22 INTERPERSONAL DIAGNOSIS OF PSYCHOPATHOLOGY

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> The symptomatic acts which are expressions of the mentally disordered are therefore most meaningful for psychiatry when their interpersonal contexts are known.
>
> —H. S. Sullivan (1962, p. 303)

The earliest formal appearance of the term "interpersonal diagnosis" may be found in Leary and Coffey's (1955) predecessor to the publication of *Interpersonal Diagnosis of Personality: A Functional Theory and Methodology for Personality Evaluation* (Leary, 1957). Since then, many new developments have occurred in interpersonal psychology that rest firmly upon and usefully extend the fundamental scaffold developed by Leary and his colleagues. Thus today, interpersonal diagnosis is neither a unitary clinical assessment procedure nor a singular approach to the study of personality and psychopathology. Interpersonal diagnosis is a theoretically integrative paradigmatic approach to personality assessment (Wiggins, 2003), psychotherapeutic practice (Anchin & Pincus, 2010; Pincus & Cain, 2008), and the study of psychopathology (Horowitz, 2004). The term has been used to describe procedures that range dramatically in complexity, from basic typological assignment of interpersonal style (Wiggins, Phillips, & Trapnell, 1989) to longitudinal examinations of interpersonal behavior over time and relationships (Moskowitz, 2005, 2009) to a comprehensive and developmentally informed clinical case conceptualization approach (Benjamin, 2003; Critchfield & Benjamin, 2008). Thus, a very molar definition of interpersonal diagnosis would be: *The use of those central and pluralistic practices employed by researchers and practitioners working within the interpersonal nexus of personality and psychopathology* (Pincus, 2005b; Pincus, Lukowitsky, & Wright, 2010; Pincus, Lukowitsky, Wright, & Eichler, 2009; see Figure 22.1).

The center of Figure 22.1 identifies four basic elements of interpersonal diagnosis that tie together its pluralistic procedures and applications. First, interpersonal diagnosis is anchored to the nomological net of interpersonal constructs contained in the interpersonal paradigm in personality and clinical psychology. In one way or another, this includes the application of the Agency and Communion metaframework (Wiggins, 1991) and its derivations of the Interpersonal Circle (IPC; Gurtman, Chapter 18 in this volume; Fournier, Moskowitz, & Zuroff, Chapter 4 in this volume; Locke, Chapter 19 in this volume;

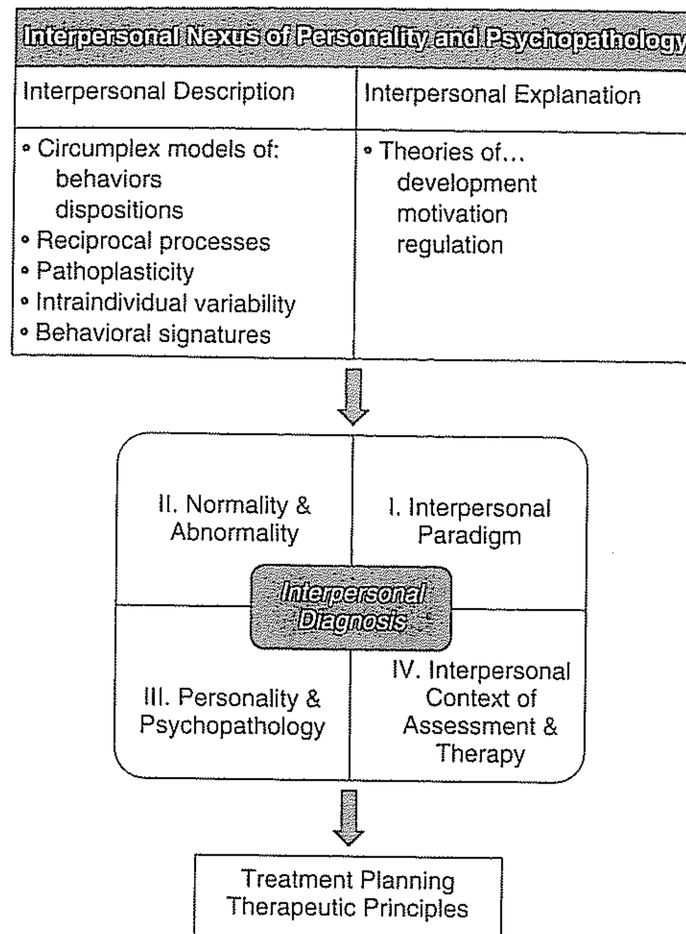

FIGURE 22.1 Interpersonal Diagnosis and the Interpersonal Nexus of Personality and Psychopathology

Wiggins, 1996) as a "key conceptual map" (Kiesler, 1996, p. 172) for an interpersonal *description* of psychopathology, in combination with the contemporary developmental, motivational, and regulatory assumptions of interpersonal theory (Benjamin, 2003, 2005b; Horowitz, 2004; Pincus, 2005a) for an interpersonal *explanation* of psychopathology. Second, interpersonal diagnosis assumes that normality and abnormality can be conceptualized with the same dimensions and are not wholly unique functional domains (O'Connor, 2002; Pincus & Gurtman, 2006). The implications of this assumption are that (a) interpersonal descriptions of normality and abnormality should be based on the same interpersonal models, constructs, and processes; and (b) abnormality is considered to be, in some way, a distortion or disturbance of normal interpersonal functioning (Benjamin, 1993; Henry, 1994). Third, interpersonal diagnosis assumes that psychopathology and personality are inextricably linked. Although this is most notable in the conceptualization of personality disorders (e.g., Benjamin, 1996; Horowitz & Wilson, 2005; Pincus, 2005a), interpersonal diagnosis also views most psychiatric symptoms as embedded within the context of personality and interpersonal functioning (e.g., Horowitz & Vitkus, 1986; Kiesler, 1996; Millon, 2005; Pincus et al., 2010). Fourth, interpersonal diagnosis recognizes that diagnostic assessment and psychotherapy most commonly take place within an interpersonal context—the relationship between patient and clinician (e.g., Adams, 1964; Anchin & Kiesler, 1982; Andrews, 1989;

McLemore & Benjamin, 1979). This highlights the need to help clinicians identify and organize the salient interpersonal data involved in the verbal reports, nonverbal behaviors, affective shifts, and symptomatic expressions of those they assess and treat.

Over its 50-year history, the methods and theory underlying interpersonal diagnosis have continued to evolve. Since its nascent development in Sullivan's (1953a, 1953b, 1954, 1956, 1962, 1964) highly generative interpersonal theory of psychiatry, interpersonal diagnosis has consistently been employed in research on, and treatment of, the categories of psychopathology found within the existing nosologies of the day, ranging from pre-DSM (Sullivan, 1953a) to DSM-V (Pincus et al., 2010). Occasionally, calls to develop an altogether alternative nosology of psychopathology based in the interpersonal paradigm have arisen (e.g., Carson, 1996; McLemore & Benjamin, 1979; Pincus & Ansell, 2003). However, this goal remains more potentiality than reality.[1] Therefore, this chapter will emphasize the utility of interpersonal diagnosis by reviewing the interpersonal constructs and concepts that are typically employed to describe abnormality and psychopathology (see Figure 22.1). We begin with a brief review of the historical origins of interpersonal diagnosis found in the works of Sullivan and Leary. This is followed by a review of the evolving interpersonal constructs and methods that can be used to describe psychopathology. We will discuss a few specific disorders as exemplars, but in-depth coverage of specific classes of psychopathology can be found in the chapters that follow in this section.

