.04	.05		
Immature Dysregulated	.21	.13	.19	.06	

Table 4

Personality Subtypes of Adolescents with Traumatic Separations from Attachment Figures in Childhood

Q factor 1- Psychopathic	*Mean*
Is rebellious or defiant toward authority figures; tends to be oppositional, contrary, quick to disagree, etc.	3.35
Tends to blame own failures or shortcomings on other people or circumstances; attributes his/her difficulties to external factors rather than accepting responsibility for own conduct or choices.	2.60
Tends to be angry or hostile (whether consciously or unconsciously).	2.60
Tends to be critical of others.	2.33
Has little empathy; seems unable or unwilling to understand or respond to others' needs or feelings.	2.26
Tends to be manipulative.	2.17
Attempts to avoid feeling helpless or depressed by becoming angry instead.	2.14
Tends to feel misunderstood, mistreated, or victimized.	2.04
Appears impervious to consequences; seems unable or unwilling to modify behavior in response to threats or negative consequences.	2.02
Is prone to intense anger, out of proportion to the situation at hand (e.g., has rage episodes).	2.02
Tends to hold grudges; may dwell on insults or slights for long periods.	1.96
Lacks close friendships and relationships.	1.94
Tends to be unreliable and irresponsible (e.g., may fail to meet school or work	1.89

Table 4 (cont'd)

obligations).	
Tends to act impulsively (e.g., acts without forethought or concern for consequences).	1.89
Takes advantage of others; has little investment in moral values (e.g., puts own needs first, uses or exploits people with little regard for their feelings or welfare, etc.).	1.89
Experiences little or no remorse for harm or injury caused to others.	1.87
Tends to be dismissive, haughty, or arrogant.	1.81
Tends to be deceitful; tends to lie or mislead.	1.68

Q factor 2- Internalizing/Avoidant	*Mean*
Tends to feel unhappy, depressed, or despondent.	3.51
Tends to feel s/he is inadequate, inferior, or a failure.	2.68
Tends to feel like an outcast or outsider.	2.44
Is prone to painful feelings of emptiness (e.g., may feel lost, bereft, abjectly alone even in the presence of others, etc.).	2.39
Tends to feel guilty (e.g., may blame self or feel responsible for bad things that happen).	2.28
Tends to be shy or self-conscious in social situations.	2.25
Tends to fear s/he will be rejected or abandoned.	2.23
Tends to feel listless, fatigued, or lacking in energy.	2.17
Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities.	2.15

Table 4 (cont'd)

Tends to feel ashamed or embarrassed.	2.02
Tends to avoid, or try to avoid, social situations because of fear of embarrassment or humiliation.	1.78
Tends to feel helpless, powerless, or at the mercy of forces outside his/her control (beyond what is warranted by the situation).	1.77
Is self-critical; sets unrealistically high standards for self and is intolerant of own human defects.	1.76
Tends to feel anxious.	1.73
Has trouble acknowledging or expressing anger toward others, and instead becomes depressed, self-critical, self-punitive, etc. (i.e., turns anger against self).	1.71
Tends to ruminate; may dwell on problems, replay conversations in his/her mind, become preoccupied with thoughts about what could have been, etc.	1.69
Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.	1.68
Tends to feel life has no meaning.	1.64

Q factor 3- Impulsive dysregulated	*Mean*
Tends to act impulsively (e.g., acts without forethought or concern for consequences).	3.13
Tends to abuse alcohol or drugs (beyond what is normative given his/her age, background, etc.).	3.00
Emotions tend to spiral out of control, leading to extremes of anxiety,	2.64

Table 4 (cont'd)

sadness, rage, etc.	
Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.	2.44
Tends to surround him/herself with peers who are delinquent or deeply alienated.	2.35
Tends to feel unhappy, depressed, or despondent.	2.31
Tends to seek thrills, novelty, excitement, etc.; appears to require a high level of stimulation.	2.17
Lacks a stable sense of who s/he is (e.g., attitudes, values, goals, and feelings about self seem unstable or ever-changing).	2.14
Is sexually promiscuous for a person of his/her age, background, etc.	2.12
Relationships tend to be unstable, chaotic, and rapidly changing.	2.12
Is unable to soothe or comfort him/herself without the help of another person (i.e., has difficulty regulating own emotions).	1.98
Tends to be sexually seductive or provocative (e.g., may be inappropriately flirtatious, preoccupied with sexual conquest, prone to use his/her physical attractiveness to an excessive degree to gain notice).	1.85
Emotions tend to change rapidly and unpredictably.	1.84
Tends to be unreliable and irresponsible (e.g., may fail to meet school or work obligations).	1.81

Table 4 (cont'd)

Tends to engage in self-mutilating behavior (e.g., self-cutting, self-burning, etc.).	1.79
Tends to run away from home.	1.65
Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.	1.64
Has trouble acknowledging or expressing anger toward others, and instead becomes depressed, self-critical, self-punitive, etc. (i.e., turns anger against self).	1.63

Q factor 4- Resilient	*Mean*
Has a good sense of humor.	3.24
Tends to be liked by other people.	3.17
Is articulate; can express self well in words.	2.78
Tends to be energetic and outgoing.	2.69
Enjoys challenges; takes pleasure in accomplishing things.	2.68
Is capable of sustaining meaningful relationships characterized by genuine intimacy and caring.	2.64
Is able to assert him/herself effectively and appropriately when necessary.	2.43
Is able to use his/her talents, abilities, and energy effectively and productively.	2.22
Appears comfortable and at ease in social situations.	2.16

Table 4 (cont'd)

Has moral and ethical standards and strives to live up to them.	2.11
Is empathic; is sensitive and responsive to other peoples' needs and feelings.	2.08
Tends to be conscientious and responsible.	1.96
Has areas of accomplishment or achievement other than school (e.g., sports, music, etc.) for which s/he gains considerable recognition.	1.93
Generally finds contentment and happiness in life's activities.	1.82
Tends to feel anxious.	1.70
Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.	1.65
Finds meaning and satisfaction in the pursuit of long-term goals and ambitions.	1.63
Tends to express anger in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).	1.60

Q factor 5- Immature Dysregulated	*Mean*
Seems childish for his/her age (e.g., acts like a younger child or primarily chooses younger peers).	2.87
Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, etc.	2.84
When upset, has trouble perceiving both positive and negative qualities in the same person at the same time (e.g., may see others in black or	2.64

Table 4 (cont'd)

white terms, shift suddenly from seeing someone as caring to seeing him/her as malevolent and intentionally hurtful, etc.).	
When distressed, tends to revert to earlier, less mature ways of coping (e.g., clinging, whining, having tantrums).	2.49
Has little psychological insight into own motives, behavior, etc.	2.40
Tends to be needy or dependent.	2.38
Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance.	2.16
Tends to have extreme reactions to perceived slights or criticism (e.g., may react with rage, humiliation, etc.).	2.14
Is unable to soothe or comfort him/herself without the help of another person (i.e., has difficulty regulating own emotions).	2.07
Tends to become irrational when strong emotions are stirred up; may show a significant decline from customary level of functioning.	2.03
Lacks social skills; tends to be socially awkward or inappropriate.	1.97
Has difficulty making sense of other people's behavior; tends to misunderstand, misinterpret, or be confused by others' actions and reactions.	1.94
Emotions tend to change rapidly and unpredictably.	1.93
Is prone to intense anger, out of proportion to the situation at hand (e.g., has rage episodes).	1.90

Table 4 (cont'd)

Tends to blame own failures or shortcomings on other people or circumstances; attributes his/her difficulties to external factors rather than accepting responsibility for own conduct or choices.	1.86
Tends to feel misunderstood, mistreated, or victimized.	1.70
Tends to be ignored, neglected, or avoided by peers.	1.58
Tends to fear s/he will be rejected or abandoned.	1.55

Table 5

*Characteristics of Adult Patients with and without Traumatic Childhood Separations from Attachment Figures**

	Adults with Traumatic Separations (N=203)	Adults without Traumatic Separations (N=988)	*t (df)*	*Sig.*
Race [a]				<.01
Caucasian	76.2	83.9		
African American	12.4	5.4		
Hispanic	6.9	5.8		
Asian	1.0	2.4		
Biracial or Other	3.5	2.5		
SES [a]				<.01
Poor	13.8	4.2		
Working class	26.6	27.4		
Middle class	31.5	40.6		
Upper middle class	22.2	24.4		
Upper class	5.9	3.7		
Age: Mean(SD)	41.40 (13.10)	42.48 (12.15)	1.13 (1183)	.26
Education [a]				<.01
Less than high school	11.8%	3.0%		
High school	17.7%	18.4%		
Some college	26.1%	24.4%		
College	18.2%	25.3%		
Graduate School	26.1%	28.8%		

Table 5 (cont'd)

Setting [a]				<.01
Private practice	66.5	74.4		
Clinic/hospital outpatient	17.7	16.6		
School	.5	.7		
Inpatient/partial program	5.4	3.4		
Residential facility	1.5	.8		
Forensic	6.9	2.0		
Other	1.5	2.0		
Time in treatment (months) Mean (SD)	18.0 (24.3)	17.2 (19.7)	-.47 (1176)	.64
GAF - Mean (SD)	56.8 (10.7)	58.2 (10.7)	1.67 (1188)	.10
Comorbid Axis I Disorders				
Major Depression	38	36	.38 (1189)	.71
Dysthymia	49	46	-.94 (1189)	.35
Bipolar	5	7	.88 (1189)	.38
Bipolar II/Cyclothymia	12	7	-2.18 (1189)	.03
Generalized Anxiety Disorder	16	19	.76 (1189)	.45
PTSD	20	15	-1.65 (1189)	.08
Social Phobia	6	9	1.39 (1189)	.17
Substance Use Disorder	25	18	-2.29 (1189)	.02
ADHD	8	6	-1.15 (1189)	.25

*Data are percentages unless otherwise specified.

[a] Subscript a denotes significance from Chi-square test

Table 6

Composite SWAP-II Description of Adults with Lengthy Traumatic Caregiver Separations (N = 203)

SWAP Items	Mean ranking
Tends to fear s/he will be rejected or abandoned.	4.04
Tends to feel unhappy, depressed, or despondent.	4.04
Is articulate; can express self well in words.	3.87
Tends to feel anxious.	3.84
Tends to feel misunderstood, mistreated, or victimized.	3.61
Tends to feel s/he is inadequate, inferior, or a failure.	3.49
Tends to be conscientious and responsible.	3.33
Tends to be angry or hostile (whether consciously or unconsciously).	3.32*
Tends to feel like an outcast or outsider.	3.27
Has moral and ethical standards and strives to live up to them.	3.24
Tends to be needy or dependent.	3.22
Tends to feel guilty (e.g. may blame self or feel responsible for bad things that happen).	3.2
Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.	3.12
Tends to react to perceived slights or criticism with rage and humiliation.	3.11*
Is prone to painful feelings of emptiness (e.g., may feel lost, bereft, abjectly alone even in the presence of others, etc.).	3.1
Tends to ruminate; may dwell on problems, replay conversations in his/her mind, become preoccupied with thoughts about what could have been, etc.	3.06
Tends to be critical of others.	3.04*
Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, etc.	3.03

*indicates that the SWAP item mean was significantly higher ($p<.05$) in the separation group than the non-separation group

Table 7

Correlations among the Adult Personality Subtypes

	Internalizing/ Avoidant	Emotionally Dysregulated	Resilient	Hostile/ Paranoid	Psychopathic
Internalizing/ Avoidant					
Emotionally dysregulated	.09				
Resilient	.19	-.04			
Hostile/ Paranoid	.01	.15	.02		
Psychopathic	-.25	.11	-.05	.15	

Table 8

Personality Subtypes in Adults with Traumatic Separations from Attachment Figures in Childhood

Q factor 1- Internalizing/Avoidant	*Mean*
Tends to feel s/he is inadequate, inferior, or a failure.	2.92
Tends to feel guilty (e.g., may blame self or feel responsible for bad things that happen).	2.83
Tends to feel anxious.	2.74
Tends to feel unhappy, depressed, or despondent.	2.72
Tends to feel ashamed or embarrassed.	2.72
Tends to be passive and unassertive.	2.39
Tends to be shy or self-conscious in social situations.	2.37
Has trouble acknowledging or expressing anger toward others, and instead becomes depressed, self-critical, self-punitive, etc. (i.e., turns anger against self).	2.33
Tends to fear s/he will be rejected or abandoned.	2.20
Has difficulty acknowledging or expressing anger.	2.14
Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.	2.05
Has moral and ethical standards and strives to live up to them.	1.96
Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.	1.95
Is self-critical; sets unrealistically high standards for self and is intolerant of own human defects.	1.93

Table 8 (cont'd)

Tends to avoid social situations because of fear of embarrassment or humiliation.	1.91
Tends to feel like an outcast or outsider.	1.75
Tends to ruminate; may dwell on problems, replay conversations in his/her mind, become preoccupied with thoughts about what could have been, etc.	1.73
Tends to be conscientious and responsible.	1.70

