

**The Interpersonal Situation:
Integrating Personality Assessment, Case Formulation, and Intervention**

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The official diagnostic system clinicians are currently asked to use to integrate their patients' personalities into a comprehensive clinical diagnosis employs a medical model that is empirically problematic and largely unhelpful for personality assessment, case formulation, treatment planning, and intervention. Trait (Widiger & Simonsen, 2005) and process based (Eaton, South, & Krueger, 2009) alternatives each address important limitations of the medical model. However, structure and process models, in isolation, fail to provide a full picture of human functioning (DeYoung, 2014; Fleenor, 2001; Pincus & Wright, 2011) and are particularly ill-suited for clinical applications (Hopwood, Zimmermann, Pincus, & Krueger, in press; Wright, 2011). Coupling evidence-based models of personality structure (Harkness, Reynolds, & Lilienfeld, 2014; Wright & Simms, 2014) with evidence-based models of the dynamic processes underlying psychopathology, personality, and clinical intervention (Ebner-Premier, Eid, Kleindienst, Stabenow, & Trull, 2009; Roche, Pincus, Rebar, Conroy, & Ram, 2014; Thomas, Hopwood, Woody, Ethier, & Sadler, 2014) offers the basis for a revolution in clinical assessment and psychiatric diagnosis (Hopwood et al., in press; Krueger, 2013).

In this context, the *Diagnostic and Statistical Manual of Mental Disorders, fifth edition* (DSM-5; American Psychiatric Association, 2013) alternative PD model represents an historical effort to integrate clinical theories of pathological personality processes (found in Criterion A), with an empirically derived dimensional trait model (found in Criterion B). However, this system is not well-integrated into a cohesive framework sufficiently buttressed by clinical theory and research. Despite offering an apparent conceptual, empirical, and clinical improvement over the categorical diagnoses of DSM-5, Section II (Krueger & Markon, 2014), the alternative model is nevertheless somewhat cumbersome and redundant, and it thus fails to provide a fully effective framework for making specific clinical formulations and predictions.

A more flexible and coherent conceptual model is needed to guide assessment, formulation, and intervention. Such a model should: a) cover the range of characteristics and difficulties that are

likely to be of clinical interest, b) conform to an evidence-based structure of individual differences, c) afford a means for describing both what a person is like in general and the processes that lead to variability and change over time, d) integrate diverse evidence-based models of psychopathology, personality, and intervention, e) provide a framework for integrating multimethod assessment data, f) be parsimonious and portable, and g) connect assessment, formulation, and intervention. In the next section, we present the *Contemporary Integrative Interpersonal Theory* of personality (CIIT: Pincus, 2005; Pincus & Ansell, 2013) and the interpersonal paradigm of personality assessment (Wiggins, 2003) as a framework for connecting structure and process for the purpose of personality-based clinical practice.

Contemporary Integrative Interpersonal Theory

CIIT provides an evidenced-based model of personality structure linked with dynamic social-cognitive, affective, and behavioral processes that offer a scientifically grounded framework to generate testable clinical hypotheses regarding diagnosis, formulation, and treatment (Anchin & Pincus, 2010; Pincus et al., 2014). In this section, we lay out specific assumptions in CIIT regarding personality structure and process.

Structural Assumptions

In the interpersonal paradigm, the organizational metaframework of agency and communion (Wiggins, 1991) provides scaffolding for defining and assessing the fundamental constructs of interpersonal functioning (**Figure 1—top**). The agency and communion metaframework gives rise to the interpersonal circumplex (IPC) model (**Figure 1—bottom**). This metaframework, and its empirically validated derivations of the IPC, are a “key conceptual map” (Kiesler, 1996, p. 172) for an interpersonal description of personality structures and personality processes.

Interpersonal theory (Wiggins, & Trapnell, 1996) and research (Ansell & Pincus, 2004) conclude that all domains of the Five-Factor Model of personality traits have agentic and communal implications.

However, whereas trait systems have traditionally emphasized that traits are amalgams of multiple levels of psychological functioning, including motives, cognition, and behaviors, the IPC system draws meaningful distinctions between these levels even as it organizes them with the same structural model. These distinctions are depicted in the top of **Figure 1** in which motives, traits, and behaviors represent different aspects of interpersonal functioning (Locke, 2011). The system also extends trait models in that interpersonal assessment focuses on both dispositions at multiple levels of functioning *and* dynamic patterns of functioning across time and situations (Pincus et al., 2014). From the CIIT perspective, aspects of interpersonal situations, including a person's particular level of warmth or dominance at any given moment, are dynamically linked experiential elements with established connections to basic traits such as neuroticism, extraversion, agreeableness, and conscientiousness (e.g., Johnson, Miller, Lynam, & South, 2012). Thus trait assessments can be used to make predictions about particular behavioral patterns in interpersonal situations.