ORIGINS OF INTERPERSONAL DIAGNOSIS

Sullivan's Views on Diagnosis of Psychopathology

Sullivan's formal discussions of diagnosis are quite sparse; even his well-known treatise on interviewing (Sullivan, 1954) does not contain a significant discussion on diagnosis per se. However, all four basic elements of interpersonal diagnosis reviewed above have their origins in Sullivanian thought and theory. Sullivan viewed diagnosis as serving both nomothetic and specific clinical aims. Regarding the former, he noted that, "The term *diagnosis*—literally a discrimination, and medically, a deciding as to the character of the situation before one—is, in the study of personality inextricably linked with prognosis—literally a foreknowing—the formulation of the probable outcome" (Sullivan, 1953b, p. 74). One goal of diagnosis is to discriminate and identify the class of psychopathology encountered. However, he goes on to assert that this is not enough, noting that, "Diagnosis and prognosis cannot be dissociated from therapeutic considerations" (p. 180), and to remind us that diagnosis must not only describe but also explain psychopathology in order that something can be done for the patient so that she or he might cease to be a patient (Sullivan, 1953a).

Perhaps the aspect of Sullivanian theory that most impacted interpersonal diagnosis was his view on the data used for diagnosis. This data is inherently interpersonal and what is diagnosed is the interpersonal *pattern* of psychopathology (*elements I & IV* of Figure 22.1). Sullivan considered mental disorders to be "patterns of inadequate or inappropriate interpersonal relations" (1953a, p. 313) and such disordered relational functioning was "characterized by the misuse of human dynamisms" (1954, p. 102).[2] Therefore, mental health is most meaningful as it pertains to interpersonal adjustment (Sullivan, 1964) and "One achieves mental health to the extent that one becomes aware of one's interpersonal relations" (Sullivan, 1953b, p. 207). *The goal of interpersonal diagnosis of psychopathology is to identify the pattern(s) of behavior that lead to disturbed interpersonal relations.* Sullivan saw the therapeutic relationship as an interpersonal situation, and thus, the therapist was considered a participant observer engaged in a real relationship with the patient. From this perspective,

an interpersonal diagnosis is derived from the therapeutic relationship itself. Because the therapist is an active participant in an ongoing relationship, reactions to the patient reflect the prominent interpersonal impacts of the patient's behavior on others and are viewed as fundamental interpersonal communications that inform clinical understanding and intervention decisions.

But the therapist is more than a participant; he or she is also an observer. Sullivan was clear that a particular stance be taken when observing the therapeutic relationship. Specifically, therapists should be acutely attuned to (a) the interpersonal communication occurring via behavior, voice tone, gesture, and symptoms, and (b) indications of interpersonal anxiety or anxiety avoidance via the interpersonal communications of the patient's presentation. Such observation allows the therapist to identify those interpersonal behaviors and patterns that are associated with security and self-esteem, and those that are associated with anxiety and its avoidance. For example, some patients are secure when taking a passive, cooperative relational stance, but can be quite anxious with self-assertion or disagreement. For others, the opposite is true. Depressive symptoms may convey the submissive interpersonal message "Help me; I can't do it by myself." Suicidality may convey the hostile interpersonal message "You're to blame for my misery" in one context, and the affiliative interpersonal message "I desperately need someone to take care of me" in another context. While waiting for a consultation on an inpatient unit, a schizophrenic patient haltingly approached the first author and said glumly, "I'm being punished for breathing fire." One common reaction to such a statement in an inpatient context is to see it as a psychotic symptom and disregard it since human beings do not breathe fire. However, when the interpersonal communication was considered, the patient appeared to be relaying a sense of frustration and hurt. When I replied, "That must feel unfair," the patient relaxed and was able to explain that he was reprimanded for smoking in his room rather than in a designated area.

According to Sullivan, the interpersonal communications of the patient's presentation will also demonstrate security operations, which serve to minimize anxiety via activation or inhibition of certain behaviors, and may operate outside the patient's awareness. Concretely, when, without awareness, a patient changes the subject abruptly, fails to comprehend the therapist, refuses to respond, exhibits nonverbal and affective shifts, or reports new symptoms, the therapist should consider "What is the interpersonal meaning of such phenomena?" Sullivan suggested that when such behaviors interfere with the integration of the therapeutic relationship, the patient is employing learned interpersonal strategies that minimize anxiety and increase security. Thus participant observation allows the therapist to conceptualize the patient's problems directly via relational experience. Since the same learned relational patterns are assumed to be common across the interpersonal situations that characterize the patient's life, this data can then be used to plan treatment that encourages new interpersonal learning within the therapeutic relationship.

Importantly, such patterns are neither random nor infinite. Sullivan (1964) noted that "While minor differences in personality are as numerous as are the cultural patterns of the homes from which people have come, the structure of society and the character of human potentialities combine to limit the conspicuous manifestations of mental disorder to a reasonably small number of patterns which can be discriminated" (p. 169). Such patterns are always defined by reference to an explicit or implicit formulation of personality (*element III* of Figure 22.1), which sets limits on the manifestations of human individuality and provides norms from which significant deviations can be regarded as disordered (Sullivan, 1962). Finally, description of normal and abnormal interpersonal patterns can be derived from a common

interpersonal framework (*element II* of Figure 22.1). Sullivan repeatedly emphasized that disordered interpersonal patterns are deviations and distortions of normal interpersonal functioning, noting that "We all show everything that any mental patient shows, except for the pattern, the accents, and so on" (1954, p. 183), and "The course of life gives everyone some experience with everything that I know to be dynamisms of mental disorder" (1956, p. 358). It was Leary and colleagues who extended Sullivan's thinking and formalized the approach by developing operationalizations of Sullivan's concepts, leading to the initial derivation and empirical validation of the IPC, and the first formal interpersonal diagnostic system (LaForge, 2004; Pincus, 1994; Wiggins, 1996).

Leary's Contributions to Interpersonal Diagnosis

Timothy Leary and the Kaiser Foundation research group (Freedman, Leary, Ossorio, & Coffey, 1951; LaForge, Leary, Naboisek, Coffey, & Freedman, 1954; Leary, 1957; Leary & Coffey, 1955) can be credited with providing the organizing framework and empirically validated structure for interpersonal diagnosis. Incorporating Sullivan's thinking and foreshadowing attachment theory, Leary (1957) argued for the primacy of the interpersonal domain in personality functioning by noting the biological reality of a child's frail nature and the necessity of social interaction for survival and achievement of maturity. Humans have biologically evolved to be social creatures and, via social learning principles, personality develops through the influence of others in interpersonal transactions across the lifespan.