Q factor 2- Emotionally Dysregulated	*Mean*
Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, etc.	3.72
Tends to become irrational when strong emotions are stirred up; may show a significant decline from customary level of functioning.	3.40
Tends to have extreme reactions to perceived slights or criticism (e.g., may react with rage, humiliation, etc.).	2.65
Emotions tend to change rapidly and unpredictably.	2.63
Is prone to intense anger, out of proportion to the situation at hand (e.g., has rage episodes).	2.53
Is prone to painful feelings of emptiness (e.g., may feel lost, bereft, abjectly alone even in the presence of others, etc.).	2.32
Tends to fear s/he will be rejected or abandoned.	2.32
When upset, has trouble perceiving both positive and negative qualities in	2.28

Table 8 (cont'd)

the same person at the same time (e.g., may see others in black or white terms, shift suddenly from seeing someone as caring to seeing him/her as malevolent and intentionally hurtful, etc.).	
Is unable to soothe or comfort him/herself without the help of another person (i.e., has difficulty regulating own emotions).	2.14
Lacks a stable sense of who s/he is (e.g., attitudes, values, goals, and feelings about self seem unstable or ever-changing).	2.14
Tends to act impulsively (e.g., acts without forethought or concern for consequences).	2.02
Tends to be angry or hostile (whether consciously or unconsciously).	1.95
Tends to feel misunderstood, mistreated, or victimized.	1.90
Tends to feel unhappy, depressed, or despondent.	1.86
When distressed, perception of reality can become grossly impaired (e.g., thinking may seem delusional).	1.85
Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.	1.73
Relationships tend to be unstable, chaotic, and rapidly changing.	1.71
Tends to be needy or dependent.	1.67
Q factor 3- Resilient	*Mean*
Is articulate; can express self well in words.	3.68

Table 8 (cont'd)

Tends to be conscientious and responsible.	3.13
Enjoys challenges; takes pleasure in accomplishing things.	3.02
Is able to use his/her talents, abilities, and energy effectively and productively.	2.72
Tends to be energetic and outgoing.	2.50
Finds meaning and satisfaction in the pursuit of long-term goals and ambitions.	2.46
Is able to assert him/herself effectively and appropriately when necessary.	2.45
Has moral and ethical standards and strives to live up to them.	2.43
Has a good sense of humor.	2.35
Tends to be liked by other people.	2.28
Is capable of sustaining meaningful relationships characterized by genuine intimacy and caring.	2.10
Is creative; is able to see things or approach problems in novel ways.	2.09
Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.	2.04
Appears comfortable and at ease in social situations.	1.91
Tends to be competitive with others (whether consciously or unconsciously).	1.89
Finds meaning and fulfillment in guiding, mentoring, or nurturing others.	1.84
Finds meaning in belonging and contributing to a larger community (e.g.,	1.80

Table 8 (cont'd)

organization, neighborhood, church).	
Tends to be controlling.	1.63

Q factor 4- Hostile/Paranoid	*Mean*
Tends to be critical of others.	3.43
Tends to hold grudges; may dwell on insults or slights for long periods.	2.94
Tends to be self-righteous or moralistic.	2.56
Tends to be angry or hostile (whether consciously or unconsciously).	2.54
Tends to be controlling.	2.48
Tends to feel misunderstood, mistreated, or victimized.	2.45
Tends to get into power struggles.	2.37
Lacks close friendships and relationships.	2.32
Is suspicious; tends to assume others will harm, deceive, conspire against, or betray him/her.	2.21
Tends to feel unhappy, depressed, or despondent.	2.02
Tends to be dismissive, haughty, or arrogant.	1.85
Tends to ruminate; may dwell on problems, replay conversations in his/her mind, become preoccupied with thoughts about what could have been, etc.	1.84
Tends to blame own failures or shortcomings on other people or circumstances; attributes his/her difficulties to external factors rather than accepting responsibility for own conduct or choices.	1.82

Table 8 (cont'd)

Tends to be oppositional, contrary, or quick to disagree.	1.81
Tends to have extreme reactions to perceived slights or criticism (e.g., may react with rage, humiliation, etc.).	1.76
Tends to be overly concerned with rules, procedures, order, organization, schedules, etc.	1.63
Has an exaggerated sense of self-importance (e.g., feels special, superior, grand, or envied).	1.58
Tends to feel like an outcast or outsider.	1.49

Q factor 5- Psychopathic	*Mean*
Has little empathy; seems unable or unwilling to understand or respond to others' needs or feelings.	2.91
Tends to be deceitful; tends to lie or mislead.	2.79
Tends to act impulsively (e.g., acts without forethought or concern for consequences).	2.72
Has little psychological insight into own motives, behavior, etc.	2.62
Tends to abuse drugs or alcohol.	2.51
Tends to be manipulative.	2.50
Tends to be unreliable and irresponsible (e.g., may fail to meet work obligations or honor financial commitments).	2.50
Takes advantage of others; has little investment in moral values (e.g., puts own needs first, uses or exploits people with little regard for their feelings	2.50

Table 8 (cont'd)

or welfare, etc.).	
Experiences little or no remorse for harm or injury caused to others.	2.43
Tends to engage in unlawful or criminal behavior.	2.30
Tends to show reckless disregard for the rights, property, or safety of others.	2.06
Appears impervious to consequences; seems unable or unwilling to modify behavior in response to threats or negative consequences.	2.03
Tends to be angry or hostile (whether consciously or unconsciously).	1.93
Tends to blame own failures or shortcomings on other people or circumstances; attributes his/her difficulties to external factors rather than accepting responsibility for own conduct or choices.	1.93
Tends to be conflicted about authority (e.g., may feel s/he must submit, rebel against, win over, defeat, etc.).	1.84
Work-life and/or living arrangements tend to be chaotic or unstable (e.g., job or housing situation seems always temporary, transitional, or ill-defined).	1.81
Seems unable to settle into, or sustain commitment to, identity-defining life roles (e.g., career, occupation, lifestyle, etc.).	1.77
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."	1.72

Table 9

Percent of Sample Meeting Criteria for Subtypes as a Function of Presence or Absence of Traumatic Separation

	Separation	*No Separation*
	N (percent of Total)	*N (percent of Total)*
Adolescents		
Psychopathic*	58 (24.6)	134 (18.8)
Internalizing/Avoidant*	33 (14.0)	141 (19.8)
Impulsive Dysregulated*	24 (10.2)	42 (5.9)
Resilient*	27 (11.4)	101 (14.2)
Immature Dysregulated	17 (7.2)	37 (5.2)
Not Classified	77 (32.6)	258 (36.2)
Total	236 (100)	713 (100)
Adults		
Internalizing/Avoidant*	60 (29.6)	337 (34.1)
Emotionally	28 (13.8)	104 (10.5)
Dysregulated*		
Resilient	24 (11.8)	129 (13.1)
Hostile/Paranoid	20 (9.9)	60 (6.1)
Psychopathic*	22 (10.8)	39 (3.9)
Not Classified	49 (24.1)	319 (32.3)
Total	203 (100)	988 (100)

*indicates that when treated dimensionally the differences between those with and without separations was significant

Table 10

Demographic Variables by Adolescent Personality Subtype (in percentages unless otherwise noted)

	Psychopathic (N = 58)	*Internalizing/ Avoidant (N = 33)*	*Impulsive Dysregulated (N = 24)*	*Resilient (N = 27)*	*Immature Dysregulated (N = 17)*
Age: Mean(SD)	15.12 (1.56)	16.25 (1.22)	16.04 (1.57)	15.59 (1.80)	15.88 (1.93)
Sex					
Female	27.6	57.6	79.2	40.7	41.2
Male	72.4	42.4	20.8	59.3	58.8
Race					
Caucasian	60.3	63.6	66.7	70.4	88.2
African American	24.1	15.2	0	14.8	0
Hispanic	13.8	6.1	25.0	11.1	11.8
Asian	1.7	3.0	4.2	0	0
Biracial or Other	0	12.1	4.2	3.7	0
SES					
Poor	22.4	6.1	17.4	7.4	23.5
Working class	37.9	36.4	30.4	29.6	35.3
Middle class	25.9	30.3	17.4	33.3	29.4
Upper middle class	10.3	15.2	26.1	25.9	11.8
Upper class	3.4	12.1	8.7	3.7	0
Separation					
Early (age 1-6)	29.3	42.4	25.0	33.3	41.1
Traumatic Impact: Mean (SD)	3.48 (1.23)	3.70 (.95)	4.00 (1.1)	3.56(1.05)	3.75 (.78)

Table 11

Demographic Variables by Adult Personality Subtype (in percentages)

	Internalizing/ Avoidant (N = 60)	*Emotionally Dysregulated (N = 28)*	*Resilient (N = 24)*	*Hostile/ Paranoid (N = 20)*	*Psychopathic (N = 22)*
Age: Mean(SD)	42.95 (10.91)	38.57 (10.81)	40.00 (14.19)	51.84 (13.64)	35.45 (13.04)
Sex					
Female	53.3	85.7	58.3	35.0	13.6
Male	46.7	14.3	41.7	65.0	86.4
Race					
Caucasian	69.5	82.1	87.5	95	45.5
African American	11.9	10.7	0	5	40.9
Hispanic	13.6	3.6	8.3	0	9.1
Asian	1.7	0	0	0	0
Biracial or Other	3.4	3.6	4.2	0	4.5
SES					
Poor	6.7	28.6	4.2	0	36.4
Working class	28.3	21.4	25.0	20	31.8
Middle class	38.3	25.0	25.0	45	22.7
Upper middle class	21.7	14.3	45.8	30	4.5
Upper class	5.0	10.7	0	5	4.5
Separation					
Early (age 1-6)	23.3	28.6	33.3	35.0	40.9
Traumatic Impact: Mean (SD)	3.63 (1.10)	3.64 (1.31)	3.92 (.93)	3.60 (1.23)	3.24 (1.00)

Table 12

Axis I and Axis II Comorbidity by Adolescent Personality Subtype (in percentages)

	Psychopathic (N = 58) M (SD)	*Internalizing/ Avoidant (N = 33) Mean (SD)*	*Impulsive Dysregulated (N = 24) M (SD)*	*Resilient (N = 27) M (SD)*	*Immature Dysregulated (N = 17) M (SD)*	*Hypotheses (contrast weights)*	*t (df)*	*Sig.*	*r*
Axis I									
Major Depressive Disorder	16 (37)	55 (51)	42 (51)	15 (36)	41 (51)	0 2 2 -6 2	3.35 (63.00)	.001	.39
Generalized Anxiety Disorder	2 (13)	9 (29)	8 (28)	19 (40)	12 (33)	-2 3 -1 -2 2	.07 (73.77)	*n.s.*	.01
Substance Use Disorder	24 (43)	24 (44)	67 (48)	0 (0)	12 (33)	2 -2 3 -4 1	5.88 (47.63)	.001	.65
Conduct Disorder	40 (49)	0 (0)	33 (48)	11 (32)	12 (33)	3 -4 3 -3 1	4.85 (68.17)	.001	.51
Oppositional Defiant Disorder	71 (46)	3 (17)	46 (51)	19 (39)	41 (49)	2 -2 2 -4 2	5.07 (71.42)	.001	.51
Attention Deficit Hyperactive Disorder	33 (47)	12 (33)	29 (46)	30 (47)	18 (39)	1 -2 2 -2 1	.82 (83.31)	*n.s.*	.09
Axis II									
Antisocial	67 (47)	6 (25)	63 (49)	11 (32)	29 (47)	3 -4 3 -3 1	6.77 (116.97)	.001	.53
Borderline	28 (45)	9 (30)	67 (48)	4 (19)	35 (49)	1 1 3 -8 3	5.63 (57.79)	.001	.60
Avoidant	12 (33)	47 (51)	13 (34)	7 (27)	35 (49)	1 5 -4 -3 1	3.72 (63.23)	.001	.42

Note: Contrast analyses did not assume equal variance.

