Assessing Personality Change in Psychotherapy With the SWAP–200: A Case Study

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CLINICAL CASE APPLICATIONS

Assessing Personality Change in Psychotherapy With the SWAP–200: A Case Study

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Many studies document the efficacy of psychotherapy for acute syndromes such as depression, but less is known about personality change in patients treated for personality pathology. The Shedler–Westen Assessment Procedure (SWAP–200; Westen & Shedler, 1999a, 1999b) is an assessment tool that measures a broad spectrum of personality constructs and is designed to bridge the gap between the clinical and empirical traditions in personality assessment. In this article, we demonstrate the use of the SWAP–200 as a measure of change in a case study of a patient diagnosed with borderline personality disorder. We collected assessment data at the start of treatment and after 2 years of psychotherapy. The findings illustrate the personality processes targeted in intensive psychotherapy for borderline personality.

There is often a schism between clinical and empirical approaches to personality assessment. Researchers tend to focus on relatively small numbers of variables that can be measured using structured assessment methods (e.g., structured research interviews or psychometric inventories). The goal is generally to determine whether the person meets diagnostic criteria for a specific psychiatric disorder or to locate the person on one or more trait dimensions. Such approaches are inherently nomothetic. In contrast, clinical personality assessment tends to be more global, person centered rather than variable centered, and concerned with the meaning and function of personality processes. Such approaches are inherently ideographic. Clinical and empirical approaches also tend to differ with respect to level of inference: Many research-oriented instruments focus on behavioral signs and symptoms and relatively obvious mental states, whereas clinical

practitioners often emphasize mental processes that must be inferred or deduced.

Our focus has been on measuring personality change in long-term psychotherapy of patients with personality disorder (PD) diagnoses. We have sought psychometrically sound methods to quantify personality change that also preserve the richness and complexity of clinical case formulation (an ideographic approach). Few PD assessment instruments meet these dual criteria. For example, the Structured Clinical Interview for DSM–IV Personality Disorders (SCID–II; First, Spitzer, Gibbon, & Williams, 1997) follows *DSM–IV* (American Psychiatric Association, 1994) in emphasizing behavioral signs and symptoms, but does not address many aspects of inner experience that often take center stage in psychotherapy. Its emphasis on dichotomous (present–absent) diagnostic decisions also limits its utility for assessing

change. Self-report inventories yield dimensional scores that are sensitive to change but tend not to address the spectrum of personality processes, implicit and explicit, emphasized by contemporary clinical theorists (e.g., Clarkin, Yeomans, & Kernberg, 1999; Kernberg, 1975, 1984; Linehan, 1993). Moreover, many self-report instruments presume, to a greater or lesser extent, that patients will report accurately on their own personality processes—a questionable presumption in patients with PDs, for whom lack of insight and self-awareness is often diagnostic (Shedler, Mayman, & Manis, 1993; Westen & Shedler, 1999a).

The Shedler–Westen Assessment Procedure–200 (SWAP–200; Shedler & Westen, 1998, 2004a, 2004b; Westen & Shedler, 1999a, 1999b) is an assessment instrument designed to bridge the gap between the clinical and empirical traditions in personality assessment. The instrument quantifies the observations and inferences of expert clinical observers and generates both individualized, ideographic case descriptions as well as dimensional scores for the 10 PDs included in *DSM–IV*. (The instrument generates a range of other indexes that are beyond the scope of this article; see Shedler & Westen, 2004a, and Westen & Shedler, 1999b). For these reason, we translated the SWAP–200 into Italian for use with our patient population (Westen, Shedler, & Lingiardi, 2003). In this article, we report the results of a single case study of a patient diagnosed with borderline PD and treated in individual psychotherapy (a passive-observational study; Kazdin, 1992). We collected assessment data at the start of treatment and again after 2 years of psychotherapy.

We make no claims regarding the general efficacy of psychotherapy for borderline PD or the relative merits of any treatment modality, and methodological limitations require cautious interpretation of the data we report. Our objectives are to illustrate the range of personality constructs emphasized by contemporary clinical practitioners who treat PDs and to demonstrate the use of the SWAP–200 for assessing personality change. (For empirical data on the efficacy of psychotherapy for severe personality pathology, see, e.g., Bateman & Fonagy, 2000, 2001; Blum, Pfohl, St. John, Monahan, & Black, 2002; Clarkin et al., 2001; Leichsenring & Leibing, 2003; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Munroe-Blum & Marziali, 1995; Stevenson & Meares, 1992.)