Leary and his associates observed interactions among group psychotherapy patients and asked, "What is the subject of the activity, e.g., the individual whose behavior is being rated, doing to the object or objects of the activity?" (Freedman et al., 1951, p. 149). In this regard, topical content was not of specific interest. Instead, observations reflected the interpersonal communications between group members, consistent with Sullivan's diagnostic data. This context-free cataloguing of patients' interpersonal behavior eventually led to an empirically derived IPC structure based on the two underlying dimensions of dominance-submission (Agency) on the vertical axis and nurturance-coldness (Communion) on the horizontal axis. While the IPC model has been empirically refined and extended over the years, its fundamental characteristics have been repeatedly validated (e.g., Gurtman & Pincus, 2000; Pincus, Gurtman, & Ruiz, 1998). Figure 22.2 presents a contemporary version of the IPC. Leary conceptualized this as the ordered classification of interpersonal mechanisms, reflexes, and behaviors around the two primary dimensions, and this circular space serves to organize the relationships between different types of interpersonal functioning at any given level of analysis (e.g., behaviors, traits, motives, etc). Importantly, in its original and subsequent incarnations, the IPC describes not only the static relations among the interpersonal variables (i.e., the ordering around the circle), but also the dynamic relations of human transaction based on the interpersonal bids and pulls of one behavior for another, i.e., complementarity (e.g., Carson, 1969; Kiesler, 1983; Sadler, Ethier, & Woody, Chapter 8 in this volume).

At the time of his book's publication, Leary was reacting strongly to the zeitgeist of symptom-focused psychiatry. In fact, the work appeared just five years after the publication of the DSM-I (American Psychiatric Association, 1952). He voiced his frustration with the common practice of the time of focusing on symptoms for diagnosis by pointing out that this limited the diagnostic nosology to those disorders that were prone to seeking out help, and further, that theories of personality were lopsidedly attendant to maladaptive rather than adaptive functioning. Among the other advances offered by Leary's volume,

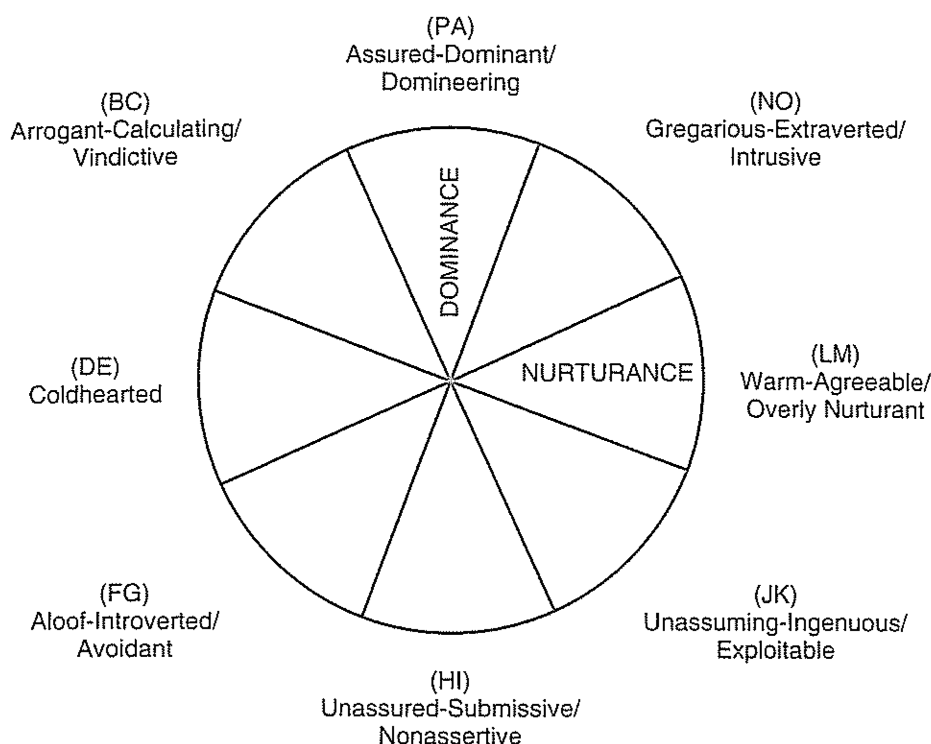

FIGURE 22.2 The Interpersonal Circle (Traits/Problems)

he argued that any system of personality needed to accommodate the full spectrum of normality and abnormality in functioning, which he considered dimensional in nature. To discriminate maladaptive from adaptive interpersonal functioning, Leary distinguished four ways to quantify patterns of interpersonal behavior: moderation versus *intensity*, flexibility versus *rigidity*, stability versus *oscillation*, and accuracy versus *inaccuracy* (i.e., the fit or match of behavior within a specific interpersonal context).[3] Importantly, these four patterns of interpersonal adjustment and maladjustment can be operationalized and quantified with specific reference to the IPC structure and they remain among the major constructs used to describe psychopathology in contemporary interpersonal diagnosis (see also Erickson, Newman, & Pincus, 2009; Pincus & Gurtman, 2006). At the time, Leary argued that the interpersonal system could serve as the foundation for an alternative taxonomy of personality styles, and that even the symptom disorders could be diagnosed through the measurement of interpersonal patterns. The remainder of this chapter discusses these types of interpersonal patterns, as well as new developments in contemporary approaches to interpersonal diagnosis of psychopathology.

CONTEMPORARY INTERPERSONAL DIAGNOSIS

To identify interpersonal patterns of psychopathology, contemporary interpersonal diagnosis employs multiple constructs, methods, and levels of analysis in describing personality and behavior. Figure 22.3 lists three major classes of interpersonal variables associated with psychopathology. *Static individual differences* are traditional behavioral and dispositional characteristics that can be derived from established psychological assessment procedures (self-reports, other-ratings, interviews). These concepts served interpersonal diagnosis

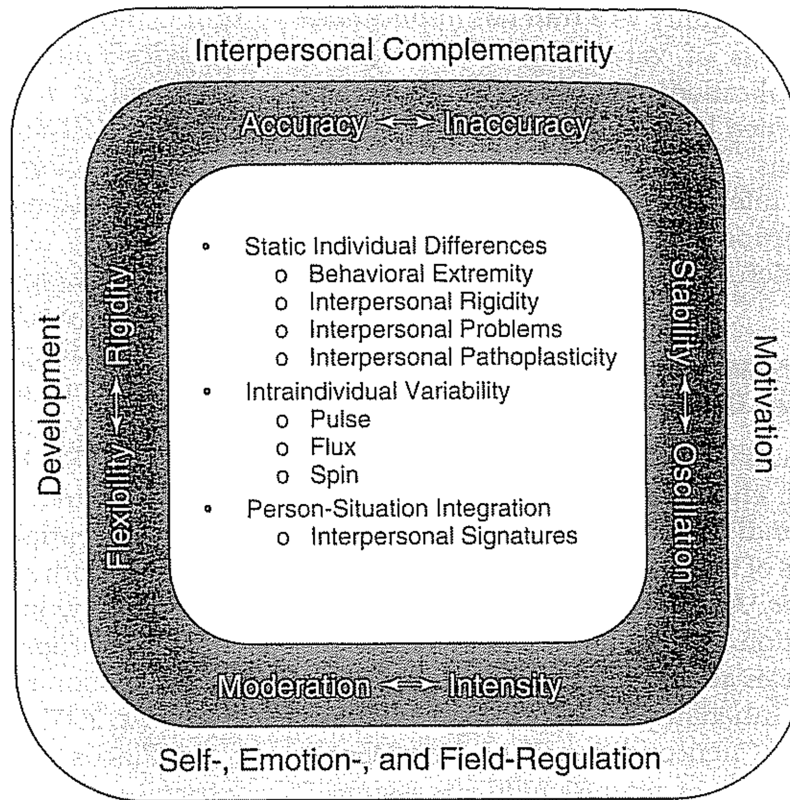

FIGURE 22.3 Variables of Interpersonal Diagnosis (white), Interpersonal Patterns of Psychopathology (black), and Assumptions of Interpersonal Theory (gray)