Table 13

Developmental and Family History by Adolescent Personality Subtype

	Psychopathic (N = 58) M (SD)	*Internalizing/ Avoidant (N = 33) Mean (SD)*	*Impulsive Dysregulated (N = 24) M (SD)*	*Resilient (N = 27) M (SD)*	*Immature Dysregulated (N = 17) M (SD)*	*Hypotheses*	*t (df)*	*Sig.*	*r*
Adaptive Functioning and Developmental History									
Global Adaptive Functioning[a]	-.41 (.63)	.19 (.53)	-.37 (.55)	.39 (.55)	-.52 (.36)	-1 0 -1 3 -1	6.92 40.85)	.001	.73
Number of Confidants[a]	1.93 (.59)	2.18 (.53)	2.29 (.69)	2.41 (.75)	1.76 (.44)	-2 -2 3 5 -4	3.76 (63.39)	.001	.43
Early-Onset Delinquency	.66 (.91)	-.18 (.47)	.43 (.99)	-.12 (.40)	.40 (1.0)	5 -5 4 -5 1	4.88 (59.62)	.001	.53
Suicide History (percent)	34 (48)	33 (48)	75 (44)	15 (36)	53 (51)	0 1 3 -5 2	5.65 (66.71)	.000	.57
Physical Abuse (percent)	33 (47)	24 (44)	50 (51)	15 (36)	59 (51)	4 1 2 -9 2	3.19 (50.43)	.001	.41
Sexual Abuse (percent)	17 (38)	18 (39)	58 (50)	7 (27)	47 (51)	0 0 3 -5 2	4.91 (62.11)	.001	.53
Family History									
Anxiety Disorder (percent)	34 (76)	55 (90)	33 (76)	74 (98)	71 (99)	-2 2 1 -2 1	-.07 (97.65)	*n.s.*	.01

Table 13 (cont'd)

Illicit Drug Use (percent)	48 (50)	42 (50)	50 (51)	37 (49)	29 (47)	1 -1 2 -3 1	.63 (64.42)	*n.s.*	.08
Criminality (percent)	41 (50)	9 (29)	21 (41)	15 (36)	18 (39)	3 -3 2 -3 1	2.96 (130.29)	.002	.25
Suicidality (percent)	41 (81)	67 (96)	67 (96)	7 (38)	94 (1.02)	1 1 2 -6 2	4.81 (63.65)	.001	.52

Note: Contrast analyses did not assume equal variance.
[a] Subscript denotes standardized variables in S.D. units

Table 14

Axis I and Axis II Comorbidity by Adult Personality Subtype (in percentages)

	Internalizing/ Avoidant (N = 60) M (SD)	*Emotionally Dysregulated (N = 28) Mean (SD)*	*Resilient (N = 24) M (SD)*	*Hostile/ Paranoid (N = 20) M (SD)*	*Psychopathic (N = 22) M (SD)*	*Hypotheses*	*t (df)*	*Sig.*	*r*
Axis I									
Major Depressive Disorder	45 (50)	46 (51)	21 (41)	40 (50)	14 (35)	2 2 -5 1 0	2.40 (41.27)	.01	.35
Generalized Anxiety Disorder	28 (45)	11 (31)	25 (44)	10 (31)	5 (21)	3 2 -2 0 -3	1.38 (107.45)	*n.s.*	.13
Substance use disorder	17 (38)	57 (50)	8 (28)	5 (22)	59 (50)	0 2 -6 1 3	4.82 (58.06)	.001	.53
Axis II									
Antisocial	7 (25)	43 (50)	00 (00)	25 (44)	90 (29)	-5 3 -5 3 4	10.48 (78.24)	.001	.76
Borderline	22 (42)	75 (44)	13 (34)	20 (41)	27 (46)	1 4 -8 2 1	4.25 (46.82)	.001	.53
Paranoid	8 (28)	50 (51)	8 (28)	55 (51)	54 (51)	-4 2 -4 4 2	5.98 (52.21)	.001	.64
Avoidant	70 (46)	36 (49)	17 (38)	50 (51)	5 (21)	4 1 -4 2 -3	6.94 (86.97)	.001	.60

Note: Contrast analyses did not assume equal variance.

Table 15

Developmental and Family History variables by Adult Personality Subtype

	Internalizing/Avoidant (N = 60) M (SD)	*Emotionally Dysregulated (N = 28) Mean (SD)*	*Resilient (N = 24) M (SD)*	*Hostile/ Paranoid (N = 20) M (SD)*	*Psychopathic (N = 22) M (SD)*	*Hypotheses*	*t (df)*	*Sig.*	*r*
Adaptive Functioning and Developmental History									
Global Adaptive Functioning[a]	.06 (.60)	-.47 (.54)	.77 (.54)	-.24 (.66)	-.58 (.51)	0 -2 5 -1 -2	9.60 (40.85)	.001	.83
Number of Confidants[a]	2.13 (.54)	2.21 (.69)	2.46 (.51)	1.84 (.38)	1.86 (.64)	-3 -1 7 -2 -1	3.82 (33.06)	.001	.55
Criminality[a]	.17 (.49)	.53 (.88)	.13 (.34)	.47 (.96)	1.55 (.91)	-4 2 -4 2 4	6.85 (54.50)	.001	.68
Suicide History (percent)	32 (47)	75 (44)	0 (0)	15 (37)	32 (48)	2 3 -7 1 1	10.92 (56.98)	.001	.82
Physical Abuse (percent)	20 (40)	42 (50)	8 (28)	25 (44)	41 (50)	1 2 -8 2 3	3.37 (59.75)	.001	.40
Sexual Abuse (percent)	28 (45)	61 (50)	4 (20)	5 (22)	27 (46)	1 3 -6 1 1	5.49 (60.61)	.001	.58
Family Member History									
Anxiety Disorder (percent)	27 (45)	25 (44)	25 (44)	5 (22)	23 (42)	3 2 -2 0 -3	.29 (76.14)	*n.s.*	.03

Table 15 (cont'd)

Illicit Drug Use (percent)	23 (43)	39 (50)	0 (0)	25 (44)	36 (49)	1 2 -7 1 3	6.15 (41.80)	.001	.69
Criminality (percent)	10 (30)	25 (44)	8 (28)	10 (31)	32 (48)	-2 2 -4 1 3	2.38 (60.42)	*.01*	.29
Suicidality (percent)	12 (32)	39 (50)	17 (38)	20 (41)	14 (35)	2 3 -7 1 1	.92 (38.83)	*n.s.*	.15

[a] Subscript a denotes standardized variables in S.D. units
Note: Contrast analyses did not assume equal variance

Table 16

Correlations of Adolescent Subtypes with Criterion Variables N=236

	Psychopathic	*Internalizing/ Avoidant*	*Impulsive Dysregulated*	*Resilient*	*Immature Dysregulated*
Axis I					
Major Depressive Disorder	-.23***	.27***	.01	-.16*	-.04
Generalized Anxiety Disorder	-.26***	.13*	-.22**	.16*	-.08
Substance use disorder	.06	-.08	.37***	-.26***	-.13*
Conduct Disorder	.32***	-.39***	.20**	-.15*	-.09
Oppositional Defiant Disorder	.49***	-.27***	.28***	-.15*	.23***
Attention Deficit Hyperactive Disorder	.15*	-.20**	.11	.07	.16*
Axis II					
Antisocial	.47***	-.52***	.46***	-.30***	.02
Borderline	.10	-.16*	.37***	-.37***	.15*
Avoidant	-.17**	.35***	-.13*	-.21**	.09
Individual History Variables					
Global Adaptive Functioning Scale	-.46***	.18**	-.42***	.59***	-.42***
Physical Abuse	-.02	-.05	.11	-.24***	.04
Sexual Abuse	-.09	-.03	.18**	-.26***	.08
Number of Confidantes	-.22**	-.10	-.01	.32***	-.19**
Early-onset Delinquency	.50***	-.47***	.47***	-.35***	.01
Suicidality	-.05	.00	.26***	-.34***	.11
Family History Variables					
Anxiety Disorder	-.13*	.06	-.11	.16*	-.05

Table 16 (cont'd)

Illicit Substance Abuse	.13	-.06	.17*	-.01	-.01
Criminality (1st degree rel)	.22**	-.25***	.11	-.15*	.03
Suicidality	-.10	.07	.01	-.21***	.10

*p<.05, **p<.01, ***p<.001

Table 17

Correlations of Adult Subtypes with Criterion Variables N=203

	Internalizing/ Avoidant	*Emotionally Dysregulated*	*Resilient*	*Hostile/ Paranoid*	*Psychopathic*
Axis I					
Major Depressive Disorder	.21**	.11	-.05	.02	-.20**
Generalized Anxiety Disorder	.18*	-.03	.11	-.07	-.14
Substance use disorder	-.23**	.27***	-.28***	-.08	.36***
Axis II					
Antisocial	-.53***	.35***	-.50***	.10	.67***
Borderline	-.17*	.54***	-.25***	-.01	.14*
Paranoid	-.45***	.41***	-.39***	.40***	.41***
Avoidant	.46***	-.06	-.12	-.07	-.35***
Individual History Variables					
Global Adaptive Functioning Scale	.28***	-.46***	.68***	-.27***	-.38***
Physical Abuse	-.10	.45***	-.32***	-.08	.11
Sexual Abuse	-.19**	.19**	-.15*	-.01	.18*
Number of Confidants	.09	-.05	.34***	-.28***	-.18*
Criminality	-.46***	.23**	-.39***	.22**	.52***
Suicidality	-.10	.45***	-.32***	-.08	.11
Family History Variables					
Anxiety Disorder	-.05	.01	.02	-.03	.00
Illicit Substance Abuse	-.13	.27***	-.25***	-.01	.18**
Criminality (1st degree rel)	-.20**	.18*	-.13	.05	.16*
Suicidality	-.14*	.18*	-.09	.10	.03

*p<.05, **p<.01, ***p<.001

Table 18

Hierarchical Linear Regression Predicting Adolescent Global Adaptive Functioning from Demographic Variables (Step 1), Childhood Trauma (Step 2), and Personality Subtypes (Step 3)

Predictor	Stand. *b*	*t*	*P*	*R*	*R2*	*F* change	*P* change
Step 1				.39	.16	10.46	.001
Age	.06	.94	.35				
Sex	-.02	-.37	.71				
Race/Ethnicity	.09	1.50	.14				
Socioeconomic Status	.38	6.23	.001				
Step 2				.43	.18	.03	.005
Age	.04	.80	.43				
Sex	-.08	-1.49	.14				
Race/Ethnicity	.06	1.34	.18				
Socioeconomic Status	.30	4.43	.001				
Childhood Trauma	-.19	-2.81	.005				
Step 3				.74	.54	34.96	.001
Age	.04	.80	.43				
Sex	-.08	-1.49	.14				
Race/Ethnicity	.06	1.34	.18				
Socioeconomic Status	.21	4.13	.001				
Childhood Trauma	-.08	-1.49	.14				
Psychopathic Subtype	-.20	-2.83	.005				
Internalizing/Avoidant Subtype	-.10	-1.55	.12				
Impulsive Dysregulated Subtype	-.23	-3.99	.001				
Resilient Subtype	.36	6.60	.001				
Immature Dysregulated Subtype	-.10	-1.85	.07				

Note: Global Adaptive Functioning Composite variable = sum of standardized ratings of GAF, personality functioning, quality of peer relationships, school functioning, and social support (# of confidants)

Table 19

Hierarchical Linear Regression Predicting Adult Global Adaptive Functioning from Demographic Variables (Step 1), Childhood Trauma (Step 2), and Personality Subtypes (Step 3)

Predictor	Stand. *b*	*t*	*p*	*R*	*R2*	*F change*	*P change*
Step 1				.34	.12	6.53	.001
Age	-.01	-.20	.84				
Sex	.10	1.54	.13				
Race/Ethnicity	.02	.29	.77				
Socioeconomic Status	.33	4.79	.001				
Step 2				.37	.13	3.6	.060
Age	-.01	-.20	.84				
Sex	.08	1.21	.23				
Race/Ethnicity	.03	.42	.67				
Socioeconomic Status	.27	3.47	.001				
Childhood Trauma	-.14	-1.89	.06				
Step 3				.73	.53	31.97	.001
Age	-.05	-.90	.37				
Sex	.15	2.55	.01				
Race/Ethnicity	.00	.04	.97				
Socioeconomic Status	.17	2.95	.004				
Childhood Trauma	.05	.74	.46				
Internalizing/Avoidant Subtype	-.03	-.36	.80				
Emotionally Dysregulated Subtype	-.12	-1.93	.06				
Resilient Subtype	.53	8.23	.001				
Hostile/Paranoid Subtype	-.07	-1.10	.27				
Psychopathic Subtype	-.11	-1.12	.26				

Note: Global Adaptive Functioning Composite variable = sum of standardized ratings of GAF, personality functioning, quality of peer relationships, school functioning, and social support (# of confidants)

APPENDIX B: MEASURES

CLINICAL DATA FORM – ADOLESCENT

ABOUT YOU (THE CLINICIAN)

1. Discipline: Psychiatry Psychology Social Work Nursing Other
2. Sex: Female Male
3. How would you describe your ***main*** theoretical orientation? *(check one)*
   Biological Eclectic (***If eclectic***, please indicate approach that ***most*** informs your work:)
   Cognitive-Behavioral Biological Psychodynamic
   Family Systems Cognitive-Behavioral Humanistic/experiential
   Psychodynamic Family Systems Other eclectic_____
   Humanistic/experiential Other _____
4. In what settings do you work? *(check **all** that apply)* Private practice
   Clinic/hospital outpatient School Hospital inpatient/partial program
   Residential facility Forensic Other
5. How many years of experience do you have post-training (i.e., post residency or licensure)? __

ABOUT THE PATIENT

DEMOGRAPHIC AND DIAGNOSTIC INFORMATION:

1. Age: _____
2. Sex: Female Male
3. Length of time in treatment with you (in months) _____
4. In what setting have you seen this patient? (*check **primary** setting*)
   Private practice Outpatient Clinic School Hospital inpatient/partial program
   Residential facility Forensic Other
5. Race/Ethnicity: Caucasian African-American Hispanic Asian Other
6. Global Assessment of Functioning (GAF) (referring to the 0-100 scale below, write a number between 0 and 100 here, being as specific as you can): _____

0	10	30	50	70	90	100
	gross *impairment/ psychotic*	serious *impairment/ psychotic*	serious *symptoms*	mild *symptoms/ recurrent problems*	minimal *symptoms*	

7. Family socioeconomic status *(circle number)*: 1 2 3 4 5

poor	*working class*	*middle class*	*upper middle class*	*upper class*

8. Current residence: Living with both parents Living with one parent (with or without another adult in the home) Joint custody Foster home Residential facility Living with other family members Other

9. Approximate IQ: _____

10. Does the patient have a learning disability? No Unsure Yes

11. Axis I diagnosis: ***Please read through the list below, and indicate whether the patient meets DSM-IV criteria for each disorder. If you are unsure, check "No."***

No	Yes	Major depressive disorder	No	Yes	Sexual disorder
No	Yes	Dysthymic disorder	No	Yes	Adjustment disorder
No	Yes	Bipolar disorder	No	Yes	Anorexia, restricting type
No	Yes	Cyclothymia or bipolar II	No	Yes	Anorexia, binge-purging type
No	Yes	Other mood disorder (e.g., NOS)	No	Yes	Bulimia
No	Yes	Generalized anxiety disorder	No	Yes	Other eating disorder (e.g., NOS)
No	Yes	Post-traumatic stress disorder	No	Yes	Psychotic disorder
No	Yes	Social phobia	No	Yes	Attention-deficit hyperactivity disorder
No	Yes	Panic disorder	No	Yes	Psychiatric disorder due to general medical condition
No	Yes	Obsessive-compulsive disorder			
No	Yes	Other anxiety disorder (e.g., NOS)	No	Yes	Conduct disorder
No	Yes	Substance use disorder	No	Yes	Oppositional defiant disorder
No	Yes	Dissociative disorder	No	Yes	Separation anxiety disorder
No	Yes	Somatoform disorder (e.g., hypochondriasis)	No	Yes	Other _____

---

12. Axis II diagnosis: ***Please read through the list below, and indicate whether the patient meets adult DSM-IV criteria for each disorder. If you are unsure, check "No."***

No	Yes	Paranoid	No	Yes	Narcissistic
No	Yes	Schizoid	No	Yes	Avoidant
No	Yes	Schizotypal	No	Yes	Dependent
No	Yes	Antisocial	No	Yes	Obsessive-compulsive
No	Yes	Borderline	No	Yes	Personality disorder NOS
No	Yes	Histrionic			

13. Chronic level of personality functioning (*circle number*):

1 — *severe personality disorder* — 2 — 3 — *substantial problems in living* — 4 — 5 — *high-functioning*

14. Quality of peer relationships (*circle number*): 1 — *very poor or absent* — 2 — 3 — 4 — 5 — *very good*

15. School functioning (*circle number*): 1 — *severe conduct problems/suspensions* — 2 — 3 — 4 — 5 — *working to full potential*

16. Has the patient ever attempted suicide? No Yes

If "yes": Rate the most severe suicide attempt (*circle number*):

1 — *mild (primarily symbolic gesture)* — 2 — 3 — *moderate (required medical attention)* — 4 — 5 — *serious (life-threatening)*

17. Has the patient had psychiatric hospitalizations? No Yes

18. Approximately how many close current relationships has the patient described to you—people in whom s/he feels comfortable confiding? None Very Few Some Many

19. Physical health (*circle number*): 1 — *serious or degenerative illness* — 2 — 3 — *chronic or frequent illness that affects adaptive functioning* — 4 — 5 — *few or occasional health concerns*

20. Approximately how often does the patient get minor illnesses such as the flu, sore throats, headaches, etc., that lead to missed appointments, days off school or work, visits to the doctor, or subjective distress?

1	2	3	4	5
rarely		*occasionally*		*very frequently*
(1 or 2 times a year)		*(a few times a year)*		*(many times per year)*

DEVELOPMENTAL AND FAMILY HISTORY:

Note: For *Developmental and Family History* items below, please check "no" if you are unsure, unless given the response option "unsure" or "unclear."

----------FAMILY ENVIRONMENT----------

For the items that follow, if the patient has had more than one mother- or father-figure, choose the person most involved in rearing the patient (who will usually be the person the patient considers his/her mother or father). If the patient had no enduring relationship with a mother- or father-figure (e.g., if parents divorced early, father disappeared, and the mother never remarried), circle N/A (not applicable).

Unless otherwise specified, describe the patient's childhood experience* through age 16. *In cases in which the family environment changed dramatically at some point and remained that way for several years, rate what you consider the most psychologically significant period.

21. Patient has been reared primarily by: both biological parents biological mother (with or without step-father) biological father (with or without step-mother) adoptive parents foster parents other

22. Relationship with mother (*circle number or N/A*):

N/A	1	2	3	4	5
	poor/ conflictual				*positive/ loving*

23. Relationship with father (*circle number or N/A*):

N/A	1	2	3	4	5
	poor/ conflictual				*positive/ loving*

24. Mother's psychological functioning (*circle number or N/A*):

N/A	1	2	3	4	5
	psychotic	*personality disorder/* severe recurrent Axis I			*hi-functioning*

25. Father's psychological functioning (*circle number or N/A*):

N/A	1	2	3	4	5
	psychotic	*personality disorder/* severe recurrent Axis I			*hi-functioning*

26. Lengthy traumatic separations from primary caregiver for more than 6 weeks:

No Yes age 1-6 Yes, age 7-12 Yes, age 13-16

If "yes":

To what extent did the patient experience the separation(s) as traumatic *(circle number)*:

1	2	3	4	5
not at all		*moderately*		*very*

Frequency of separations *(circle number)*:

1	2	3	4	5
once	*infrequently*	*periodically*	*frequently*	*permanently*

27. Parental divorce/permanent separation:
No Yes, age 1-6 Yes, age 7-12 Yes, age 13-16 N/A (e.g., never lived with both parents)

28. Mother died during patient's childhood: No Yes age 1-6 Yes, age 7-12 Yes, age 13-16

29. Father died during patient's childhood: No Yes age 1-6 Yes, age 7-12 Yes, age 13-16

30. Describe the stability of the primary caregiver's sexual/romantic relationships (*circle number or N/A*):

N/A	1	2	3	4	5
	monogamous/ stable		*somewhat unstable/ changing*		*multiple/ indiscriminate partners*

31. Has the patient ever been in foster care? No Yes
If "yes": Approximately how many placements has the patient been in? _____

32. Has the patient ever been sent to live with other family members or friends because of parental difficulties providing a stable home life? No Yes

33. Have the parents or family ever been investigated for child mistreatment or neglect?
No Yes

34. Has the patient had an alcoholic parent or stepparent living in the home for a substantial period of time? No Yes

35. Was the patient's mother sexually abused as a child? No Unsure Yes

36. Approximate number of residence changes (family moves) during patient's childhood, other than those due to parental job transfers: 0-1 2-3 4-6 >6

37. Rate the extent to which the family environment has been predictable, stable, and consistent (*circle number*):

1	2	3	4	5
chaotic				*predictable/consistent*

38. Rate the extent to which the family environment has been warm and nurturing (*circle number*):

1	2	3	4	5
cold/hostile				*warm/nurturing*

39. Has the patient had someone (other than a parent) s/he could consistently turn to for emotional support during difficult times in childhood (e.g., grandparent, family friend, teacher)?
No Yes

----------PHYSICAL & SEXUAL ABUSE----------

40. Has the patient been physically abused? No Unclear Yes (approximate age at first abuse: _____)
If "yes," (circle numbers):

Severity of physical abuse:	1	2	3	4	5
	no physical injury		*bruises, welts*		*broken bones, burns, etc.*

Frequency of physical abuse:	1	2	3	4	5
	once		periodic		weekly or more

41. Has the patient witnessed domestic violence? No Unclear Yes

42. Has the patient been sexually abused? No Unclear Yes (approximate age at first abuse: _____)

If "yes":

Severity of sexual abuse: *(circle number)*: 1 2 3 4 5
non-contact exposure, kissing *oral sex* *penetration*

Degree of force used *(circle number)*: 1 2 3 4 5
minimal *verbal coercion* *physical violence/coercion*

Frequency of sexual abuse *(circle number)*: 1 2 3 4 5
once *periodic* *weekly*

Main perpetrator of sexual abuse (choose one): father step-father/mother's lover
mother brother other relative non-relative

Approximate total number of perpetrators: _____

Did the patient disclose the sexual abuse to a parent (other than the abuser)? No Yes

If "yes": How did parent(s) respond to the disclosure? (*circle number*):

1 2 3 4 5
denied abuse/ blamed child *supportive, accepting, help-seeking*

----------CHILD/ADOLESCENT BEHAVIOR----------

43. Has the patient had enuresis (bed-wetting)? No Yes
44. Has the patient ever set fires? No Yes
45. Has the patient tortured animals? No Yes
46. Has the patient run away from home? *(circle number)*:

1 2 3 4 5
no *a few times* *frequently*

47. Has the patient abused alcohol or other illegal substances? No Yes (age began: ____)
48. Has the patient initiated physical fights with peers? *(circle number)*:

1 2 3 4 5
no *a few times* *frequently*

49. Has the patient had problems at school with discipline, truancy, suspensions, etc.
No Yes (age began: ___)
50. General performance in school (*circle number*): 1 2 3 4 5
failing/ dropped out *passing* grades *high* achievement
51. Has the patient gotten in trouble for chronic lying? No Yes (age began: __)
52. Has the patient had a problem with stealing? 1 2 3 4 5
no *a few times* *frequently*
53. Has the patient engaged in frequent or serious vandalism? No Yes
54. Has the patient committed violent crimes? *(circle number)*:

1 2 3 4 5
no *unarmed violence* *armed violence (e.g., guns, knives, etc.)*

55. Has the patient been involved in gang activity? No Yes
56. Has the patient committed crimes alone (without the involvement of others)? No Yes

57. Has the patient ever been arrested? (circle number): 1 2 3 4 5
no a few times frequently

58. Has the patient had sexual intercourse (excluding any sexual abuse)? No Unsure Yes

If "yes": At what age did s/he first have sexual intercourse (excluding any sexual abuse)?
_____

59. Has the patient engaged in promiscuous sex? No Yes (age began: _____)

60. At what age was the patient's first contact with a mental health professional? _____

— PARENTAL PSYCHOPATHOLOGY AND FAMILY PSYCHIATRIC HISTORY--

Please do not leave any of the following questions blank. If you do not know, or if the data are unclear, please mark "Unsure."

61. Please indicate any history of psychiatric disorders in the patient's mother or father (or mother- or father-figure, in cases in which the primary parental figures were not the biological parents).

Mother				**Father**		
No	Unsure	Yes	**Psychotic disorder (schizophrenia or schizoaffective)**	No	Unsure	Yes
No	Unsure	Yes	**Bipolar disorder**	No	Unsure	Yes
No	Unsure	Ye	**Major depression**	No	Unsure	Yes
No	Unsure	Yes	**Anxiety disorder**	No	Unsure	Yes
No	Unsure	Yes	**Alcoholism**	No	Unsure	Yes
No	Unsure	Yes	**Prescription drug abuse**	No	Unsure	Yes
No	Unsure	Yes	**Illicit substance abuse**	No	Unsure	Yes
No	Unsure	Yes	**Criminality**	No	Unsure	Yes
No	Unsure	Yes	**Suicide**	No	Unsure	Yes
No	Unsure	Yes	**Suicide attempts**	No	Unsure	Yes
No	Unsure	Yes	**Eating disorder**	No	Unsure	Yes
No	Unsure	Yes	**Severe personality disorder (e.g., borderline, antisocial)**	No	Unsure	Yes

62. Finally, please indicate any history of psychiatric disorders in the patient's first- and second-degree ***biological*** relatives (e.g., if biological mother, father, or *any* biological sibling has a psychotic disorder, indicate "yes" for history of psychosis in first-degree relatives). For these ratings, be sure to include only ***biological*** relatives.