One interesting behavioral pattern directly involves the structure of the IPC. Recent research suggests that, although dominance and warmth as measured by IPC instruments are generally orthogonal in the population, they can correlate within individuals (e.g., Fournier et al., 2008, 2009; Roche, Pincus, Hyde, Conroy, & Ram, 2013; Roche et al., 2014). Within person covariance might occur if a person is able to be warm when in charge but is cold when someone else takes the lead. Deviations from orthogonality can also occur in perception, such as when an individual thinks that others are only warm when they are being submissive, such that a show of assertiveness in another is taken as cold or hostile. Such patterns are likely to interfere with interpersonal functioning and thus have important clinical implications.

Process Assumptions

The core assumption of the interpersonal perspective is that the most important expressions of personality and psychopathology occur in phenomena involving more than one person. Sullivan (1953a,

1953b) suggested that individuals live in communal existence with the social environment and express integrating tendencies which bring people together in the mutual pursuit of satisfactions (generally a large class of biologically grounded needs), security (i.e., anxiety-free functioning), and self-esteem. A potential misinterpretation of the term “interpersonal” is to assume it refers to a limited class of phenomena that can be observed only in the immediate interaction between two proximal people. In contrast, in CIIT interpersonal functioning is assumed to occur not only between people, but also inside people’s minds via the capacity for mental representation of self and others (e.g., Blatt, Auerbach, & Levy, 1997; Lukowitsky & Pincus, 2011). *Interpersonal situations* occur in perceptions of contemporaneous events, memories of past experiences, dreams, and fantasies or expectations of future experiences. Both proximal and internal interpersonal situations continuously influence an individual’s learned relational strategies, regulatory functioning, and self-concept.

Interpersonal processes involve interpersonal patterns of perceiving, interpreting, feeling, and behaving over time. These patterns are socially reinforced through various transactional influences impacting self and others throughout development as they resolve, negotiate, or exacerbate the unfolding interpersonal situations that make up human life. Interpersonal behaviors probabilistically invite or evoke delimited classes of responses from the other in a continual, dynamic transactional process. Thus reciprocal interpersonal patterns are the consistent agentic and communal behavioral responses to the perceived agentic and communal characteristics of others in an interpersonal situation (Pincus et al., 2010).

The IPC provides conceptual anchors and a lexicon to systematically describe reciprocal interpersonal patterns. The most basic of these patterns is referred to as interpersonal *complementarity* (Carson, 1969; Kiesler, 1983). Interpersonal complementarity occurs when the agentic and communal needs of both persons are met in the interpersonal situation, leading to stability and likely recurrence of the pattern. Complementarity is defined via the IPC based on the social exchange of status (agency) and

love (communion) as reflected in oppositeness for the vertical dimension (i.e., dominance pulls for submission; submission pulls for dominance) and sameness for the horizontal dimension (friendliness pulls for friendliness; hostility pulls for hostility). Although complementarity is neither the only reciprocal interpersonal pattern that can be described by the IPC nor a proposed universal law of interaction, empirical studies consistently find support for its probabilistic predictions (Sadler, Ethier, & Woody, 2011). This research suggests that complementarity should be considered a common baseline for the reciprocal influence of interpersonal behavior associated with healthy socialization; and, deviations from complementary interpersonal patterns are more likely to disrupt interpersonal relations or be self-destructive or costly. Chronic deviations from complementarity across relationships may be indicative of pathological personality functioning (Hopwood et al., 2013; Roche, Pincus, Conroy, Hyde, & Ram, 2013).

Consistent with object relations (Fairbairn, 1952) or social cognitive (Shoda, Mischel, & Wright, 1994) personality process models, CIIT proposes that mediating internal psychological features (e.g., self–other schemas, motives and needs embedded in these schemas, and emerging emotional experiences) influence the likelihood of complementary interpersonal patterns. Chronic deviations from normative social processes suggest impairments in: (1) recognizing the consensual understanding of interpersonal situations, (2) adaptively communicating one’s own interpersonal needs and motives, and (3) comprehending the needs of others and the intent of their interpersonal behavior. In such cases, the individual may react chaotically or rigidly pull for responses that complement his or her own interpersonal behavior, but have significant difficulty replying with responses complementary to others’ behavior. This reduces the likelihood that the agentic and communal needs of both persons will be satisfied in the interpersonal situation (Hopwood et al., 2013; Horowitz et al., 2006; Pincus & Hopwood, 2012). Psychopathology is understood in terms of these kinds of disturbances (Pincus & Wright, 2011).