well, from Leary's initial formulations through the mid-1990s. In his encyclopedic review of that era, Kiesler (1996) recognized the limitations of the approach, noting, "If interpersonal diagnosis is to contribute to a full understanding of mental disorders, its assessment must systematically incorporate the important situational and temporal factors relevant to expression of each disorder's maladaptive interpersonal pattern" (p. 202). The very advances Kiesler called for nearly 15 years ago are now being realized. The last decade has witnessed a dramatic evolution in the conceptualization and measurement of personality (Fleeson & Noftle, 2008), leading to *intraindividual variability* approaches to the study of personality consistency (e.g., Fleeson, 2004), as well as new models of *person-situation integration* (e.g., Funder, 2009).

Figure 22.3 is organized to remind the reader that the variables of interpersonal diagnosis (white center), interpersonal patterns of psychopathology (black ring), and assumptions of interpersonal theory (gray ring) are interpenetrating rather than mutually exclusive. Each concentric ring holds a set of increasingly broader theoretical and empirical constructs associated with interpersonal diagnosis. As one moves from the white center to the black ring to the gray ring, the context and scope of interpersonal diagnosis expands substantially. The location of a given construct within a ring (i.e., top, bottom, left, right) is wholly arbitrary and does not imply a specific link to similarly located constructs at different levels—all constructs are interpenetrating. There are few one-to-one correspondences between interpersonal variables (white center) and interpersonal patterns (black center) and interpersonal patterns (black ring). Rigidity and accuracy have been studied from both dispositional and variability approaches. Interpersonal problems

may have implications for all interpersonal patterns. Rigidity as a trait has implications for aspects of variability, which in turn has implications for accuracy. Finally, as represented by the gray ring, interpersonal diagnosis is fundamentally embedded within interpersonal theory's conceptions of reciprocal transaction, development, motivation, and regulation.

Interpersonal Description of Psychopathology: Individual Differences

Static individual differences are, as typically defined, enduring, dispositional attributes of the individual expressed in distinctive patterns of thought, perception, feeling, and behavior. As McAdams (1995) points out, dispositions typically describe individual differences at a fairly broad or general level and are inherently "decontextualized" and relatively "nonconditional" (p. 365). Hence, the variables of interest here are assumed to reflect a general feature of the person's tendencies (e.g., "I am shy") that are presumed to be relatively stable over time and found in an aggregate of interpersonal situations. Importantly, however, there are not one-to-one relationships between traits and behaviors, leaving the interpersonal meaning of a given behavior ambiguous without consideration of the person's motive or goal in that interpersonal situation (Horowitz et al., 2006). Thus, a certain trait or behavior (whether adaptive or maladaptive) may not necessarily be expressed in a particular interpersonal situation, relationship, or episode; or dictate a particular emergent process. For this level of specificity, contemporary interpersonal diagnosis relies on additional theoretical constructs.

Behavioral extremity and interpersonal rigidity. When referenced to the IPC, extremity (i.e., enacting behaviors in intense forms) and rigidity (i.e., displaying a limited repertoire of interpersonal behaviors) are critical variables for conceptualizing patterns of psychopathology within the interpersonal tradition. Although the two are assumed to co-occur, they are conceptually distinct (O'Connor & Dyce, 2001). In the context of IPC models, extremity reflects a specific behavior's intensity on a particular dimension, and is represented linearly, by the behavior's distance from the origin of the circle. Behaviors can vary from relatively mild expressions of a trait dimension close to the origin (e.g., expresses one's preferences) to extreme versions at the periphery of the circle (e.g., insists/demands others do his/her bidding). This intensity dimension is an inherent feature of the circle originally conceived by Leary and, more recently, by Kiesler's (1983, 1996) refined articulation of the IPC. Extreme behaviors that populate the circle's periphery are likely to be undesirable for both self and others. Their lack of moderation would rarely make them situationally appropriate or successful (for theoretical elaborations, consult Carson, 1969; Horowitz, 2004; or Kiesler, 1996).

As Pincus (1994) pointed out, whereas extremity (or intensity) is a property of an individual's single *behavior*, rigidity is a characteristic of a whole *person*, or more specifically, a summary of his or her limited number of different behaviors across various interpersonal situations. From Leary (1957) on, interpersonalists have argued that disordered individuals tend to enact or rely on a limited or restricted range of behaviors, failing to adapt their behaviors to the particular demands of a given situation. From a circumplex perspective, they tend to draw from a small segment of the IPC, rather than draw broadly as the situation requires. In contrast, interpersonally flexible individuals are capable of adjusting their behaviors appropriately to the cues of others in order to act effectively (see, e.g., Carson, 1991; Paulhus & Martin 1987, 1988). Hence, they are more likely to engage in and sustain behavior patterns that are mutually satisfying to their relational partners (e.g., Kiesler, 1996).

From the static dispositional perspective, rigidity has been assessed using methods for scoring a person's circular profile that derive originally from LaForge et al. (1954; see also Gurtman, 1994, Chapter 18

in this volume). Specifically, the profile's *vector length*, or VL, has been used as an index of rigidity (e.g., Leary, 1957; Tracey, 2005; Wiggins et al., 1989). Like behavioral intensity, VL is also a quantification of distance from the IPC origin. However, it is a geometric summary of an individual's ratings on dispositions around the entire IPC rather than the linear level of the relative intensity of a specific behavior or a direct measure of restricted behavioral range. A high VL profile tends to have greater differentiation across octant scale scores, which is commonly caused by a pronounced elevation in a single region of the circumplex. Gurtman and Balakrishnan (1998) have extensively discussed and critiqued the presumed link between VL and rigidity, drawing the distinction between VL as statistical index (known properties) and as potential clinical indicator (hypothesis). As a statistic, VL is technically a measure of a circular profile's differentiation moderated by the profile's "fit" to a circular model (Gurtman, 1994).

Whether VL is a valid indicator of rigidity, however, is an ongoing empirical matter. Research has demonstrated that in heterogeneous samples, VL is not highly correlated with general maladjustment (e.g., Paulhus & Martin, 1988; Gurtman, 1996; Gurtman & Balakrishnan, 1998; Ruiz et al., 2004; Wiggins et al., 1989; cf. O'Connor & Dyce, 2001), although when limited to a specific angular location (i.e., in samples selected as homogeneous in interpersonal style), VL is correlated with conceptually consistent forms of maladjustment (Wiggins et al., 1989). Further evidence suggests that the relationship between VL and maladjustment is complex and may be mediated "upstream" by accuracy, i.e., complementarity (Tracey, 2005), and moderated by cognitive adherence to IPC structure (Tracey & Rohlfing, 2010).