First Degree Relatives *(biological mother, father, or sibling)*				**Second Degree Relatives** *(grandparent, aunt or uncle, niece or nephew, half-sibling)*		
No	Unsure	Yes	**Psychotic disorder (schizophrenia or schizoaffective)**	No	Unsure	Yes
No	Unsure	Yes	**Bipolar disorder**	No	Unsure	Yes
No	Unsure	Yes	**Major depression**	No	Unsure	Yes
No	Unsure	Yes	**Anxiety disorder**	No	Unsure	Yes
No	Unsure	Yes	**Alcoholism**	No	Unsure	Yes
No	Unsure	Yes	**Prescription drug abuse**	No	Unsure	Yes
No	Unsure	Yes	**Illicit substance abuse**	No	Unsure	Yes
No	Unsure	Yes	**Criminality**	No	Unsure	Yes
No	Unsure	Yes	**Suicide**	No	Unsure	Yes
No	Unsure	Yes	**Suicide attempts**	No	Unsure	Yes
No	Unsure	Yes	**Eating disorder**	No	Unsure	Yes
No	Unsure	Yes	**Severe personality disorder (e.g., borderline, antisocial)**	No	Unsure	Yes

CLINICAL DATA FORM

ABOUT YOU (THE CLINICIAN)

1. Discipline: Psychiatry Psychology
2. Sex: Female Male
3. How would you describe your ***main*** theoretical orientation? *(check one)*

   Biological

   Eclectic (***If eclectic***, please indicate approach that ***most*** informs your work:)

   Cognitive-Behavioral
   Family Systems
   Psychodynamic
   Humanistic/experiential

   Biological
   Cognitive-Behavioral
   Family Systems
   Other _____

   Psychodynamic
   Humanistic/experiential
   Other eclectic _____

4. In what settings do you work? ***(check all that apply)***

   Clinic/hospital outpatient
   Residential facility
   School
   Forensic
   Private practice
   Hospital inpatient/partial program
   Other

5. How many years of experience do you have post-training (i.e., post residency or licensure)? ___

ABOUT THE PATIENT

DEMOGRAPHIC AND DIAGNOSTIC INFORMATION:

1. Age: _____
2. Sex: Female Male
3. Length of time in treatment with you (in months) _____
4. In what setting have you seen this patient? (*check **primary** setting*)

   Private practice Outpatient clinic School
   Hospital inpatient/partial program Residential facility Forensic Other
5. Race/ethnicity: Caucasian African-American Hispanic Asian Other
6. Global Assessment of Functioning (GAF) (*referring to the 0-100 scale below, write a number between 0 and 100 here, being as specific as you can*): _____

0	10	30	50	70	90	100
	gross *impairment/ psychotic*	serious *impairment/ psychotic*	serious *symptoms*	mild *symptoms/ recurrent problems*	minimal *symptoms*	

7. Socioeconomic status of family of origin *(circle number)*:

1	2	3	4	5
poor	*working class*	*middle class*	*upper middle class*	*upper class*

8. Education *(circle number)*:

1	2	3	4	5
less than high school	*high school*	*some college*	*college*	*graduate education*

9. Marital Status:

   Married (first marriage) Married (remarried)
   Unmarried with long-term partner Divorced Separated
   Single (never married) Widowed

10. Axis I diagnosis: ***Please read through the list below, and indicate whether the patient meets DSM-IV criteria for each disorder. If you are unsure, check "No."***

No	Yes	Major depressive disorder	No	Yes	Dissociative disorder
No	Yes	Dysthymic disorder	No	Yes	Somatoform disorder (e.g.,hypochondriasis)
No	Yes	Bipolar disorder	No	Yes	Sexual disorder
No	Yes	Cyclothymia or bipolar II	No	Yes	Adjustment disorder
No	Yes	Other mood disorder (e.g., NOS)	No	Yes	Anorexia, restricting type
No	Yes	Generalized anxiety disorder	No	Yes	Anorexia, binge-purging type
No	Yes	Post-traumatic stress disorder	No	Yes	Bulimia
No	Yes	Social phobia	No	Yes	Other eating disorder (e.g., NOS)
No	Yes	Panic disorder	No	Yes	Psychotic disorder
No	Yes	Obsessive-compulsive disorder	No	Yes	Attention-deficit/hyperactivity disorder
No	Yes	Other anxiety disorder (e.g., NOS)	No	Yes	Psychiatric disorder due to general medical condition
No	Yes	Substance use disorder	No	Yes	Other _____

11. Axis II diagnosis: ***Please read through the list below, and indicate whether the patient meets DSM-IV criteria for each disorder. If you are unsure, check "No."***

No	Yes	Paranoid	No	Yes	Narcissistic
No	Yes	Schizoid	No	Yes	Avoidant
No	Yes	Schizotypal	No	Yes	Dependent
No	Yes	Antisocial	No	Yes	Obsessive-compulsive
No	Yes	Borderline	No	Yes	Personality disorder NOS
No	Yes	Histrionic			

12. Chronic level of personality functioning (*circle number*):

1	2	3	4	5
severe personality disorder		*substantial problems in living*		*high-functioning*

13. Quality of romantic relationships (*circle number*):

1	2	3	4	5
very poor/ unstable/absent				*loving & stable*

14. Quality of friendships (*circle number*): 1 2 3 4 5 *very poor/ unable to maintain* … *close/ stable*

15. Employment history (*circle number*): 1 2 3 4 5 *unable to keep a job* … *working to full potential*

16. Has the patient ever attempted suicide? No Yes

If "yes": Rate the most severe suicide attempt (*circle number*):

1	2	3	4	5
mild (primarily symbolic gesture)		*moderate (required medical attention)*		*serious (life-threatening)*

17. Has the patient ever self-mutilated? (excluding suicide attempts): No Yes

If "yes": Describe the extent of the self-mutilation:

1	2	3	4	5
minor/superficial injury				significant

18. Has the patient had psychiatric hospitalizations? No Yes

19. Has the patient been arrested in the last 5 years? No Yes
20. Has the patient committed a violent crime in the last 5 years? No Yes
21. Has the patient been raped or been the victim of a serious sexual assault in adulthood?
No Once More than once
22. Has the patient been in a physically abusive relationship as an adult? No Yes
If yes, was the patient primarily victim, perpetrator, or both (***check both if both apply)***?
victim perpetrator
23. Has the patient lost a job in the last 5 years because of interpersonal problems at work?
No Yes N/A
24. Approximately how many close current relationships has the patient described to you—people in whom s/he feels comfortable confiding? None Very Few Some Many

25. Physical health (*circle number*): 1 2 3 4 5
serious or degenerative illness — *chronic or frequent illness that affects* adaptive functioning — *few or occasional health concerns*

26. Approximately how often does the patient get minor illnesses such as the flu, sore throats, headaches, etc., that lead to missed appointments, days off work, visits to the doctor, or subjective distress

1 2 3 4 5
rarely (1 or 2 times a year) — *occasionally (a few times a year)* — *very frequently (many times per year)*

DEVELOPMENTAL AND FAMILY HISTORY:

Note: For *Developmental and Family History* items below, please check "no" if you are unsure, unless given the response option "unsure" or "unclear."

----------FAMILY ENVIRONMENT----------

27. Patient was reared primarily by: both biological parents biological mother (with or without step-father) biological father (with or without step-mother) adoptive parents foster parents other

For the items that follow, if the patient has had more than one mother- or father-figure in childhood, choose the person most involved in rearing the patient (who will usually be the person the patient considers his/her mother or father). If the patient had no enduring relationship with a mother- or father-figure as a child (e.g., if parents divorced early, father disappeared, and the mother never remarried), circle N/A (not applicable).

Unless otherwise specified, describe the patient's childhood experience through age 16. In cases in which the family environment changed dramatically at some point and remained that way for several years, rate what you consider the most psychologically significant period.

28. Relationship with mother as a child (*circle number or N/A*):
N/A 1 2 3 4 5
poor/ conflictual — *positive/ loving*

29. Relationship with father as a child (*circle number or N/A*):
N/A 1 2 3 4 5
poor/ conflictual — *positive/ loving*

30. Mother's psychological functioning (*circle number or N/A*):

N/A	1	2	3	4	5
	psychotic	*personality disorder/ severe recurrent Axis I*			*hi-functioning*

31. Father's psychological functioning (*circle number or N/A*):

N/A	1	2	3	4	5
	psychotic	*personality disorder/ severe recurrent Axis I*			*hi-functioning*

32. Lengthy traumatic separations from primary caregiver for more than 6 weeks:
No Yes age 1-6 Yes, age 7-12 Yes, age 13-16
If "yes":
To what extent did the patient experience the separation(s) as traumatic *(circle number)*:

1	2	3	4	5
not at all		*moderately*		*very*

Frequency of separations *(circle number)*:

1	2	3	4	5
once	*infrequently*	*periodically*	*frequently*	*permanently*

33. Parental divorce/permanent separation during childhood:
No Yes age 1-6 Yes, age 7-12 Yes, age 13-16 N/A (e.g., never lived with both parents)
34. Mother died during patient's childhood:
No Yes age 1-6 Yes, age 7-12 Yes, age 13-16
35. Father died during patient's childhood:
No Yes age 1-6 Yes, age 7-12 Yes, age 13-16
36. Describe the stability of the primary caregiver's sexual/romantic relationships (*circle number or N/A*):

N/A	1	2	3	4	5
	monogamous/ stable		*somewhat unstable/ changing*		*multiple/ indiscriminate partners*

37. Was the patient ever in foster care as a child? No Yes

If "yes": Approximately how many placements was the patient in? _____

38. Was the patient ever sent to live with other family members or friends because of parental difficulties providing a stable home life? No Yes
39. Were the parents or family ever investigated for child mistreatment or neglect? No Yes
40. Did the patient have an alcoholic parent or step-parent living in the home for a substantial period of time when s/he was a child or adolescent? No Yes
41. Was the patient's mother sexually abused as a child?: No Unsure Yes
42. Approximate number of residence changes (family moves) in patient's childhood, other than those due to parental job transfers: 0-1 2-3 4-6 >6
43. Rate the extent to which the family environment was predictable, stable, and consistent (*circle number*):

1	2	3	4	5
chaotic				*predictable/consistent*

44. Rate the extent to which the family environment was warm and nurturing (*circle number*):

1	2	3	4	5
cold/hostile				*warm/nurturing*

45. Did the patient have someone (other than a parent) s/he could consistently turn to for emotional support during difficult times in childhood (e.g., grandparent, family friend, teacher)? No Yes

----------PHYSICAL & SEXUAL ABUSE----------

46. Was the patient physically abused as a child? No Unclear Yes (approximate age at first abuse: _____)

If "yes" (circle numbers):

Severity of physical abuse: 1 2 3 4 5
no physical injury *bruises, welts* *broken bones, burns, etc.*

Frequency of physical abuse: 1 2 3 4 5
once periodic weekly or more

47. Did the patient witness domestic violence as a child? No Unclear Yes

48. Was the patient sexually abused as a child? No Unclear Yes (approximate age at first abuse: _____)

If "yes":

Severity of sexual abuse: *(circle number)*: 1 2 3 4 5
non-contact exposure, kissing *oral sex* *penetration*

Degree of force used *(circle number)*: 1 2 3 4 5
minimal *verbal coercion* *physical violence/coercion*

Frequency of sexual abuse *(circle number)*: 1 2 3 4 5
once *periodic* *weekly*

Main perpetrator of sexual abuse (choose one): father step-father/mother's lover mother brother other relative non-relative

Approximate total number of perpetrators: _____

Did the patient disclose the sexual abuse to parent(s) as a child/adolescent? No Yes

If "yes": How did parent(s) respond to the disclosure? (*circle number*):

1 2 3 4 5
denied abuse/ blamed child *supportive, accepting, help-seeking*

----------CHILD/ADOLESCENT BEHAVIOR----------

49. Was the patient enuretic as a child (bed-wetting)? No Yes

50. Did the patient engage in fire-setting as a child/adolescent? No Yes

51. Did the patient torture animals as a child/adolescent? No Yes

52. Did the patient run away from home as a child/adolescent? (circle number):

1 2 3 4 5
no *a few times* *frequently*

53. Did the patient abuse alcohol or other illegal substances as a child/adolescent? No Yes (age began: ____)

54. Did the patient initiate physical fights with peers as a child/adolescent?
No Yes (age began: ____)

55. Did the patient have problems with discipline, truancy, suspensions, etc., at school?
No Yes (age began: ___)

56. General performance in school (*circle number*): 1 2 3 4 5
failed/ dropped out *passing grades* *high achievement*

57. Did the patient get in trouble for chronic lying as a child/adolescent?
No Yes (age began: ____)

58. Did the patient engage in frequent stealing as a child/adolescent?
No Yes (age began: ____)

59. Did the patient commit violent or armed crimes as a child/adolescent?
No Yes (age began: ____)

60. Was the patient ever arrested as a child/adolescent? *(circle number)*:

1 2 3 4 5
no a few times frequently

61. At approximately what age did the patient first have sexual intercourse (excluding sexual abuse)? _____ N/A

62. Did the patient engage in promiscuous sex as a child/adolescent? No Yes (age began: _____)

63. Did the patient have close friends as a child/adolescent? No Very Few Some Many

64. Was the patient ever evaluated or treated by a mental health professional as a child/adolescent?
No Yes
If "yes": What was the patient's approximate age at first mental health contact: _____

—PARENTAL PSYCHOPATHOLOGY AND FAMILY PSYCHIATRIC HISTORY—

Please do not leave any of the following questions blank. If you do not know, or if the data are unclear, please mark "Unsure."

65. Please indicate any history of psychiatric disorders in the patient's mother or father (or mother- or father-figure, in cases in which the primary parental figures were not the biological parents).