The Interpersonal Situation

Pincus and Ansell (2003) summarized Sullivan's concept of the *interpersonal situation* as "the experience of a pattern of relating self with other associated with varying levels of anxiety (or security) in which learning takes place that influences the development of self-concept and social behavior" (p. 210). From the perspective of CIIT, the interpersonal situation is the key human experience where social-learning occurs, and over the lifespan, it promotes personality organization, development, and adjustment (Pincus & Ansell, 2013). Interactions with others develop into increasingly complex patterns of interpersonal experience that are encoded in memory via age-appropriate social learning from infancy throughout the lifespan. According to Sullivan, interpersonal learning of self-concept and social behavior is based on an anxiety gradient associated with interpersonal situations, which ranges from rewarding (highly secure, esteem-promoting) through various degrees of anxiety (insecurity, low self-esteem). The interpersonal situation underlies the genesis, development, maintenance, and mutability of personality and psychopathology through the continuous patterning and re-patterning of interpersonal experience in an effort to increase security and self-esteem while avoiding anxiety. Over time, developmental experiences give rise to mental representations of self and others (what Sullivan termed personifications) as well as to enduring patterns of adaptive or disturbed interpersonal relating. Individual variation in learning occurs due to the interaction between the developing person's level of cognitive maturation and the facilitative or toxic characteristics of the interpersonal situations encountered. In both proximal interactions and mental representation, the affective valence associated with an interpersonal situation is a function of one's ability to satisfy basic motives for interpersonal security and self-esteem. When needs for security and self-esteem are met, the interaction is pleasant and the behavior is reinforced; when these needs are frustrated, it is unpleasant, prompting dysregulation and distress and a need to cope and adapt.

In **Figure 2**, we present a model that builds upon the IPC to account for the structure of interpersonal situations (revised from Hopwood et al., 2013). Both self and other are depicted and both

include their own self and affect systems (it is important to recall that the other may either be a proximal individual or a mental representation). The *self system* is organized by underlying agentic and communal interpersonal motives (Grosse-Holtforth, Thomas, & Caspar, 2011; Horowitz et al., 2006) that lead to behavioral styles, aversions, problems, and capabilities via social learning. Identity, self-concept, and self-worth vary according to the degree to which interpersonal motives are satisfied. The *affect system*, which is structured by affective arousal and valence (Posner, Russell, & Peterson, 2005), has a highly sensitive and dynamic relationship with the self-system that is indicated by the bidirectional arrows between the interpersonal and affective circles within the self and the other. For instance, emotional experiences provide critical feedback regarding motive satisfaction that can color and intensify or dull interpersonal behavior. In turn, interpersonal behavior modulates affective experiences via the achievement of interpersonal goals.

The *interpersonal field* encapsulates the relationship between the self and other. Each person's independent perceptions of self (curved arrows) and other (unidirectional arrows) are represented as inputs, perceived in terms of their agentic and communal behaviors and impacts. The specific behaviors enacted within the field (which are simultaneously output and input) are indicated by the bidirectional arrow between self and other. Overall, the integration of structure and process of the interpersonal field is best captured by the entirety of the interpersonal situation as indicated by the box outlining the figure. Within the interpersonal field, perceptual processes moderate the functioning of the self system, affect system, and behavior.

Personality Pathology as Dysregulation and Distortion in Interpersonal Situations

In CIIT, personality pathology is defined as the severity of *dysregulation* and *distortion* in interpersonal situations (Pincus, 2005; 2011). The severity of personality pathology is characterized by pervasiveness and intensity of *dysregulation* and *distortion*, whereas the style of PD is characterized by consistent relational *patterns of dysregulation and distortion*, i.e., input–intermediary–output chains,

encompassing perception, interpretation, motivation, affect, and behavior in the interpersonal situation (Hopwood et al., 2013; Pincus & Hopwood, 2012; Wright, 2014).

Dysregulation. The failure to achieve security and self-esteem in interpersonal situations causes dysregulation in the self (e.g. ego threat), affect (e.g., anger), and the interpersonal field (e.g., hostility) (Pincus, 2005; Pincus et al., 2010; see **Figure 3**). *Self regulation* involves the ability to effectively manage one's social cognition and self-concept, or how one thinks about oneself in relation to others in interpersonal situations (Sullivan, 1953b). *Affect regulation* involves the ability to modulate one's inner emotional states and affective expression (Gratz & Roemer, 2004), or how one feels in interpersonal situations. *Field regulation* involves modulating the processes by which one relates to others in interpersonal transactions, or how one behaves and impacts others' behavior in interpersonal situations (Wiggins & Trobst, 1999). One way to organize these concepts is that self, affective, and field regulation domains correspond to how one thinks about oneself and others, feels about oneself and others, and behaves in interpersonal situations.