VL does not, in its calculation, include naturally occurring interpersonal behaviors sampled across time or situations (seemingly central to the full meaning of rigidity). The only study to investigate the association between IPC VL and variability in behavior sampled over time did not find evidence of a link (Erickson et al., 2009). We believe it is best to conceptualize VL calculated from self- or other-reports as IPC "profile differentiation," representing the degree to which a respondent discriminates between aspects of interpersonal functioning that are very much like the self or target, in contrast to those qualities that are not characteristic of the self or target (Gurtman & Balakrishnan, 1998; Wright, Pincus, Conroy, & Hilsenroth, 2009). It may be useful to add the interpretation of VL as "differentiation," and its social-cognitive implications, to the dispositional variables used in interpersonal diagnosis.

Interpersonal problems. Measures assessing maladaptive interpersonal characteristics and processes provide a proximal approach to describing patterns of psychopathology. In this respect, the development of the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Urēno, & Villaseñor, 1988), along with explication of the interpersonal problems construct have been critical events in the recent history of interpersonal diagnosis (Gurtman, 1996; Horowitz et al., 2006). The evolution of the IIP has been described in detail by Horowitz and his colleagues in a number of sources (e.g., Horowitz, 1979, 1996; Horowitz & Vitkus, 1986). The IIP's item set was developed from the complaints voiced by prospective psychotherapy patients during intake interviews. This test construction method gives the IIP two appealing features. First, the items possess good ecological validity (Gurtman, 1996) that may be lacking in other instruments, and second, the item pool offers a fairly broad and comprehensive "universe of content" for delineating specific interpersonal difficulties. Interpersonal problems take two forms, interpersonal deficits or "things you find hard to do" (e.g., "It's hard for me to join in on groups"), and interpersonal excesses or "things you do too much" (e.g., "I argue with people too much"). On this basis, Horowitz et al. (1988)

published a 127-item version of the IIP. This version presents a superset of the current 64-item IIP-Circumplex Scales (IIP-C; Alden, Wiggins, & Pincus, 1990; Horowitz, Alden, Wiggins, & Pincus, 2000), which in turn was reduced to a 32-item short form (IIP-SC; Hopwood, Pincus, DeMoor, & Koonce, 2008; Soldz, Budman, Demby, & Merry, 1995). In its circumplex forms, the IIP captures the maladaptive variants of the basic IPC content domains (see Figure 22.2). IIP instruments exhibit sensitivity to change across psychodynamic, cognitive, and pharmacological treatments (Horowitz et al., 1988; Markowitz et al., 1996; Vittengl, Clark, & Jarrett, 2003), and are widely used in contemporary psychotherapy and psychopathology research (e.g., Borkovec, Newman, Pincus, & Lytle, 2002; Hopwood, Clarke, & Perez, 2007; Huber, Henrich, & Klug, 2007; Ruiz et al., 2004).

Limitations of static individual differences. Studies empirically linking psychopathology and static individual differences in interpersonal dispositions are numerous and, for some forms of psychopathology, such mapping is relatively successful in describing core maladaptive interpersonal patterns. For example, rigidity is most central to the concept of personality disorder. Research linking interpersonal dispositions to particular DSM personality disorder diagnoses (e.g., Pincus & Wiggins, 1990; Soldz, Budman, Demby, & Merry, 1993; Wiggins & Pincus, 1989) confirmed that personality disorder, consistent with the DSM definition, was reflected in overly extreme and rigid agentic and/or communal behavior that caused impairment and/or subjective distress. For example, histrionic personality disorder is consistently associated with IPC octant NO, implying extreme extraversion that, when rigidly enacted, leads to intrusive interpersonal problems (e.g., "I want to be noticed too much"). In contrast, avoidant personality disorder is consistently associated with IPC octants FG and HI, implying extreme introversion and submissiveness that, when rigidly enacted, leads to avoidant and nonassertive interpersonal problems (e.g., "I find it hard to socialize with other people," "I find it hard to be self-confident when I am with other people"). However, static mapping research has only succeeded in capturing a subset of personality disorders. Specifically, the paranoid (BC—vindictive), schizoid (DE/FG—cold, avoidant), avoidant (FG/HI—avoidant, nonassertive), dependent (JK—exploitable), histrionic (NO—intrusive), and narcissistic (PA/BC—domineering, vindictive) personality disorders are associated with specific IPC locations. Beyond these results, the other personality disorders (e.g., borderline—Leihener et al., 2003; Ryan & Shean, 2007) and most symptom syndromes (e.g., anxiety disorders—Kachin, Newman, & Pincus, 2001; Salzer et al., 2008) do not appear to consistently present with a single, prototypic interpersonal phenomenology. Thus, to fully apply interpersonal diagnosis, we must move beyond basic descriptions of psychopathology founded on the covariation of symptoms/disorders with interpersonal characteristics assessed as static individual differences and investigate both pathoplastic and dynamic associations. We turn to these elements of interpersonal diagnosis next.

Advances in Interpersonal Diagnosis

Interpersonal Pathoplasticity

Whereas some forms of psychopathology can be summarized by relatively uniform interpersonal features across similarly diagnosed patients, others seem to have a kaleidoscopic relationship to the interpersonal system, wherein personality and psychopathology intertwine to produce variability in expression of the disorder. Interpersonal pathoplasticity can be said to occur when there exists a significant quantitative relationship between psychopathology and interpersonal behavior, but there is not a singular qualitative interpersonal signature associated with the form of psychopathology (Pincus

et al., 2010; see also Klein, Wonderlich, & Shea, 1993; Widiger & Smith, 2008). Interpersonal pathoplasticity accounts for the lack of one-to-one coherence between some forms of psychopathology and interpersonal styles, in contrast to a purely etiological relationship that presumes that the same underlying process gives rise to the psychopathology and the interpersonal style. Pathoplasticity is part of the inextricable link between personality and psychopathology, in that the latter is always expressed within the larger context of the former (Millon, 2005), and it would be unreasonable to assume that the expression of pathology would not be influenced by one's characteristic manner of relating to others, and vice versa. Not only can interpersonal pathoplasticity describe the observed heterogeneity in expression of psychopathology (e.g., Cain, Pincus, & Grosse-Holtforth, in press; Kachin et al., 2001; Salzer et al., 2008), it can also predict variability in response to psychotherapy within a disorder (e.g., Alden & Capreol, 1993; Borkovec et al., 2002; Cain et al., in press; Salzer, Pincus, Winkelbach, Lechsenring, & Leibing, in press) and account for a lack of uniformity in regulatory strategies displayed by those who otherwise are struggling with similar symptoms (e.g., Slaney, Pincus, Wang, & Uliaszek, 2006; Wright, Pincus, Conroy, & Elliot, 2009). Differences in patients' interpersonal diagnoses will affect the manner in which they express their distress and make bids for the type of interpersonal situation they feel is needed to regulate their self, affect, and relationships.