Mother				Father		
No	Unsure	Yes	**Psychotic disorder (schizophrenia or schizoaffective)**	No	Unsure	Yes
No	Unsure	Yes	**Bipolar disorder**	No	Unsure	Yes
No	Unsure	Yes	**Major depression**	No	Unsure	Yes
No	Unsure	Yes	**Anxiety disorder**	No	Unsure	Yes
No	Unsure	Yes	**Alcoholism**	No	Unsure	Yes
No	Unsure	Yes	**Prescription drug abuse**	No	Unsure	Yes
No	Unsure	Yes	**Illicit substance abuse**	No	Unsure	Yes
No	Unsure	Yes	**Criminality**	No	Unsure	Yes
No	Unsure	Yes	**Suicide**	No	Unsure	Yes
No	Unsure	Yes	**Suicide attempts**	No	Unsure	Yes
No	Unsure	Yes	**Eating disorder**	No	Unsure	Yes
No	Unsure	Yes	**Severe personality disorder (e.g., borderline, antisocial)**	No	Unsure	Yes

66. Now, please indicate any history of psychiatric disorders in the patient's first- and second-degree ***biological*** relatives (e.g., if biological mother, father, or *any* biological sibling has a psychotic disorder, indicate "yes" for history of psychosis in first-degree relatives). For these ratings, be sure to include only ***biological*** relatives.

First Degree Relatives *(biological mother, father, or sibling)*				**Second Degree Relatives** *(grandparent, aunt or uncle, niece or nephew, half-sibling)*		
No	Unsure	Yes	**Psychotic disorder (schizophrenia or schizoaffective)**	No	Unsure	Yes
No	Unsure	Yes	**Bipolar disorder**	No	Unsure	Yes
No	Unsure	Yes	**Major depression**	No	Unsure	Yes
No	Unsure	Yes	**Anxiety disorder**	No	Unsure	Yes
No	Unsure	Yes	**Alcoholism**	No	Unsure	Yes
No	Unsure	Yes	**Prescription drug abuse**	No	Unsure	Yes
No	Unsure	Yes	**Illicit substance abuse**	No	Unsure	Yes
No	Unsure	Yes	**Criminality**	No	Unsure	Yes
No	Unsure	Yes	**Suicide**	No	Unsure	Yes
No	Unsure	Yes	**Suicide attempts**	No	Unsure	Yes
No	Unsure	Yes	**Eating disorder**	No	Unsure	Yes
No	Unsure	Yes	**Severe personality disorder (e.g., borderline, antisocial)**	No	Unsure	Yes

EFFECTIVENESS OF TREATMENT:

67. Has the patient been in psychotherapy with you? No Yes

If "yes," how effective has psychotherapy been to date? (i.e., how much change or benefit)

N/A (began recently) 1 2 3 4 5

not at all *somewhat* *highly*

68. Has the patient taken psychotropic medication at any time during treatment with you? No Yes

If "yes", please check all medication categories that apply. If you know the specific drug(s), please indicate this by checking the appropriate box(es). (If more than one drug was tried, please check all applicable).

Antidepressants

SSRI (e.g., Prozac, Paxil, Zoloft, Celexa)
Tricyclic (e.g., Elavil, Anafranil, Norpramin, Tofranil, Pamelor)
MAO inhibitor (e.g., Nardil, Eldepryl, Parnate)
Other antidepressant (e.g., Effexor, Wellbutrin, Remeron, Serzone)

How effective was the medication? (If more than one used, rate the most effective one)

1 2 3 4 5

not at all, or intolerable side effects *somewhat* *highly, controlled all or most symptoms*

Anxiolytics (anti-anxiety)

Buspar
Benzodiazepine (e.g., Xanax, Valium, Librium, Ativan, Klonopin)

How effective was the medication? (If more than one used, rate the most effective one)

1	2	3	4	5
not at all, or intolerable side effects		*somewhat*		*highly, controlled all or most symptoms*

Mood stabilizers (e.g., Lithium, Tegretol, Depakote, Lamictal, Neurontin)

How effective was the medication? (If more than one used, rate the most effective one)

1	2	3	4	5
not at all, or intolerable side effects		*somewhat*		*highly, controlled all or most symptoms*

Antipsychotics (e.g., Haldol, Thorazine, Prolixin, Zyprexa)

How effective was the medication? (If more than one used, rate the most effective one)

1	2	3	4	5
not at all, or intolerable side effects		*somewhat*		*highly, controlled all or most symptoms*

SWAP-II-A

1 Tends to feel guilty (e.g., may blame self or feel responsible for bad things that happen).
2 Is able to use his/her talents, abilities, and energy effectively and productively.
3 Takes advantage of others; has little investment in moral values (e.g., puts own needs first, uses or exploits people with little regard for their feelings or welfare, etc.).
4 Has an exaggerated sense of self-importance (e.g., feels special, superior, grand; believes s/he is the object of envy; tends to boast or brag).
5 Tends to be ignored, neglected, or avoided by peers.
6 Is troubled by recurrent obsessional thoughts that s/he experiences as intrusive.
7 Appears conflicted about his/her racial or ethnic identity (e.g., undervalues and rejects, or overvalues and is preoccupied with, own cultural heritage).
8 Seems childish for his/her age (e.g., acts like a younger child or primarily chooses younger peers).
9 When upset, has trouble perceiving both positive and negative qualities in the same person at the same time (e.g., may see others in black or white terms, shift suddenly from seeing someone as caring to seeing him/her as malevolent and intentionally hurtful, etc.).
10 Is preoccupied with aggressive games, fantasies, firearms, etc.
11 Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.
12 Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, etc.
13 Tends to use his/her psychological or medical problems to avoid school, work, or responsibility (whether consciously or unconsciously).
14 Tends to blame own failures or shortcomings on other people or circumstances; attributes his/her difficulties to external factors rather than accepting responsibility for own conduct or choices.
15 Lacks a stable sense of who s/he is (e.g., attitudes, values, goals, and feelings about self seem unstable or ever-changing).
16 Tends to be angry or hostile (whether consciously or unconsciously).
17 Tends to be ingratiating or submissive with peers (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 Tends to stir up conflict or animosity between other people (e.g., may portray a situation differently to different people, leading them to form contradictory views or work at cross purposes).

19 Enjoys challenges; takes pleasure in accomplishing things.
20 Tends to be deceitful; tends to lie or mislead.
21 Tends to be hostile toward members of the opposite sex, whether consciously or unconsciously (e.g., may be disparaging or competitive).
22 Tends to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.).
23 Tends to get involved in romantic or sexual "triangles" (e.g., becomes interested in people who are already attached, sought by someone else, etc.).
24 Tends to be unreliable and irresponsible (e.g., may fail to meet school or work obligations).
25 Has difficulty acknowledging or expressing anger.
26 Tends to get drawn into relationships outside the family in which s/he is emotionally or physically abused, or needlessly puts self in dangerous situations (e.g., walking alone or meeting strangers in unsafe places).
27 Has panic attacks (i.e., episodes of acute anxiety accompanied by strong physiological responses).
28 Tends to be preoccupied with concerns about dirt, cleanliness, contamination, etc. (e.g., drinking from another person's glass, sitting on public toilet seats, etc.).
29 Has difficulty making sense of other people's behavior; tends to misunderstand, misinterpret, or be confused by others' actions and reactions.
30 Tends to feel listless, fatigued, or lacking in energy.
31 Tends to show reckless disregard for the rights, property, or safety of others.
32 Is capable of sustaining meaningful relationships characterized by genuine intimacy and caring.
33 Is conflicted or inhibited about achievement or success (e.g., achievements may be below potential, may sabotage self just before attaining important goals, etc.).
34 Tends to be sexually seductive or provocative (e.g., may be inappropriately flirtatious, preoccupied with sexual conquest, prone to use his/her physical attractiveness to an excessive degree to gain notice).
35 Tends to feel anxious.
36 Tends to feel helpless, powerless, or at the mercy of forces outside his/her control (beyond what is warranted by the situation).
37 Finds meaning in belonging and contributing to a larger community (e.g., volunteer organizations, teams, neighborhood groups, church, etc.).
38 Tends to feel s/he is not his/her true self with others; may feel false or fraudulent.
39 Appears to gain pleasure or satisfaction by being sadistic or aggressive (whether consciously or unconsciously) or bullying others.

40 Tends to engage in criminal or delinquent behavior (moderate placement of this item implies occasional or petty crimes such as shoplifting or vandalism).
41 Appears unable to describe important others in a way that conveys a sense of who they are as people; descriptions of others come across as two-dimensional and lacking in richness.
42 Tends to feel envious.
43 Tends to seek power or influence with peers (whether in beneficial or destructive ways).
44 When distressed, perception of reality can become grossly impaired (e.g., thinking may seem delusional).
45 Is prone to idealizing people; may see admired others as perfect, larger than life, all wise, etc.
46 Tends to be suggestible or easily influenced.
47 Attempts to avoid or flee depressive feelings through excessive optimism, activity, energy, etc.
48 Seeks to be the center of attention.
49 When distressed, tends to revert to earlier, less mature ways of coping (e.g., clinging, whining, having tantrums).
50 Tends to feel life has no meaning.
51 Tends to be liked by other people.
52 Has little empathy; seems unable or unwilling to understand or respond to others' needs or feelings.
53 Seems to treat others primarily as an audience to witness own importance, brilliance, beauty, etc.
54 Tends to feel s/he is inadequate, inferior, or a failure.
55 Finds meaning and fulfillment in guiding, mentoring, or nurturing others.
56 Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities.
57 Religious or spiritual beliefs are central to his/her identity and experience.
58 Has little or no interest in sexuality (e.g., does not engage in age-appropriate fantasy, exploration, or experimentation, or shows little curiosity).
59 Is empathic; is sensitive and responsive to other peoples' needs and feelings.
60 Tends to be shy or self-conscious in social situations.
61 Tends to disparage qualities traditionally associated with own gender (e.g., a girl who disdains nurturance and overvalues power; a boy who disdains power and overvalues emotional sensitivity).
62 Tends to be preoccupied with food, diet, or eating.
63 Is able to assert him/herself effectively and appropriately when necessary.
64 Mood tends to cycle over intervals of weeks or months between excited and depressed states (high placement implies bipolar mood disorder).

65 Attempts to control or dominate a significant other (e.g., sibling, parent, boyfriend, girlfriend) through violence or intimidation.
66 Is excessively devoted to school, work, or productivity, to the detriment of fun, pleasure, or friendships.
67 Tends to be stingy and withholding (of time, money, affection, etc.).
68 Has a good sense of humor.
69 Decisions and actions are unduly influenced by efforts to avoid perceived dangers; is more concerned with avoiding harm than pursuing desires.
70 Has uncontrolled eating binges followed by "purges" (e.g., makes self vomit, abuses laxatives, fasts, etc.); has bulimic episodes.
71 Tends to seek thrills, novelty, excitement, etc.; appears to require a high level of stimulation.
72 Tends to perceive things in global and impressionistic ways (e.g., misses details, glosses over inconsistencies, mispronounces names).
73 Tends to "catastrophize"; is prone to see problems as disastrous, unsolvable, etc.
74 Expresses emotion in exaggerated and theatrical ways.
75 Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance.
76 Manages to elicit in others feelings similar to those s/he is experiencing (e.g., when angry, acts in such a way as to provoke anger in others; when anxious, acts in such a way as to induce anxiety in others).
77 Tends to be needy or dependent.
78 Tends to express anger in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).
79 Attempts to deny or "override" fear or anxiety by rushing headlong into feared situations, taking unnecessary risks, etc.
80 Tends to be bullied, harassed, or teased by peers.
81 Repeatedly re-experiences or re-lives a past traumatic event (e.g., has intrusive memories or recurring dreams of the event; is startled or terrified by present events that resemble or symbolize the past event).
82 Derives satisfaction or self-esteem from being, or being seen as, "bad" or "tough."
83 Beliefs and expectations seem cliché or stereotypical, as if taken from storybooks or movies.
84 Tends to be competitive with others (whether consciously or unconsciously).
85 Has conscious homosexual desires (moderate placement implies bisexuality, high placement implies homosexuality).
86 Tends to feel ashamed or embarrassed.
87 Tends to run away from home.
88 Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves.