OVERVIEW OF THE SWAP–200

The SWAP–200 is a set of 200 personality-descriptive statements, each printed on a separate index card (Shedler & Westen, 1998; Westen & Shedler, 1999a, 1999b). A clinician who knows a patient well can describe him or her by arranging the statements into eight categories, from those that are not descriptive (assigned a value of "0") to those that are highly descriptive (assigned a value of "7"). Thus, the procedure yields a numeric score from 0 to 7 for each of 200 personality-descriptive variables. An interactive, Web-based

version of the instrument is also available (the Web version can be previewed at http://www.psychsystems.net/guest.cfm). Items are written in straightforward, experience-near language (e.g., "Tends to be passive and unassertive" or "Has an exaggerated sense of self-importance"), and items that require inferences about internal mental processes are written without recourse to jargon (e.g., "Tends to see own unacceptable feelings or impulses in other people instead of in him/herself"). The instrument is based on the Q-sort method which requires clinicians to arrange items into a fixed distribution (Block, 1978).

The item set was developed and revised over a 7-year period and incorporates constructs drawn from a wide range of sources including Axis II diagnostic criteria included in *DSM–III* (3rd ed.; American Psychiatric Association, 1980) through *DSM–IV*, selected Axis I criteria that could reflect personality traits (e.g., depression and anxiety), research in personality psychology, the clinical literature on PDs written over the past 50 years (e.g., Kernberg, 1975, 1984; Kohut, 1971), and the feedback of hundreds of psychologists and psychiatrists who used earlier versions of the instrument to describe their patients (Shedler & Westen, 1998; Westen & Shedler, 1999a).

Reliability and Validity

The reliability of a Q-sort personality description refers to agreement between raters regarding the ordering of the items or statements, traditionally measured by Pearson's *r* (Block, 1978). For example, a SWAP–200 description of a patient consists of one column by 200 rows of data (with each row containing the score [0 to 7] for the corresponding SWAP–200 item). Each additional rater adds one additional column of data, and interrater reliability is computed by correlating pairs of columns. Item scores are typically averaged across all available raters to obtain an aggregate Q-sort description. The reliability of the aggregate description is estimated by the Spearman–Brown formula (when there are two raters) or coefficient alpha (when there are multiple raters). The approach is identical to that used to estimate the internal reliability of a psychometric scale except that the raters are treated as test items and the Q-sort items are treated as cases.

In prior studies, reliability of SWAP–200 personality descriptions has ranged from .75 to .89 (Marin-Avellan, McGauley, Campbell, & Fonagy, 2005; Shedler & Westen, 1998; Westen & Muderrisoglu, 2003).[1] In addition, scores derived from the SWAP–200 have correlated with a wide range of external criterion measures in both adult and adolescent samples including genetic history variables such as psychosis in first- and second-degree relatives, developmental history variables such as childhood sexual and physical

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[1]The reported reliability coefficients include both raw correlations and Spearman–Brown adjusted correlations.

abuse, life events such as psychiatric hospitalizations and suicide attempts, ratings of adaptive functioning, and so on (e.g., Westen & Muderrisoglu, 2003; Westen & Shedler, 1999a; Westen, Shedler, Durrett, Glass, & Martens, 2003; Westen & Weinberger, 2004).

Ideographic and Nomothetic Assessment

Investigators can obtain individualized (ideographic) personality portraits by listing the statements that receive the highest rankings in a patient's SWAP–200 description (i.e., items with scores of 5, 6, and 7). Investigators can also derive dimensional PD scores that measure the similarity or "match" between a patient's SWAP–200 description and prototype SWAP–200 descriptions representing each *DSM–IV* PD (Westen & Shedler, 1999a). The PD scores can be expressed as T scores and graphed to create a PD profile resembling a Minnesota Multiphasic Personality Inventory (MMPI) profile (see Figure 1). A "healthy functioning" index is included as well.[2]

CASE DESCRIPTION

"Melania" is a 30-year-old White woman who self-referred for psychotherapy. Her presenting complaints included substance abuse and an inability to extricate herself from an emotionally and physically abusive relationship. The initial assessment included a psychiatric intake interview and administration of both the Structured Clinical Interview for *DSM–IV* (SCID; First, Spitzer, Gibbon, & Williams, 1996) and the SCID–II (First et al., 1997). Melania met SCID criteria for an Axis I diagnosis of substance abuse and SCID–II criteria for an Axis II diagnosis of borderline PD with histrionic traits. The intake interviewer assigned a score of 45 on the Global Assessment of Functioning Scale (GAF) scale, indicating severe symptoms and impairment in functioning.

Case Background

Melania is the younger of two sisters. Her early family environment was marked by bitter parental strife and neglect. A recurring family scenario is illustrative: Melania's mother would scream at her husband, telling him he was a failure and that she did not want to live with him; she would then slam the door and lock herself in her room, leaving Melania frightened and in tears. Both parents would

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[2]The PD prototype descriptions were developed by asking panels of expert clinicians to use the SWAP–200 to describe hypothetical, prototypical patients illustrating each PD in its ideal or pure form. PD scores are computed by correlating a patient's SWAP–200 description with the PD prototype descriptions. For ease of interpretation, the correlation coefficients are transformed into a T score based on normative data. The healthy functioning index was created using a similar method and reflects clinicians' consensual understanding of healthy personality functioning. See Westen and Shedler (1999a) for a detailed discussion.

then ignore Melania and forget to feed her. Melania's parents divorced when she was 8 years old. After the divorce, Melania lived alone with her mother who showed little concern for her welfare. Periods of neglect alternated with episodes of invasive attention, a pattern that continued into adulthood. Melania saw little of her father whom she believed hated her. She envied and resented her sister whom she perceived as the perfect, loved daughter. In contrast, Melania saw herself as the unwanted family failure. These feelings persisted into adulthood, with Melania envying her sister's successful career, family, and social life.