Evidence is accruing that a number of symptom syndromes do not have a characteristic interpersonal profile, instead being associated with a broad range of interpersonal problems, and sometimes specific subtypes of problems (Wright et al., 2009). For example, a series of studies examining generalized anxiety disorder (GAD) have consistently found a relationship between this disorder and interpersonal problems generally—but failed to find a unitary interpersonal style, instead repeatedly identifying four distinct and prototypical interpersonal clusters within DSM-IV diagnosed GAD patients (Kasoff, 2002; Pincus et al., 2005; Salzer et al., 2008). Labeled Nonassertive, Cold, Exploitable, and Intrusive, these clusters, or subtypes, of patients reported distinct patterns of interpersonal problems but exhibited no significant differences in symptom severity or psychiatric co-occurrence. However, subtypes did vary in domains of worry content and controllability (Sibrava et al., 2007). Thus, GAD patients have increased interpersonal problems, but the types of problems an individual patient has varies as a function of their interpersonal diagnosis. These subtypes likely adopt different interpersonal regulatory strategies as they attempt to navigate the swells of their worry. For example, the interpersonally cold subtype may respond to increased worry by withdrawing from others in the hopes of avoiding the worries about outcomes. In contrast, the intrusive subtype may insert themselves into the interpersonal situations of others in the hopes that they will provide the needed assurance and social resources to manage their uncontrollable worry. In a similar fashion to GAD, two distinct groups of social phobics (one warmer and one colder) have been identified based on unique sets of interpersonal problems in both anxious student and patient samples (Cain et al., in press; Kachin et al., 2001), and these groupings were not better accounted for by symptom severity or co-occurring diagnoses. The relationship of eating disorders with interpersonal style also appears to be pathoplastic (Ambwani & Hopwood, 2009; Hopwood et al., 2007). Finally, theorists from multiple theoretical perspectives have suggested a pathoplastic model of depression vulnerability: Communal (dependent/sociotropic/anaclitic) versus Agentic (self-critical/automous/introjective) (Blatt, 2004; Beck, 1983), and evidence exists for pathoplasticity in perceived causal pathways (Keller, Neale, & Kendler, 2007), but it is not yet clear that there is a true interpersonal

pathoplasticity in depressive phenomenology (see Barrett & Barber, 2007). More research is needed to elucidate the relationship between interpersonal problems and depression.

A number of studies have investigated the effect of interpersonal problem type on treatment outcome. Examination of treatment response of GAD patients to cognitive-behavioral therapy found that end-state functioning immediately after treatment was greater for the Nonassertive and Exploitable than the Cold and Intrusive GAD patients (Kasoff, 2002). At six-month follow-up, the functioning of Nonassertive and Exploitable GAD patients continued to improve, while the functioning of Cold and Intrusive GAD patients declined. Kasoff (2002) suggested that submissive GAD clusters had a better therapy outcome than more dominant GAD clusters due to their personality compatibility with the patient–therapist role relationships in cognitive-behavior therapy (Borkovec et al., 2002; Horowitz, Rosenberg & Bartholomew, 1993; for divergent results see also Puschner, Kraft, & Bauer, 2004). Cain et al. (in press) found that interpersonally warmer social phobics showed significantly greater symptomatic improvement and satisfaction following therapy than their colder counterparts. In a related study, Alden and Capreol (1993) found that the effective treatment components for social anxiety in patients with avoidant personality disorder also differed depending on their level of communion. While all patients exhibited significant nonassertive interpersonal problems, those whose nonassertiveness was colored by higher communion benefited best from intimacy-focused skills training, whereas those patients with lower communion benefited only from graduated exposure. Thus, interpersonal diagnosis informs treatment planning beyond symptom disorder diagnosis by identifying different maladaptive behavior patterns that cause relational disturbance and perpetuate negative outcomes (e.g., Benjamin, 2003, 2005a).

For many disorders, the lack of one-to-one correspondence with interpersonal functioning results in a rich and complex heterogeneity as the pathology is variously altered through an individual's characteristic interpersonal strengths, vulnerabilities, and self-, affect-, and field-regulation strategies (Pincus, 2005a; Wiggins & Trobst, 1999). Thus, interpersonal diagnosis contributes to the broader diagnostic enterprise by providing incrementally useful information about moderators that affect the description, explanation, and assessment of psychopathology, along with uniquely informed treatment planning and prognostic recommendations (Anchin & Kiesler, 1982; Anchin & Pincus, 2010; Pincus & Cain, 2008).

Intraindividual Variability

The addition of pathoplasticity greatly extends the empirical and practical utility of interpersonal diagnosis. However, describing psychopathology using dispositional personality concepts implying marked consistency of relational functioning is still insufficient, and does not exhaust contemporary interpersonal diagnostic approaches. Even patients described by a particular interpersonal style do not robotically emit the same behaviors without variation. Recent advances in the measurement and analysis of intraindividual variability (e.g., Baird, Le, & Lucas, 2006; Erickson et al., 2009; Heller, Watson, Komar, Min, & Perunovic, 2007; Shoda, Mischel, & Wright, 1994) converge to suggest that temporal intraindividual variability of behavior warrants assessment. This accumulating body of research indicates that individuals are characterized not only by their stable individual differences in trait levels of behavior, but also by stable differences in their variability in psychological states (Fleeson, 2001), behaviors (Moskowitz, 2010), and affect (Eid & Diener, 1999; Kuppens, Van Mechelen, Nezlak, Dossche, & Timmermans, 2007) across time and situations.

Interpersonal flux, pulse, and spin. Moskowitz and Zuroff (2004, 2005) introduced the terms *flux*, *pulse*, and *spin* to

describe the stable levels of intraindividual variability in interpersonal behaviors sampled from the interpersonal circumplex. *Flux* refers to variability about an individual's mean behavioral score on agentic or communal dimensions (e.g., dominant flux, submissive flux, friendly flux, hostile flux). *Spin* refers to variability of the angular coordinate about the individual's mean interpersonal style. And *pulse* refers to variability of the overall extremity of the emitted behavior. Low spin would thus reflect a narrow repertoire of interpersonal behaviors enacted over time and is an alternative and more proximal measure of interpersonal rigidity than the computation of VL from self- or other-reports of interpersonal dispositions. Low pulse reflects little variability in behavioral intensity, and if it were associated with a high mean intensity generally, it would be consistent with the enactment of consistently extreme interpersonal behaviors. This dynamic lexicon has important implications for the assessment of normal and abnormal behavior. Theoretical analyses, as well as empirical results, suggest that the assessment of intraindividual variability offer unique and important new methods for the description of psychopathology.