89 Is resilient in the face of stress; seems to be able to face loss, trauma, or deeply troubling events with appropriate feeling and to continue to function effectively.
90 Is prone to painful feelings of emptiness (e.g., may feel lost, bereft, abjectly alone even in the presence of others, etc.).
91 Is self-critical; sets unrealistically high standards for self and is intolerant of own human defects.
92 Is articulate; can express self well in words.
93 Seems naïve or innocent; appears to know less about the ways of the world than might be expected given his/her age, intelligence, or background.
94 Tends to surround him/herself with peers who are delinquent or deeply alienated.
95 Appears comfortable and at ease in social situations.
96 Tends to elicit dislike or animosity in others.
97 Has trouble sitting still; is restless, fidgety, or hyperactive.
98 Tends to fear s/he will be rejected or abandoned.
99 Is unduly frightened by sexuality; appears to associate sex with danger (e.g., injury, punishment, contamination).
100 Tends to think in abstract and intellectualized terms, even in matters of personal import.
101 Generally finds contentment and happiness in life's activities.
102 Has a deep sense of inner badness; sees self as damaged, evil, or rotten to the core (whether consciously or unconsciously).
103 Tends to have extreme reactions to perceived slights or criticism (e.g., may react with rage, humiliation, etc.).
104 Appears to have little need for human company or contact; is emotionally detached or indifferent.
105 Is suspicious; tends to assume others will harm, deceive, conspire against, or betray him/her.
106 Tends to express emotion appropriate in quality and intensity to the situation at hand.
107 Tends to express qualities or mannerisms traditionally associated with own gender to an exaggerated or stereotypical degree (i.e., a hyper-feminine girl; a hyper-masculine, "macho" boy).
108 Tends to restrict food intake to the point of being underweight and malnourished.
109 Tends to engage in self-mutilating behavior (e.g., self-cutting, self-burning, etc.).
110 Tends to become attached to, or romantically interested in, people who are emotionally unavailable.
111 Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.

112 Appears impervious to consequences; seems unable or unwilling to modify behavior in response to threats or negative consequences.
113 Experiences little or no remorse for harm or injury caused to others.
114 Tends to be critical of others.
115 Is prone to violence (e.g., may break things, provoke fights, or become physically assaultive).
116 Tends to see own unacceptable feelings or impulses in other people instead of in him/herself.
117 Is unable to soothe or comfort him/herself without the help of another person (i.e., has difficulty regulating own emotions).
118 Has difficulty maintaining attention and focus on tasks; is easily distracted by sights, sounds, unrelated thoughts, or other competing stimuli.
119 Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.
120 Has moral and ethical standards and strives to live up to them.
121 Is creative; is able to see things or approach problems in novel ways.
122 Attempts to avoid feeling helpless or depressed by becoming angry instead.
123 Tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered.
124 Tends to avoid, or try to avoid, social situations because of fear of embarrassment or humiliation.
125 Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or "off").
126 Appears to have a limited or constricted range of emotions.
127 Tends to feel misunderstood, mistreated, or victimized.
128 Fantasizes about ideal, perfect love.
129 Tends to be overly compliant or obedient with authority figures.
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 Appears conflicted about experiencing pleasurable emotions; tends to inhibit excitement, joy, pride, etc.
132 Is sexually promiscuous for a person of his/her age, background, etc.
133 Tends to be dismissive, haughty, or arrogant.
134 Tends to act impulsively (e.g., acts without forethought or concern for consequences).
135 Is hypochondriacal; has exaggerated fears of contracting medical illness (e.g., worries excessively about normal aches and pains).
136 Tends to believe in supernatural, paranormal, or superstitious phenomena or to be drawn to "alternative" belief systems (e.g., astrology, tarot,

crystals, psychics, auras).

137 Is confused, conflicted, or uncertain about his/her sexual orientation (e.g., may struggle to keep homosexual feelings out of awareness, have an exaggerated fear of homosexuality, etc.).

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

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

140 Sexual fantasies or activities are unusual, idiosyncratic, or rigidly scripted (e.g., dominance, submission, voyeurism, fetishes, etc.).

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

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

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

145 Thought processes or speech tend to be circumstantial, vague, rambling, digressive, etc. (e.g., may be unclear whether s/he is being metaphorical or whether thinking is confused or peculiar).

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

147 Tends to abuse alcohol or drugs (beyond what is normative given his/her age, background, etc.).

148 Has little psychological insight into own motives, behavior, etc.

149 Tends to feel like an outcast or outsider.

150 Tends to identify with admired others to an exaggerated degree, taking on their attitudes, mannerisms, etc., in a way that is not normative for his/her age, background, etc.

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

152 Tends to repress or "forget" distressing events, or distort memories of distressing events beyond recognition.

153 Relationships tend to be unstable, chaotic, and rapidly changing.

154 Tends to draw others into scenarios, or "pull" them into roles, that feel alien or unfamiliar (e.g., being uncharacteristically insensitive or cruel, feeling like the only person in the world who can help, etc.).

155 Tends to describe experiences in generalities; is reluctant to provide details, examples, or supporting narrative.

156 Has a disturbed or distorted body-image (e.g., may see self as unattractive, grotesque, disgusting, etc.)

157 Tends to become irrational when strong emotions are stirred up; may

show a significant decline from customary level of functioning.

158 Has areas of accomplishment or achievement other than school (e.g., sports, music, etc.) for which s/he gains considerable recognition.

159 Tends to deny or disavow own need for nurturance, caring, comfort, etc. (e.g., may regard such needs as weakness, avoid depending on others or asking for help, etc.)

160 Lacks close friendships and relationships.

161 Tends to deny, disavow, or squelch his/her own realistic hopes, dreams, or desires to protect against anticipated disappointment (whether consciously or unconsciously).

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

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

164 Tends to be self-righteous or moralistic.

165 Tends to distort unacceptable wishes or feelings by transforming them into their opposite (e.g., may express excessive concern while showing signs of unacknowledged hostility, disgust about sexual matters while showing signs of unacknowledged excitement, etc.).

166 Tends to alternate between undercontrol and overcontrol of needs and impulses (e.g., sometimes acts on desires impulsively while at other times denying them entirely).

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

168 Struggles with genuine wishes to kill him/herself.

169 Fears becoming like a parent (or parent figure) about whom s/he has strong negative feelings.

170 Is rebellious or defiant toward authority figures; tends to be oppositional, contrary, quick to disagree, etc.

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

172 Tends to give up quickly when frustrated or challenged.

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

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

175 Tends to be conscientious and responsible.

176 Tends to confuse own thoughts, feelings, or personality traits with those of others (e.g., may use the same words to describe him/herself and another person, believe the two share identical thoughts and feelings, etc.).

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 Tends to feel bored.

179 Tends to be energetic and outgoing.

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

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

182 Tends to be controlling.

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

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

185 Is prone to intense anger, out of proportion to the situation at hand (e.g., has rage episodes).

186 Seems preoccupied with sex or sexuality, in a way that is not normative for his/her age (e.g., makes constant sexualized comments, masturbates compulsively, etc.).

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

188 Has difficulty separating from a parent (e.g., fears something terrible will happen to the parent if s/he leaves, resists going to school, cannot spend the night away from home).

189 Tends to feel unhappy, depressed, or despondent.

190 Appears to feel privileged and entitled; expects preferential treatment.

191 Emotions tend to change rapidly and unpredictably.

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

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

194 Tends to be manipulative.

195 Tends to be preoccupied with death and dying.

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

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 Has trouble acknowledging or expressing anger toward others, and instead becomes depressed, self-critical, self-punitive, etc. (i.e., turns anger against self).

199 Tends to be passive and unassertive.

200 Tends to ruminate; may dwell on problems, replay conversations in his/her mind, become preoccupied with thoughts about what could have been, etc.

SWAP-II

1 Tends to feel guilty (e.g., may blame self or feel responsible for bad things that happen).
2 Is able to use his/her talents, abilities, and energy effectively and productively.
3 Takes advantage of others; has little investment in moral values (e.g., puts own needs first, uses or exploits people with little regard for their feelings or welfare, etc.).
4 Has an exaggerated sense of self-importance (e.g., feels special, superior, grand, or envied).
5 Tends to be emotionally intrusive (e.g., may not respect other people's needs for autonomy, privacy, etc.).
6 Is troubled by recurrent obsessional thoughts that s/he experiences as intrusive.
7 Appears conflicted about his/her racial or ethnic identity (e.g., undervalues and rejects, or overvalues and is preoccupied with, own cultural heritage).
8 Tends to get into power struggles.
9 When upset, has trouble perceiving both positive and negative qualities in the same person at the same time (e.g., may see others in black or white terms, shift suddenly from seeing someone as caring to seeing him/her as malevolent and intentionally hurtful, etc.).
10 Believes that some important other has a special, seemingly magical ability to know his/her innermost thoughts or feelings (e.g., imagines rapport is so perfect that ordinary communication is superfluous).
11 Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.
12 Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, etc.
13 Tends to use his/her psychological or medical problems to avoid work or responsibility (whether consciously or unconsciously).
14 Tends to blame own failures or shortcomings on other people or circumstances; attributes his/her difficulties to external factors rather than accepting responsibility for own conduct or choices.
15 Lacks a stable sense of who s/he is (e.g., attitudes, values, goals, and feelings about self seem unstable or ever-changing).
16 Tends to be angry or hostile (whether consciously or unconsciously).
17 Tends to be ingratiating or submissive (e.g., consents to things s/he does not want to do, in the hope of getting support or approval).
18 Tends to stir up conflict or animosity between other people (e.g., may portray a situation differently to different people, leading them to form contradictory views or work at cross purposes).
19 Enjoys challenges; takes pleasure in accomplishing things.
20 Tends to be deceitful; tends to lie or mislead.

21 Tends to be hostile toward members of the opposite sex, whether consciously or unconsciously (e.g., may be disparaging or competitive).
22 Tends to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.).
23 Tends to become involved in romantic or sexual "triangles" (e.g., is drawn to people who are already attached, sought by someone else, etc.).
24 Tends to be unreliable and irresponsible (e.g., may fail to meet work obligations or honor financial commitments).
25 Has difficulty acknowledging or expressing anger.
26 Tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused, or needlessly puts self in dangerous situations (e.g., walking alone or agreeing to meet strangers in unsafe places).
27 Has panic attacks (i.e., episodes of acute anxiety accompanied by strong physiological responses).
28 Tends to be preoccupied with concerns about dirt, cleanliness, contamination, etc. (e.g., drinking from another person's glass, sitting on public toilet seats, etc.).
29 Has difficulty making sense of other people's behavior; tends to misunderstand, misinterpret, or be confused by others' actions and reactions.
30 Tends to feel listless, fatigued, or lacking in energy.
31 Tends to show reckless disregard for the rights, property, or safety of others.
32 Is capable of sustaining meaningful relationships characterized by genuine intimacy and caring.
33 Is conflicted or inhibited about achievement or success (e.g., achievements may be below potential, may sabotage self just before attaining important goals, etc.).
34 Tends to be sexually seductive or provocative (e.g., may be inappropriately flirtatious, preoccupied with sexual conquest, prone to "lead people on," etc.).
35 Tends to feel anxious.
36 Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.
37 Finds meaning in belonging and contributing to a larger community (e.g., organization, neighborhood, church).
38 Tends to feel s/he is not his/her true self with others; may feel false or fraudulent.
39 Appears to gain pleasure or satisfaction by being sadistic or aggressive toward others (whether consciously or unconsciously).
40 Tends to engage in unlawful or criminal behavior.
41 Appears unable to describe important others in a way that conveys a sense of who they are as people; descriptions of others come across as two-dimensional and lacking in richness.
42 Tends to feel envious.
43 Tends to seek power or influence over others (whether in beneficial or destructive ways).
44 When distressed, perception of reality can become grossly impaired (e.g., thinking may seem delusional).
45 Is prone to idealizing people; may see admired others as perfect, larger than life,

all wise, etc.

46 Tends to be suggestible or easily influenced.

47 Attempts to avoid or flee depressive feelings through excessive optimism, activity, energy, etc.

48 Seeks to be the center of attention.

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

50 Tends to feel life has no meaning.

51 Tends to be liked by other people.

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

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

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

55 Finds meaning and fulfillment in guiding, mentoring, or nurturing others.

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

57 Religious or spiritual beliefs are central to his/her identity and experience.

58 Has little or no interest in sex.

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

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

61 Tends to disparage qualities traditionally associated with own gender (e.g., a woman who disdains nurturance and overvalues power; a man who disdains power and overvalues emotional sensitivity).

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

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

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

65 Attempts to dominate a significant other (e.g., spouse, lover, family member) through violence or intimidation.

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

67 Tends to be stingy and withholding (e.g., of time, money, affection, ideas).

68 Has a good sense of humor.

69 Decisions and actions are unduly influenced by efforts to avoid perceived dangers; is more concerned with avoiding harm than pursuing desires.

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

71 Tends to seek thrills, novelty, excitement, etc.; appears to require a high level of stimulation.

72 Tends to perceive things in global and impressionistic ways (e.g., misses details, glosses over inconsistencies, mispronounces names).

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

74 Expresses emotion in exaggerated and theatrical ways.

75 Tends to think in concrete terms and interpret things in overly literal ways; has

limited ability to appreciate metaphor, analogy, or nuance.

76 Manages to elicit in others feelings similar to those s/he is experiencing (e.g., when angry, acts in such a way as to provoke anger in others; when anxious, acts in such a way as to induce anxiety in others).

77 Tends to be needy or dependent.

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

79 Attempts to deny or "override" fear or anxiety by rushing headlong into feared situations, taking unnecessary risks, etc.

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

81 Repeatedly re-experiences or re-lives a past traumatic event (e.g., has intrusive memories or recurring dreams of the event; is startled or terrified by present events that resemble or symbolize the past event).