By adolescence, Melania had developed behavioral problems. She often skipped school and spent her days sleeping or wandering the streets. At age 18, she left home and began what she described as "life on the streets." She engaged in a series of impulsive, chaotic, and rapidly changing sexual relationships that led to three induced abortions by age 24. She abused street drugs and eventually developed a pattern of cocaine and heroine abuse (snorting). At the time she started therapy, Melania was snorting cocaine or heroin nearly every day. Melania also engaged in petty criminal activity including shoplifting and stealing from her employers.

Melania held a series of low-paying jobs that were not commensurate with her ability or education (e.g., working as a maid), never earning more than 500 to 600 Euros per month. (Despite her emotional difficulties, Melania had done well in school. She earned her secondary school diploma and also completed some college. She is fluent in English, well read in fiction and poetry, and knowledgeable about international affairs.) Melania failed to hold any job for more than a few months and was fired from each job when her employers caught her stealing. Melania sabotaged her work prospects in other ways, for example, by skipping work and by attending job interviews dressed inappropriately or under the influence of drugs.

In her mid-20s, Melania moved in with her boyfriend, a small-time drug dealer who exploited her financially and abused her physically. He earned little or no money and spent his days sleeping or watching television while Melania worked. Melania paid the rent and supported him financially. Approximately two to four times per month, Melania had sex with other men to obtain money or drugs for her boyfriend. He sometimes beat her when he was dissatisfied with what she brought home.

Treatment

Melania stated in the intake interviews that she wanted to "understand why I can't give up my boyfriend" despite recognizing that the relationship was "painful and insane." She was frightened by her drug use, which had increased during the past year. She also expressed a desire "to heal the split between my parents and me." She was referred for psychoanalytic psychotherapy, a treatment modality that has shown both efficacy and effectiveness in the treatment of borderline

PD (e.g., Bateman & Fonagy, 1999, 2000, 2001; Chiesa & Fonagy, 2003; Clarkin et al., 2001; Clarkin & Levy, 2003). The therapist was a male psychiatrist with approximately 12 years of practice experience posttraining and considerable training and experience in treating severe PDs. At the time of this report, Melania had completed 2 years of therapy at a frequency of three sessions per week.

Treatment model.   The therapy was conducted in accord with generally recognized psychodynamic principles (e.g., Blagys & Hilsenroth, 2000) and followed the treatment model described by Horwitz et al. (1996). The approach emphasized (a) maintaining a stable therapeutic relationship and consistently addressing breaches in the relationship as they arose; (b) identifying recurring relationship patterns manifested in the therapy relationship and linking them with patterns in important current and early relationships; (c) addressing defenses with the goal of helping Melania develop more adaptive ways of regulating intense affect; and (d) working to consolidate contradictory, unintegrated aspects of Melania's identity and self-experience.

A detailed description of the course of treatment is beyond the scope of this article, but some brief examples may clarify the application of these principles. The emphasis in treatment shifted over time from a more supportive to a more interpretive mode. At the beginning of treatment, the therapist focused heavily on ruptures in the therapy relationship and their repair. For example, Melania often skipped sessions. The therapist responded by telephoning Melania to remind her of the continuity of his concern and presence even in her physical absence. When Melania responded by telling him that therapy was a waste of time and that she planned to resume her drug use, he insisted that she return to discuss what was going on between them (i.e., what in the therapy relationship may have precipitated her reaction) even if the meeting proved to be their last. Such interventions became unnecessary by the end of the 1st year of treatment, as Melania no longer skipped sessions and had developed increased capacity to express painful affect through words rather than self-punitive action. Later in therapy, Melania came to refer to these phone calls as "the times when you came to pull me back from the edge of the abyss."

As the therapy shifted toward a more interpretive mode, the therapist drew connections between Melania's current and past relationships. For example, he pointed out that Melania's relationship with her mother had led her to equate being cared for with being misunderstood, neglected, and abused, and that she was recreating this pattern in her current relationships (e.g., with her boyfriend). Therapy provided Melania with a new and different kind of relationship in which intimacy and abuse were not synonymous, and in which she could gain insight into the role relationships she created and recreated.