For example, Russell, Moskowitz, Zuroff, Sookman, and Paris (2007) differentiated individuals with BPD from nonclinical control participants based on intraindividual variability of interpersonal behavior over a 20-day period. Specifically, individuals with BPD reported a similar mean level of agreeable (communal) behavior, as compared to their nonclinical counterparts, but BPD participants displayed greater flux in their agreeable behaviors, suggesting that control participants demonstrated consistent agreeable behavior across situations, while individuals with BPD varied greatly in their agreeable behaviors, vacillating between high and low levels. Results also suggested elevated mean levels of submissive behaviors in conjunction with low mean levels of dominant behavior coupled with greater flux in dominant behaviors for individuals with BPD relative to the control participants. However, the groups did not differ in the variability of submissive behaviors. In other words, individuals with BPD were consistently submissive relative to normal controls, but also demonstrated acute elevations and declines in their relatively low level of dominant behavior. Finally, as predicted, individuals with BPD endorsed higher mean levels of quarrelsome behavior, and higher levels of flux in quarrelsome behavior, when compared to controls. Individuals with BPD also demonstrated greater spin than their nonclinical counterparts, suggesting greater behavioral lability. Future work on other personality disorders also appears promising. Although the DSM categories of dependent and narcissistic personality disorder (NPD) map onto consistent IPC locations cross-sectionally, recent theory and research characterizing broader conceptions of these disorders (e.g., Cain, Pincus, & Ansell, 2008; Bornstein, 2005) suggest they are actually characterized by variability in interpersonal behavior. Pincus (2005a) proposed using flux, pulse, and spin to differentiate the phenomenological expression of these broader conceptions of dependent and narcissistic personality disorders.

Describing psychopathology in terms of intraindividual variability in interpersonal behavior is not limited to personality disorders, although less theoretical rationale and research has been proposed for symptom syndromes. Consistent with the results suggesting greater spin in BPD patients than controls, Moskowitz and Zuroff (2005) found that trait neuroticism was positively correlated with interpersonal spin. Consider Mineka, Watson, and Clark's (1998) integrative hierarchical model of anxiety and depression. In this model, depression and anxiety share a common, higher-order factor of negative affectivity, and each disorder is differentiated by its own specific factor. This could suggest that high levels of negative affect, combined with individuals' agentic and communal motives and traits, could give rise to variable interpersonal behavior across interpersonal situations. Moskowitz and Zuroff

(2005) suggested that high levels of negative affectivity may lead individuals to experience interpersonal situations as threatening or dangerous and employ various interpersonal strategies to cope. For example, highly anxious individuals may try to cope with perceived interpersonal threats by arguing with the others, by smiling and laughing in order to build closer connections to others, or by passively giving in to others. They concluded that, "trying a variety of behaviors to cope with frequent perceptions of interpersonal danger would contribute to spin, frequent switching among the interpersonal circumplex behaviors" (p. 143). One can also imagine that individuals with dysthymia may exhibit chronic passivity (i.e., low spin around intense submissiveness), leading to a failure to engage in agentic actions to change the circumstances and promote self-esteem (e.g., Horowitz & Vitkus, 1986). In contrast, individuals with bipolar disorder or impulse control disorders may exhibit a high amount of flux, pulse, and spin contingent upon their mood states.

Person-Situation Integration

Advances in the study of intraindividual variability have stimulated a major reconceptualization of personality consistency (Fleeson & Noftle, 2008; Funder, 2006). Moving beyond traditional conceptions of cross-situational consistency, personality is considered to reflect stability of behavior within situations and variability of behavior across situations. This increases the salience of contextual factors without losing the essence of personality itself. Assessing personality consistency via the identification of stable *if-then* behavioral signatures (Shoda, Mischel, & Wright, 1993, 1994) has thus become an important arena of personality research (Mischel & Shoda, 1998; Mischel, Shoda, & Mendoza-Denton, 2002). In this approach, the stability of personality and core patterns of psychopathology are anchored to consistent contingent *if-then* structures of behavioral and emotional responses (*thens*) in situations the individual experiences as functionally equivalent (*ifs*).

Conceptualizing and measuring patterns of variability and stability of interpersonal behavior over time and across situations is an important development for interpersonal diagnosis that has the potential to enhance the sophistication of our current diagnostic systems (Pincus, 2005a, Pincus et al., 2009; Pincus et al., 2010). Some diagnoses, such as trichotillomania, imply rather classic conceptions of cross-situational consistency—chronic hair pulling without significant situational contingencies. The prominent features of others, such as bipolar disorder, are best characterized by variability in mood and behavior over time. Finally, many diagnostic features are actually based on implicit or explicit *if-then* behavioral signatures (see, e.g., Eaton, South, & Krueger, 2009; Leising & Müller-Plath, 2009). For example, a cardinal symptom of borderline personality disorder (BPD) could be phrased as, "*if* the person perceives abandonment, *then* frantic efforts to avoid it are enacted." Defining symptoms of social anxiety disorder could be phrased as, "*if* the person perceives scrutiny, dislike, or disapproval from others, *then* anxiety is experienced and avoidance behaviors are enacted."

A key implication of situation–behavior contingencies is the need to identify the psychologically salient features of situations, and this requires an organizing psychological theory. Consistent with our analysis of many *if-then* diagnostic features of psychopathology, recent work in personality, social, and clinical psychology converges in emphasizing the salience of interpersonal features of situations (e.g., Pincus et al., 2009; Reis, 2008). Importantly, this is directly incorporated into interpersonal diagnosis by the assessment of interpersonal behavior contextualized within interpersonal situations both assessed on the common metric of agentic and communal dimensions, i.e., *interpersonal signatures* (Fournier, Moskowitz, & Zuroff, 2008, 2009; Moskowitz, 2009). That is,

the patterns of disturbed interpersonal functioning interpersonal diagnosis strives to identify can be contextualized by linking the perceived agentic and communal characteristics of the other person(s) in an interpersonal situation (*ifs*) with the symptomatic or maladaptive behavioral and emotional responses (*thens*) of the patient. Our view is that pathological interpersonal signatures often reflect coping behaviors (*thens*) activated by distorted perceptions of interpersonal situations (*ifs*). Consistent with the fundamental elements of interpersonal diagnosis, these contextualized patterns can be organized through the lens of Agency and Communion, and applied at a variety of descriptive levels, ranging from molar dispositional profiles (e.g., Pincus & Wiggins, 1990; Wiggins & Pincus, 1989) to highly articulated behavioral patterns (e.g., Benjamin, 1996) to the structure of social-cognitive schemas (e.g., Horowitz & Wilson, 2005) and articulations of internal object-relations (Pincus, 2005a).