82 Is capable of hearing information that is emotionally threatening (i.e., that challenges cherished beliefs, perceptions, and self-perceptions) and can use and benefit from it.

83 Beliefs and expectations seem cliché or stereotypical, as if taken from storybooks or movies.

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

85 Has conscious homosexual desires (moderate placement implies bisexuality, high placement implies homosexuality).

86 Tends to feel ashamed or embarrassed.

87 Sense of identity revolves around a "cause," movement, or label (e.g., adult child of alcoholic, adult survivor, environmentalist, born-again Christian, etc.); may be drawn to extreme or all-encompassing belief systems.

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

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

90 Is prone to painful feelings of emptiness (e.g., may feel lost, bereft, abjectly alone even in the presence of others, etc.).

91 Is self-critical; sets unrealistically high standards for self and is intolerant of own human defects.

92 Is articulate; can express self well in words.

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

94 Has an active and satisfying sex life.

95 Appears comfortable and at ease in social situations.

96 Tends to elicit dislike or animosity in others.

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

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

99 Appears to associate sex with danger (e.g., injury, punishment, contamination), whether consciously or unconsciously.
100 Tends to think in abstract and intellectualized terms, even in matters of personal import.
101 Generally finds contentment and happiness in life's activities.
102 Has a deep sense of inner badness; sees self as damaged, evil, or rotten to the core (whether consciously or unconsciously).
103 Tends to have extreme reactions to perceived slights or criticism (e.g., may react with rage, humiliation, etc.).
104 Appears to have little need for human company or contact; is emotionally detached or indifferent.
105 Is suspicious; tends to assume others will harm, deceive, conspire against, or betray him/her.
106 Tends to express emotion appropriate in quality and intensity to the situation at hand.
107 Tends to express qualities or mannerisms traditionally associated with own gender to an exaggerated or stereotypical degree (i.e., a hyper-feminine woman; a hyper-masculine, "macho" man).
108 Tends to restrict food intake to the point of being underweight and malnourished.
109 Tends to engage in self-mutilating behavior (e.g., self-cutting, self-burning, etc.).
110 Tends to become attached to, or romantically interested in, people who are emotionally unavailable.
111 Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.
112 Appears impervious to consequences; seems unable or unwilling to modify behavior in response to threats or negative consequences.
113 Experiences little or no remorse for harm or injury caused to others.
114 Tends to be critical of others.
115 Is prone to violence (e.g., may break things or become physically assaultive).
116 Tends to see own unacceptable feelings or impulses in other people instead of in him/herself.
117 Is unable to soothe or comfort him/herself without the help of another person (i.e., has difficulty regulating own emotions).
118 Has difficulty maintaining attention and focus on tasks; is easily distracted by sights, sounds, unrelated thoughts, or other competing stimuli.
119 Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.
120 Has moral and ethical standards and strives to live up to them.
121 Is creative; is able to see things or approach problems in novel ways.
122 Attempts to avoid feeling helpless or depressed by becoming angry instead.
123 Tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered.
124 Tends to avoid social situations because of fear of embarrassment or humiliation.

125 Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or "off").
126 Appears to have a limited or constricted range of emotions.
127 Tends to feel misunderstood, mistreated, or victimized.
128 Fantasizes about ideal, perfect love.
129 Tends to be conflicted about authority (e.g., may feel s/he must submit, rebel against, win over, defeat, etc.).
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 Appears conflicted about experiencing pleasurable emotions; tends to inhibit excitement, joy, pride, etc.
132 Tends to have numerous sexual involvements; is promiscuous.
133 Tends to be dismissive, haughty, or arrogant.
134 Tends to act impulsively (e.g., acts without forethought or concern for consequences).
135 Is hypochondriacal; has exaggerated fears of contracting medical illness (e.g., worries excessively about normal aches and pains).
136 Tends to believe in supernatural, paranormal, or superstitious phenomena or to be drawn to "alternative" belief systems (e.g., astrology, tarot, crystals, psychics, auras).
137 Is confused, conflicted, or uncertain about his/her sexual orientation (e.g., may struggle to keep homosexual feelings out of awareness, have an exaggerated fear of homosexuality, etc.).
138 Tends to enter altered, dissociated states when distressed (e.g., the self or world feels strange, unreal, or unfamiliar).
139 Tends to hold grudges; may dwell on insults or slights for long periods.
140 Sexual fantasies or activities are unusual, idiosyncratic, or rigidly scripted (e.g., dominance, submission, voyeurism, fetishes, etc.).
141 Is invested in seeing and portraying self as emotionally strong, untroubled, and emotionally in control, despite clear evidence of underlying insecurity, anxiety, or distress.
142 Tends to make repeated suicidal threats or gestures, either as a "cry for help" or as an effort to manipulate others.
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 Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential.
145 Thought processes or speech tend to be circumstantial, vague, rambling, digressive, etc. (e.g., may be unclear whether s/he is being metaphorical or whether thinking is confused or peculiar).
146 Tends to elicit boredom in others (e.g., may talk incessantly, without feeling, or about inconsequential matters).

147 Tends to abuse drugs or alcohol.
148 Has little psychological insight into own motives, behavior, etc.
149 Tends to feel like an outcast or outsider.
150 Tends to identify with admired others to an exaggerated degree, taking on their attitudes, mannerisms, etc. (e.g., may be drawn into the "orbit" of a strong or charismatic personality).
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 Tends to repress or "forget" distressing events, or distort memories of distressing events beyond recognition.
153 Relationships tend to be unstable, chaotic, and rapidly changing.
154 Tends to draw others into scenarios, or "pull" them into roles, that feel alien or unfamiliar (e.g., being uncharacteristically insensitive or cruel, feeling like the only person in the world who can help, etc.).
155 Tends to describe experiences in generalities; is reluctant to provide details, examples, or supporting narrative.
156 Has a disturbed or distorted body-image (e.g., may see self as unattractive, grotesque, disgusting, etc.).
157 Tends to become irrational when strong emotions are stirred up; may show a significant decline from customary level of functioning.
158 Appears afraid of commitment to a long-term love relationship.
159 Tends to deny or disavow own need for nurturance, caring, comfort, etc. (e.g., may regard such needs as weakness, avoid depending on others or asking for help, etc.)
160 Lacks close friendships and relationships.
161 Tends to deny, disavow, or squelch his/her own realistic hopes, dreams, or desires to protect against anticipated disappointment (whether consciously or unconsciously).
162 Expresses contradictory feelings or beliefs without being disturbed by the inconsistency; has little need to reconcile or resolve contradictory ideas.
163 Appears to want to "punish" self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification.
164 Tends to be self-righteous or moralistic.
165 Tends to distort unacceptable wishes or feelings by transforming them into their opposite (e.g., may express excessive concern while showing signs of unacknowledged hostility, disgust about sexual matters while showing signs of unacknowledged excitement, etc.).
166 Tends to alternate between undercontrol and overcontrol of needs and impulses (e.g., sometimes acts on desires impulsively while at other times denying them entirely).
167 Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered).
168 Struggles with genuine wishes to kill him/herself.

169 Is afraid or conflicted about becoming like a parent (or parent figure) about whom s/he has strong negative feelings (e.g., may go to lengths to avoid or reject attitudes or behaviors associated with that person).
170 Tends to be oppositional, contrary, or quick to disagree.
171 Appears to fear being alone; may go to great lengths to avoid being alone.
172 Seems unable to settle into, or sustain commitment to, identity-defining life roles (e.g., career, occupation, lifestyle, etc.).
173 Tends to become absorbed in details, often to the point that s/he misses what is significant.
174 Expects self to be "perfect" (e.g., in appearance, achievements, performance, etc.).
175 Tends to be conscientious and responsible.
176 Tends to confuse own thoughts, feelings, or personality traits with those of others (e.g., may use the same words to describe him/herself and another person, believe the two share identical thoughts and feelings, etc.).
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 Has a pervasive sense that someone or something necessary for happiness has been lost forever, whether consciously or unconsciously (e.g., a relationship, youth, beauty, success).
179 Tends to be energetic and outgoing.
180 Has trouble making decisions; tends to be indecisive or to vacillate when faced with choices.
181 Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.
182 Tends to be controlling.
183 Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.
184 Verbal statements seem incongruous with accompanying affect, or incongruous with accompanying non-verbal messages.
185 Is prone to intense anger, out of proportion to the situation at hand (e.g., has rage episodes).
186 Has difficulty directing both tender feelings and sexual feelings toward the same person (e.g., sees others as nurturing and virtuous or sexy and exciting, but not both).
187 Tends to feel guilty or ashamed about his/her sexual interests or activities (whether consciously or unconsciously).
188 Work-life and/or living arrangements tend to be chaotic or unstable (e.g., job or housing situation seems always temporary, transitional, or ill-defined).
189 Tends to feel unhappy, depressed, or despondent.
190 Appears to feel privileged and entitled; expects preferential treatment.
191 Emotions tend to change rapidly and unpredictably.

192 Tends to be overly concerned with rules, procedures, order, organization, schedules, etc.
193 Lacks social skills; tends to be socially awkward or inappropriate.
194 Tends to be manipulative.
195 Tends to be preoccupied with death and dying.
196 Finds meaning and satisfaction in the pursuit of long-term goals and ambitions.
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 Has trouble acknowledging or expressing anger toward others, and instead becomes depressed, self-critical, self-punitive, etc. (i.e., turns anger against self).
199 Tends to be passive and unassertive.
200 Tends to ruminate; may dwell on problems, replay conversations in his/her mind, become preoccupied with thoughts about what could have been, etc.

AXIS II CHECKLIST

Please circle **NO** or **YES** to indicate whether the statement describes your patient's enduring personality functioning. If you are unsure whether an item is really true of the patient (or true enough to rate as present), circle **NO**.

1. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
2. Adopts a miserly spending style toward both self an others; money is viewed as something to be hoarded for future catastrophes
3. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
4. Almost always chooses solitary activities
5. Appears indifferent to the praise or criticism of others
6. Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
7. Behavior or appearance that is odd, eccentric, or peculiar
8. Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
9. Chronic feelings of emptiness
10. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
11. Considers relationships to be more intimate than they actually are
12. Consistently uses physical appearance to draw attention to self
13. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
14. Displays rapidly shifting and shallow expression of emotions
15. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather that negative judgments about self
16. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
17. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
18. Frantic efforts to avoid real or imagined abandonment (do not diagnose for self-mutilating or suicidal behavior)
19. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
20. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
21. Has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
22. Has a style of speech that is excessively impressionistic and lacking in detail

23. Has difficulty expressing disagreement with others because of fear of loss of support or approval (do not diagnose for realistic fears of retribution)
24. Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
25. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
26. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual part
27. Ideas of reference (excluding delusions of reference)
28. Identity disturbance: markedly and persistently unstable self-image or sense of self
29. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating; do not diagnose for suicidal or self-mutilating behavior)
30. Impulsivity or failure to plan ahead
31. Inappropriate or constricted affect
32. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
33. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
34. Irritability and aggressiveness, as indicated by repeated physical fights or assaults
35. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
36. Is inhibited in new interpersonal situations because of feelings of inadequacy
37. Is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
38. Is often envious of others or believes that others are envious of him or her
39. Is overconscientious, scrupulous, and inflexible about matters of morality, ethics or values (not accounted for by cultural or religious identification)
40. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
41. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
42. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
43. Is preoccupied with being criticized or rejected in social situations
44. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
45. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
46. Is suggestible, i.e., easily influenced by others or circumstances
47. Is unable to discard worn-out or worthless objects even when they have no sentimental value
48. Is uncomfortable is situations in which he or she is not the center of attention

49. Is unrealistically preoccupied with fears of being left to take care of himself or herself
50. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing
51. Is unwilling to get involved with people unless certain of being liked
52. Lack of close friends or confidants, other than first-degree relatives
53. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
54. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
55. Lacks empathy; is unwilling to recognize or identify with the feelings and needs of others
56. Needs others to assume responsibility for most major areas of his or her life
57. Neither desires nor enjoys close relationships, including being part of a family
58. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
59. Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or sterotyped)
60. Persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights
61. Reads hidden demeaning or threatening meanings into benign remarks or events
62. Reckless disregard for the safety of self or others
63. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
64. Requires excessive admiration
65. Shows arrogant, haughty behaviors or attitudes
66. Shows emotional coldness, detachment, or flattened affectivity
67. Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
68. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed
69. Shows rigidity and stubbornness
70. Shows self-dramatization, theatricality, and exaggerated expression of emotion
71. Suspects, without sufficient bases, that others are exploiting, harming, or deceiving him or her
72. Suspiciousness or paranoid ideation
73. Takes pleasure in few, if any, activities
74. Transient, stress-related paranoid ideation or severe dissociative symptoms
75. Unusual perceptual experiences, including bodily illusions
76. Urgently seeks another relationship as a source of care and support when a close relationship ends
77. Views self as socially inept, personally unappealing, or inferior to others
78. Has little, if any, interest in having sexual experiences with another person

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