The therapist worked with unintegrated aspects of identity by identifying and addressing the contradictory ways in which Melania experienced and presented herself. For example, he pointed out that sometimes Melania presented herself like "Cinderella" and sometimes like "Mother Theresa." When the Cinderella facet of her identity came to the fore, Melania looked dirty and disheveled and experienced herself as abandoned, neglected, and bereft: "I am ugly and bad and nobody can love me." When someone expressed interest in her, Melania presented as a self-sacrificing saint, working tirelessly to "rescue" the other at the sacrifice of her own needs and welfare (Melania's relationship with her boyfriend contained both of these elements). Eventually, Melania was able to recognize and even joke about such contradictions. She developed the capacity to care for others without sacrificing her own well-being, and to both love and be loved.

ASSESSMENT

A total of 10 consecutive therapy sessions from early in the treatment and 10 consecutive therapy sessions from late in treatment were tape recorded and transcribed. Two clinical judges reviewed transcripts of the first 10 psychotherapy sessions and provided SWAP–200 descriptions of Melania based on the information available in the transcripts. The clinical judges were doctoral level clinical psychologists with approximately 5 years practice experience each. After reviewing the transcripts and completing the SWAP–200 procedure, the clinical judges met and discussed discrepancies until achieving consensus regarding the major assessment issues. The SWAP–200 scores were then aggregated across the two clinical judges to obtain a single SWAP–200 description. After 2 years of psychotherapy, the assessment procedure was repeated.[3]

Assessment Feedback

After completing the initial SWAP–200 ratings, the clinical judges provided feedback to the treating therapist regarding the assessment findings. This feedback directly informed the treatment. It confirmed some of the therapist's diagnostic impressions regarding, for example, the pervasiveness of primitive defenses associated with borderline PD (e.g., splitting or dichotomous thinking), brought into sharp focus Melania's damaged sense of self, and highlighted the depth of her depression, which she had been unable to express verbally and which had not been detected by the SCID interview at intake. Some of the assessment findings challenged the therapist's formulations and called attention to areas of functioning he had overlooked. For example, there was much debate and discussion regarding the ranking of SWAP–200 items addressing envy, rage, rivalry, and attempts to control others.

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[3]The interrater correlation between the clinical judges was $r =$ .898 at Time 1 and $r = .976$ at Time 2. These correlation coefficients were obtained after discussion between the raters and therefore do not reflect interrater reliabilities between independent assessors.
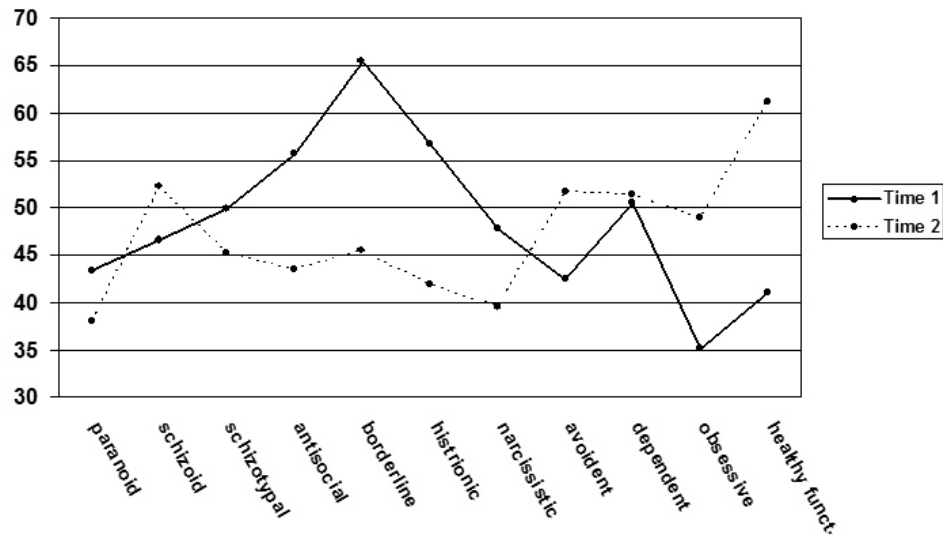
FIGURE 1   Melania's personality disorder profiles at Time 1 and Time 2.

These items brought into focus Melania's relationship with her sister, which was characterized by bitter envy that Melania had not communicated directly. Each of the major areas of functioning highlighted by the SWAP–200 assessment data became a focus of therapeutic attention over the course of treatment.

FINDINGS

Time 1: PD Score Profile

The solid line in Figure 1 shows Melania's PD scores at Time 1 (at the beginning of treatment) for the 10 PDs included in *DSM–IV* as well as her score on the healthy functioning index. For ease of interpretation, we converted the PD scores to T scores ($M = 50$, $SD = 10$) based on norms established in a psychiatric sample of patients with Axis II diagnoses (Westen & Shedler, 1999a). To maintain continuity with the *DSM–IV* categorical diagnostic system, Shedler and Westen have suggested T = 60 as a threshold for making a categorical PD diagnosis and T = 55 as a threshold for diagnosing "features."[4]

Melania's PD profile shows a marked elevation for borderline PD (T = 65.42, approximately 1½ *SD*s above the sample mean) with secondary elevations for histrionic PD (T = 56.62) and antisocial PD (T = 55.7). Using the recommended cutoff score of T ≥ 60 for categorical PD diagnoses, the SWAP–200 duplicates the SCID–II diagnosis of borderline PD with histrionic features and also diagnoses antisocial features (which were not captured by the SCID–II but are

clearly consistent with the case background). Noteworthy is the T score of 41.02 for the healthy functioning index, nearly a standard deviation below the mean, even in a reference sample of patients with Axis II diagnoses. The score indicates significant impairment and parallels the low GAF score assigned by the intake interviewer.