At a descriptive level similar to DSM criteria, some of the cardinal symptoms of pathological narcissism or NPD could be phrased as interpersonal signatures: "*if* the person meets new peers, *then* self-promoting, attention-seeking, or competitive behaviors are enacted;" "*if* the person perceives lack of admiration, *then* he or she angrily devalues the other(s);" "*if* the person assumes authority over others, *then* self-serving and exploitative behavior is enacted;" or "*if* idealized expectations for self or others are disappointed, *then* he or she responds with shameful withdrawal and social avoidance." Problems arise because intense needs for self-esteem support, admiration, and superiority likely give rise to the characteristic schemas of the pathologically narcissistic individual, who consistently misinterprets a broad array of situations as opportunities for self-enhancement or threats to their ideal self-image (*ifs*), responding with characteristically narcissistic disaffiliative self-protective behaviors and agentic self-enhancement strategies (*thens*). In new situations, these trump and violate normative behavioral patterns, and ultimately lead to vicious circles, self-fulfilling prophecies, disturbed interpersonal relations, and functional impairment (Pincus & Lukowitsky, 2010; Pincus & Roche, in press).[4]

Person-situation integration is a promising advance for contemporary interpersonal diagnosis for a number of reasons. First, it is possible to parsimoniously describe interpersonal behaviors and interpersonal situations using a common metric—the Agency and Communion metaframework. Second, empirical research confirms the normative behavioral contingencies of interpersonal situations described by the principles of interpersonal complementarity (Sadler et al., Chapter 8 in this volume), supporting the proposition that chronic deviations from complementarity may indicate the presence of psychopathology. Interpersonal signatures provide precise descriptions of contextualized behavioral patterns and strong tests of accuracy-inaccuracy (i.e., complementarity). Third, we propose that a focal question for the study of psychopathology is "Why do individuals deviate from their sociocultural conventions of dyadic interaction?" The framework points to multiple possible sources of disturbed interpersonal functioning (e.g., distortions in interpersonal perception and meaning-making processes; maladaptive, underdeveloped, or overvalued interpersonal goals, motives, expectancies, beliefs, and competencies).

CONCLUSIONS AND FUTURE DIRECTIONS

Although we have emphasized the interpersonal paradigm, and the agency and communion metaframework, it is important to note that one need not work exclusively from within the paradigm to focus on salient interpersonal factors in personality and psychopathology. More broadly, we see interpersonal diagnosis as reviewed here as having intersections with many emerging trends in psychological science. Advances in intraindividual variability

and person-situation integration promote greater synthesis of social, personality, and clinical psychology (Lukowitsky, Pincus, Hill, & Loos, 2008; Swann & Seyle, 2005).[5] In addition, interpersonal diagnosis also intersects with advances in social neuroscience (Harmon-Jones & Winkielman, 2007), as contemporary theoretical (e.g., Depue, 2006) and empirical (e.g., aan het Rot et al., 2006) efforts are forging clear links between neural pathways and interpersonal behavior. The ease with which these advances, and others, can be operationalized within the interpersonal paradigm demonstrate that the approach is not only theoretically integrative (Horowitz et al., 2006; Pincus & Ansell, 2003), but highly interdisciplinary as well.

Given emerging advances in interpersonal diagnosis, the future appears vital and exciting. While we certainly hold no special prescience on the matter, we can offer some conclusions and suggested directions for the approach. First, although there have been occasional calls for developing an interpersonal diagnostic system that is an alternative to the DSM system (or other established systems), we believe there is substantial wisdom in psychology's and psychiatry's cumulative observations of psychopathology, such that the major classes of dysfunction (e.g., mood, anxiety, eating, psychosis, etc.) do seem reasonably identified, and we do not foresee development of a unique diagnostic nosology based solely on an agency and communion metaframework. Given that interpersonal functioning is an integrative pantheoretical nexus for the description and explanation of personality and psychopathology (Pincus, 2005b; Pincus et al., 2010), we feel interpersonal diagnosis can usefully augment existing and future psychiatric diagnoses in multiple ways.

First, we would advocate for interpersonal diagnosis of individual patients using agentic and communal interpersonal constructs (e.g., behaviors, traits, motives, problems, strengths) to provide a context for understanding presenting symptoms and for treatment planning. Second, based on the contemporary scope of interpersonal diagnosis, augmentation of the DSM could include subclassification of disorders as characterized by (a) prototypical interpersonal characteristics (e.g., chronic submissiveness in dysthymia; chronic distrust in paranoia), (b) pathoplastic interpersonal subtypes (e.g., generalized anxiety disorder, social phobia), and (c) interpersonal variability (e.g., BPD; dissociative identity disorder). This descriptive augmentation is consistent with evolving models of personality disorder classification that integrate dimensional and categorical approaches (e.g., Krueger, Skodal, Livesley, Shrout, & Huang, 2008), and we see no reason such efforts cannot be extended to symptom syndromes.

The interpersonal nexus of psychopathology includes description and explanation of disorder. Explanation requires integration of the developmental, motivational, and regulatory concepts of interpersonal theory to generate testable hypotheses for future research. In this regard, the identification of pathological interpersonal signatures can point to potential underlying psychosocial mechanisms of disorder. Identifying stable *if-then* interpersonal signatures associated with the exacerbation or diminution of specific symptoms or symptom profiles allows for functional, etiological, and maintenance hypotheses integrating behavioral, social-cognitive, dispositional, and emotional constructs within the agency and communion metaframework.

Interpersonal aspects of description and explanation provide valuable information for the clinician above and beyond psychiatric diagnosis. Knowing a new patient's psychiatric diagnosis does not convey much about who this person is, how their symptoms manifest, and why they persist. If the patient's interpersonal problems are added to the diagnostic picture, the clinician may immediately have some initial ideas about what the patient experiences as significant interpersonal stressors, what social maintenance factors may be involved

in the disorder, and what possibilities are indicated for tailoring treatment approaches effectively to the patient's personality. Initial sessions may further diagnosis by identifying pathological interpersonal signatures associated with symptom amplification (e.g., Sadikaj, Russell, Moskowitz, & Paris, in press), leading to targets for behavioral change. Although empirical investigations of interpersonal dispositions associated with psychopathology are abundant, research on interpersonal pathoplasticity, variability, and behavioral signatures has only emerged in the last decade, taking advantage of new developments in psychological science. While it is too early to provide definitive, empirically validated interpersonal augmentation of most disorders, we conclude by highlighting three fruitful interrelated areas for future research. First, psychopathology research should continue efforts to establish and clarify the nature of pathological interpersonal patterns (prototypic, pathoplastic, situationally-contingent) associated with different disorders. Second, psychotherapy research should aim to demonstrate the incremental utility of interpersonal diagnostic information for treatment planning, treatment effectiveness, and treatment efficacy. And third, empirical tests of the dynamics of behavior, emotion, and symptom change using multilevel modeling and latent growth curve frameworks can examine whether changes in interpersonal behavior predict changes in symptoms, further supporting the pantheoretical focus on interpersonal functioning in the conceptualization and treatment of psychopathology.

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NOTES

1. An example of a related approach to generating an alternative interpersonal nosology can be found in the systems-based "relational diagnosis" movement (e.g., Kaslow, 1996; Kaslow & Patterson, 2006). However, this approach does not necessarily incorporate the four basic elements of interpersonal diagnosis described here.
2. Dynamisms are the Sullivanian term for individuals' slowly changeable but recognizably recurrent and typical patterns of interpersonal behavior and emotion (e.g., a chronically irritable and argumentative interpersonal presentation).
3. Like Sullivan, Leary contended that those behaviors that are adaptive are those that are culturally valued and commonly socialized. This formulation offers flexibility in conceptualization by allowing for cultural framing of what is considered "disordered."
4. Note the consistency with Sullivan's conception of disturbed interpersonal relations as the "misuse" of human dynamisms.
5. This conclusion is certainly not new. Such possibilities were even discussed at length in Sullivan's (1964) final book, *The Fusion of Psychiatry and Social Science*.