Time 1: Idiographic Case Description

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

Melania experiences severe depression and dysphoria. She tends to feel unhappy, depressed, or despondent, appears to find little or no pleasure or satisfaction in life's activities, feels life is without meaning, and tends to feel like an outcast or outsider. She tends to feel guilty and to feel inadequate, inferior, or a failure. Her behavior is often self-defeating and self-destructive. She appears inhibited about pursuing goals or successes, is insufficiently concerned with meeting her own needs, and seems not to feel entitled to get or ask for things she deserves. She appears to want to "punish" herself by creating situations that lead to unhappiness or actively avoiding opportunities for pleasure and gratification. Specific self-destructive tendencies include getting drawn into and remaining in relationships in which she is emotionally or physically abused, abusing illicit drugs, and acting impulsively and without regard for consequences. She shows little concern for consequences in general.

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[4]A T-score cutoff of 60 may seem low to readers familiar with other tests. Recall, however, that the normative sample consists of patients with PD diagnoses. Thus, a T score of 50 indicates "average" functioning for a patient with a PD, and a T score of 60 represents a 1 *SD* elevation relative to other patients with PDs.

TABLE 1
Most Descriptive SWAP–200 Items (Time 1)

Item	Text	Score[a]
26	Tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused.	7
33	Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential.	7
56	Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities.	7
134	Tends to act impulsively, without regard for consequences.	7
149	Tends to feel like an outcast or outsider; feels as if s/he does not truly belong.	7
161	Tends to abuse illicit drugs.	7
15	Lacks a stable image of who s/he is or would like to become (e.g., attitudes, values, goals, and feelings about self may be unstable and changing).	6.5
88	Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves.	6.5
163	Appears to want to "punish" self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification.	6.5
21	Tends to be hostile toward members of the opposite sex, whether consciously or unconsciously (e.g., may be disparaging, competitive, etc.).	6
76	Manages to elicit in others feelings similar to those he or she is experiencing (e.g., when angry, acts in such a way as to provoke anger in others; when anxious, acts in such a way as to induce anxiety in others).	6
90	Tends to feel empty or bored.	6
99	Appears to associate sexual activity with danger (e.g., injury, punishment, contamination, etc.), whether consciously or unconsciously.	6
122	Living arrangements tend to be chaotic or unstable (e.g., living arrangements are temporary, transitional, or ill-defined; may have no telephone or permanent address).	6
162	Expresses contradictory feelings or beliefs without being disturbed by the inconsistency; has little need to reconcile or resolve contradictory ideas.	6
188	Work life tends to be chaotic or unstable (e.g., working arrangements seem always temporary, transitional, or ill-defined).	6
189	Tends to feel unhappy, depressed, or despondent.	6
153	Interpersonal relationships tend to be unstable, chaotic, and rapidly changing.	5.5
50	Tends to feel life has no meaning.	5
52	Has little empathy; seems unable to understand or respond to others' needs and feelings unless they coincide with his/her own.	5
54	Tends to feel s/he is inadequate, inferior, or a failure.	5
57	Tends to feel guilty.	5
79	Tends to see certain others as "all bad," and loses the capacity to perceive any positive qualities the person may have.	5
112	Tends to be unconcerned with the consequences of his/her actions; appears to feel immune or invulnerable.	5
117	Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect.	5
157	Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning.	5
176	Tends to confuse own thoughts, feelings, or personality traits with those of others (e.g., may use the same words to describe the self and another person, believe the two share identical thoughts and feelings, treat the person as an "extension" of him/herself, etc.).	5
71	Tends to seek thrills, novelty, adventure, etc.	4.5
158	Appears afraid of commitment to a long-term love relationship.	4.5
181	Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.	4.5

Note. SWAP–200 = Shedler–Westen Assessment Procedure.
[a]SWAP–200 items are scored from 0 (*least descriptive*) to 7 (*most descriptive*).

Melania shows many personality traits associated specifically with borderline PD. Her relationships are unstable, chaotic, and rapidly changing. She has little empathy and seems unable to understand or respond to others' needs and feelings unless they coincide with her own. Moreover, she tends to confuse her own thoughts, feelings, and personality traits with those of others, and she often acts in such a way as to elicit her own feelings in other people (for example, provoking anger when she herself is angry, or inducing anxiety in others when she herself is anxious).

Melania expresses contradictory feelings without being disturbed by the inconsistency, and she seems to have little need to reconcile or resolve contradictory ideas. She is prone to see certain others as "all bad," losing the capacity to perceive any positive qualities they may have. She lacks a stable image of who she is or would like to become (e.g., her attitudes, values, goals, and feelings about self are unstable and changing), and she tends to feel empty. Affect regulation is poor: She tends to become irrational when strong emotions are stirred up and shows a noticeable decline from her customary

level of functioning. She also seems unable to soothe or comfort herself when distressed and requires the involvement of another person to help her regulate affect. Both her living arrangements and her work life tend to be chaotic and unstable.

Finally, Melania's attitudes toward men and sexuality are problematic and conflictual. She tends to be hostile toward members of the opposite sex (whether consciously or unconsciously), and she associates sexual activity with danger (e.g., injury, punishment). She appears afraid of commitment to a long-term love relationship, instead choosing partners who are inappropriate in terms of age, status (e.g., social, economic, intellectual), or other factors.

The preceding narrative description provides a detailed and clinically poignant portrait of a severely troubled borderline patient. The description is consistent with the spirit of clinical case formulation and helps illustrate the difference between empirical (nomothetic) and clinical (idiographic) approaches to personality assessment. In this instance, how-

ever, all findings are derived from the same assessment instrument and grounded in quantitative data.

Time 2: PD Score Profile

The dotted line in Figure 1 shows Melania's PD scores after 2 years of psychotherapy at a frequency of three sessions per week. Melania's scores on the borderline, histrionic, and antisocial dimensions (which were previously elevated) have all dropped below T = 50, and she no longer warrants a PD diagnosis. Her score on the healthy functioning index has increased significantly, from 41.0 to 61.2 (a change of 2 *SD*s), indicating considerable improvement in overall functioning. Her score on the obsessive dimension has increased as well, reflecting a shift from impulsivity toward higher level defenses such as intellectualization (see detailed discussion following).

Time 2: Ideographic Assessment of Change

For each SWAP–200 item, we created a change score by subtracting the score at Time 1 from the Score at Time 2. Table 2 lists the SWAP–200 items with the highest change scores (≥ 4) in descending order of absolute value. The table also lists the actual SWAP–200 scores at Time 2 (last column) to indicate the item's absolute (rather than relative) importance in describing Melania's personality functioning. The data tell a more complex story than the dimensional scores we reported previously. The following findings are noteworthy:

> Melania has developed strengths and inner resources that were not evident at the time of the earlier assessment. She has come to terms with painful experiences from the past, finding meaning in, and growing from, these experiences; she has become more articulate and better able to express herself in words; she has a newfound ability to appreciate and respond to humor; she is more capable of recognizing alternative viewpoints, even in matters that stir up strong feelings; she is more empathic and sensitive to other's needs and feelings; and she is more likeable.
>
> There is marked improvement in many areas associated specifically with borderline psychopathology. With respect to affect regulation, Melania is less prone to become irrational when strong emotions are stirred up, she is more likely to express affect appropriate in quality and intensity to the situation at hand, and she is better able to sooth or comfort herself when distressed. She is less prone to confuse her own thoughts and feelings with those of others, less manipulative, and less likely to devalue others and see them as "all bad." She has come to terms with negative feelings toward her parents.
>
> Melania is also less impulsive, more conscientious and responsible, and more aware of the consequences of her actions. Her living arrangements are more stable, as is her work life. Melania's use of illicit drugs has decreased significantly, and she is less drawn to abusive relationships.
>
> As the more severe aspects of borderline personality pathology have receded, other conflicts and symptoms have

moved to the fore. For example, Melania appears to have developed somewhat obsessional defenses against painful affect. She adheres more rigidly to daily routines and becomes anxious or uncomfortable when they are altered. She is more prone to think in an abstract and intellectualized manner and tries to see herself as logical and rational, uninfluenced by emotion.

> Despite her wish to act logically and rationally, Melania seems engaged in an active struggle to control her affect and impulses. She tends to oscillate between undercontrol and overcontrol of needs and wishes, either expressing them impulsively or disavowing them entirely. She has more difficulty allowing herself to experience strong pleasurable emotions (e.g., excitement, joy). She is more prone to repress, "forget," or otherwise distort distressing events.
>
> Finally, there are changes in Melania's relationships and orientation toward sexuality. Whereas before she presented in a histrionic manner (i.e., with exaggerated feminine traits), she is now more disparaging of traditional feminine traits, instead emphasizing independence and achievement. Whereas previously she engaged in multiple chaotic sexual relationships, she now seems conflicted about her intimacy needs. She craves intimacy but tends to reject it when offered. She has more difficulty directing both sexual and tender feelings toward the same person, seeing men as either respectable and virtuous, or sexy and exciting, but not both. She is more likely to hold grudges.

Changes in Life Circumstances

The SWAP–200 is designed to assess personality and emphasizes internal psychological processes. Changes in personality should, however, presage changes in behavior and external life circumstances. The following changes in Melania's life circumstances occurred over the course of her treatment and parallel the personality changes assessed by the SWAP–200.

Melania's drug use decreased dramatically. At the start of treatment, Melania was snorting cocaine or heroine nearly every day, in increasing amounts. During the 6 months prior to the Time 2 assessment, Melania used cocaine only twice, both times during extremely stressful events (e.g., breaking up with her boyfriend). She extricated herself from the relationship with her abusive boyfriend and started a new relationship with a man who has a stable career, does not use drugs, and treats her respectfully. She no longer engages in prostitution or promiscuous sex, and she no longer steals or shoplifts. She has held the same job for more than a year. Prior to therapy, Melania never earned more than 500 to 600 Euros per month. By the Time 2 assessment, she was earning 1,600 Euros per month. Previously she sabotaged herself during job interviews. In contrast, she prepared for the interview for her current job, dressed appropriately, and practiced for the interview by role-playing with a friend. There has also been a change in Melania's relationship toward work. Whereas previously she worked only to meet immediate needs, she now regards work as an avenue for personal development and a means of achiev-

TABLE 2
SWAP–200 Items Showing Greatest Change From Time 1 to Time 2

Item	Text	Change[a]	Time 2 Score
186	Has difficulty directing both tender feelings and sexual feelings toward the same person (e.g., sees people as respectable and virtuous, or sexy and exciting, but not both).	+6.5	6.5
106	Tends to express affect appropriate in quality and intensity to the situation at hand.	+6.5	6.5
122	Living arrangements tend to be chaotic or unstable (e.g., living arrangements are temporary, transitional, or ill-defined; may have no telephone or permanent address).	−6	0
188	Work life tends to be chaotic or unstable (e.g., working arrangements seem always temporary, transitional, or ill-defined).	−6	0
89	Appears to have come to terms with painful experiences from the past; has found meaning in, and grown from such experiences.	+6	6
92	Is articulate; can express self well in words.	+6	7
131	Has difficulty allowing self to experience strong pleasurable emotions (e.g., excitement, joy, pride).	+6	6
161	Tends to abuse illicit drugs.	−5.5	1.5
68	Appreciates and responds to humor.	+5.5	7
100	Tends to think in abstract and intellectualized terms, even in matters of personal import.	+5.5	5.5
134	Tends to act impulsively, without regard for consequences.	−5.5	1.5
111	Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.	+5	5
61	Tends to disparage qualities traditionally associated with own sex while embracing qualities traditionally associated with opposite sex (e.g., a woman who devalues nurturance and emotional sensitivity while valuing achievement and independence).	+5	5
166	Tends to oscillate between undercontrol and overcontrol of needs and impulses (i.e., needs and wishes are expressed impulsively and with little regard for consequences, or else disavowed and permitted virtually no expression).	+5	5
199	Tends to be passive and unassertive.	+5	7
79	Tends to see certain others as "all bad," and loses the capacity to perceive any positive qualities the person may have.	−5	0
157	Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning.	−5	0
112	Tends to be unconcerned with the consequences of his/her actions; appears to feel immune or invulnerable.	−5	0
117	Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect.	−5	0
176	Tends to confuse own thoughts, feelings, or personality traits with those of others (e.g., may use the same words to describe the self and another person, believe the two share identical thoughts and feelings, treat the person as an "extension" of him/herself, etc.).	−5	0
144	Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential.	+4.5	4.5
26	Tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused.	−4.5	2.5
51	Tends to elicit liking in others.	+4	5
59	Is empathic; is sensitive and responsive to other peoples' needs and feelings.	+4	4
123	Tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered.	+4	4
139	Tends to hold grudges; may dwell on insults or slights for long periods.	+4	4
167	Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered).	+4	4
43	Tends to seek power or influence over others (whether in beneficial or destructive ways).	−4	0
52	Has little empathy; seems unable to understand or respond to others' needs and feelings unless they coincide with his/her own.	−4	1
152	Tends to repress or "forget" distressing events, or distort memories of distressing events beyond recognition.	+4	4
169	Fears becoming like a parent (or parent figure) about whom s/he has strong negative feelings; may go to lengths to avoid or reject attitudes or behaviors associated with that person.	−4	0
175	Tends to be conscientious and responsible.	+4	5
194	Tries to manipulate others' emotions to get what s/he wants.	−4	0

Note.   SWAP–200 = Shedler–Westen Assessment Procedure.
[a]Change scores were calculated by subtracting Time 1 scores from Time 2 scores.

ing future goals. She has enrolled in continuing education courses and is saving money toward the realistic future goal of opening and managing a hostel.

There have also been concrete changes in Melania's relationships with her family members (one of her stated treatment goals). Previously, Melania viewed her father as a cold, selfish man who kept her at a distance because he hated her. Toward the end of her second year of treatment, Melania offered this more balanced view: "Maybe he was distant and not involved in family life, but this was also because of the difficult relationship he had with my mother, not because he hated me." She reestablished a relationship with him and even helped care for him when he was ill. Her relationship with her mother had previously oscillated between periods of rage, during which they had no contact at all, and periods of enmeshment, during which they spent hours on the phone talking about how much they needed one another. The relationship has become less intense but more stable. Melania now speaks to her mother twice per week on average, and there are fewer outbursts of rage and "love."

Finally, Melania's relationship with her sister is much improved. Her sister is married and has a baby, whom Melania previously resented and envied. Melania now takes pride in her niece, is allowed to care for her, and takes pleasure in doing so. A particularly moving moment occurred near the end of the second year in therapy, near Christmas, when Melania brought her niece with her to her therapy appointment and introduced her to her therapist with obvious pride.

Melania's comments.   Melania did not review the case write-up but did provide converging written information in the form of emails and notes to her therapist. In an email to her therapist in her third year of treatment (subsequent to the Time 2 assessment), Melania wrote the following:

> How long have we been here? Am I still the same troubled girl, always in crisis? You are still here for me, you don't hurt me, and I have let you take my hand and lead me through the pain. I know a part of me has known devastation, but with you, doctor, another Melania has been born, a person who knows how to hold her own hand. We have crossed together through the devastation and the memories filled with pain. Now I am older and I know I can suffer without wanting to die. I know that pain is not forever and I have my life to live.

In another note subsequent to the Time 2 assessment, Melania wrote (referring to her relationship with her boyfriend), "Thank you for having taught me to let myself be loved, a task much more difficult than giving love." Collateral contact with Melania's sister serendipitously provided additional data. Melania's sister had telephoned the therapist at the beginning of treatment, seeking advice about how to cope with her (Should she invite Melania to Sunday brunch with her family? Introduce her to friends? Give her money?). The therapist reassured the sister that her emotional (not financial) support could only be beneficial, but he did not offer specific advice. Near the end of the second year of treatment, Melania's sister called the therapist again, this time to say "thank you" because Melania seemed so much better.

DISCUSSION

Measuring change in patients with personality pathology is problematic. In psychotherapy outcome studies of patients with Axis I disorders, change may be assessed adequately with symptom-oriented measures. For example, it is reasonable to assess improvement in patients with major depression using self-report measures that emphasize acute symptoms (e.g., mood, sleep disturbance, appetite disturbance). In assessing personality pathology, matters are more complicated.

PDs are global syndromes encompassing patterns of cognition, affectivity, interpersonal functioning, impulse regulation, and so on. Moreover, the *DSM–IV* explicitly defines

PDs in terms of inner experience as well as overt behavior. Many aspects of inner experience are subtle, implicit rather than explicit, and neither directly observable nor readily accessible via self-report.

In real-world clinical practice, assessment of personality pathology is largely inferential. Clinicians do not typically assess personality pathology by asking patients direct questions about their personalities. Instead, clinicians of all theoretical orientations report that they listen to their patients' accounts of their lives and important relationships, note how the patients interact with them in the consulting room, then draw their own conclusions (Westen, 1997).

Outcome studies of psychotherapy for borderline PD have attempted to circumvent such difficulties in part by relying on records of concrete events such as documented suicide attempts, psychiatric emergency room visits, psychiatric hospital admissions and lengths of stay, and so on. Such measures are coarse, and many patients with PDs do not make suicide attempts or get hospitalized. PD researchers have often been forced to make difficult trade-offs between clinical relevance and empirical rigor. It is a common lament among clinical practitioners who treat PDs that outcome studies do not address the things that "really" change in psychotherapy.

The SWAP–200 was designed to bridge the gap between clinical and empirical approaches to personality assessment. It seeks to operationalize subtle psychological processes and many facets of inner experience (as well as more overt behavioral signs and symptoms) by harnessing and quantifying the observations and inferences of expert clinical observers. In this study, the clinical observers were independent clinicians (not the treating therapist) working from written transcripts of psychotherapy sessions.

There are many methodological limitations in single case studies, and this study is no exception. The methodology does not permit inferences regarding the efficacy of treatment in general or the efficacy of particular interventions. Clinical raters are subject to confirmatory and other biases, despite steps taken in the development of the SWAP–200 to minimize observer bias and maximize reliability. Although the SWAP–200 assessments in this study were conducted 2 years apart, it is nevertheless possible that the raters recognized that the assessments were of the same patient early and late in treatment. If so, the assessors' expectations may have influenced their ratings. Finally, in the absence of a control condition, it is impossible to attribute all of the observed changes to psychotherapy. The effects of history, maturation, intervening life events, and so forth are all reflected in the outcome.

Nevertheless, the findings are highly suggestive and point the way toward research strategies that can reliably address a wide range of clinically relevant personality constructs. The methods we described in this article represent one step in the direction of integrating the clinical and empirical traditions in personality assessment.

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