Distortion. Sullivan (1953b) proposed the concept of "parataxic distortion" to describe the potentially biasing influence of internal subjective interpersonal situations on observable interpersonal behavior. Distortions are thought to occur when one's mental representation of an interpersonal situation does not match an objective interpretation of the situation, instead fitting the contours of an alternative, internal, and psychologically impactful or conflictual situation. In this sense, maladaptive interpersonal behavior can oftentimes be understood as a logical response to a misperception, deeply rooted in an individual's social learning history.

The Interpersonal Situation as an Integrative Framework for Personality Assessment

Traditional conceptualizations of personality traits have emphasized stability and cross-situational generality and thus research has prioritized studying the structure of between-person differences (Fleeson, 2012). In contrast, theories of personality pathology rooted in clinical practice

often describe dysfunction in terms of dynamic within-person processes (Beck, Freeman, & Davis, 2004; Clarkin, Yeomans, & Kernberg, 2006; Kohut, 1977; Pincus, 2005). The dynamic processes that form the focus of clinical description and intervention generally involve an interaction between the patients and the situational contexts within which their symptoms emerge (Pincus, Lukowitsky, Wright, & Eichler, 2009).

In the past, bridging the gap between the empirically derived dimensional personality traits and the more clinically salient processes related to PDs has been difficult (Benjamin, 1993). However, advances in the study of within-person fluctuation of personality states have ushered in an empirically tractable way of studying personality traits as ensembles of processes (Fleeson, 2001; Fleeson & Ghallager, 2009; Fleeson & Nofhle, 2008). Investigations into the structure of personality have rigorously mapped the important orienting dimensions for the empirical study of processes. These advances, coupled with increased interest in person-situation integration (e.g., Donnellan, Lucas, & Fleeson, 2009; Fournier et al., 2008), have laid the groundwork for the pursuit of a dynamic, process-based understanding of clinically relevant personality features that is rooted in the basic science of personality.

The interpersonal situation inherently represents an integrated structure and process perspective on personality. It provides an organizing theory, as well as empirically validated trait structure (interpersonal and affect circles) and empirically validated interpersonal processes (reciprocal patterns/complementarity). The interpersonal situation specifies the important inputs, mediators, and outputs of interest in process-based formulations (e.g., Wang, et al., 2014) and provides a systematic lexicon to organize structural and dynamic constructs (e.g., Lukowitsky & Pincus, 2011) that is based in personality science.

Thus the key concepts of CIIT provide scaffolding for an evidence-based approach to conceptualizing and treating clinically relevant aspects of personality. Within this lens, individual differences in personality and symptoms are based on the same empirically supported structure such

that personality pathology is considered a distortion or disturbance of normal interpersonal functioning. CIIT allows clinicians to identify and organize the salient interpersonal data regarding patients' typical ways of seeing themselves and others, patients' typical ways of reacting and relating to others in the moment, and patients' maladaptive interpersonal patterns emerging over time both in the consulting room (e.g., Thomas et al., 2014; Tracey, Bludworth, & Glidden-Tracey, 2012) and across the natural settings of daily life (e.g., Roche et al., 2014; Sadikaj, Moskowitz, Russell, Zuroff, & Paris, 2013; Wright, Hopwood, & Simms, in press).

Personality Diagnosis and the Interpersonal Situation—The Case of David

In the remainder of this chapter we demonstrate the value of using the interpersonal situation to organize clinical formulations by describing “David,” a 26 year old Latino man who presented for a personality assessment after contemplating suicide. David was married to “Jenna” and they had a 2 year old daughter. Three weeks prior to moving back to their mutual hometown to be closer to their parents, David became so distressed that he left his phone and keys at the house and walked for several miles. He made his way to some train tracks where he sat, feeling “dazed”. For several hours he considered throwing himself in front of a moving train, before ultimately returning home. Although he did not seek medical help at the time, his wife insisted on a psychological assessment. David presented three weeks after moving into an apartment in his hometown, six weeks after the incident.

David appeared motivated despite having been referred by Jenna. Although he reported occasional suicidal ideation, current risk was judged to be low. The *Personality Assessment Inventory* (Morey, 1991) was used to assess general features of personality and psychopathology. Validity scales were all within normal limits. His only significant elevations (i.e., $T > 70$) were on the suicidal ideation and stress scales. Depression, his next highest elevation, was 61T. The overall pattern of scores suggested passivity and isolation.

Interpersonal Assessment: Across Levels, Across Interactions, Within Interactions

Interpersonal theory has long emphasized the systematic assessment of clinical characteristics across levels of personality functioning, situations, and time (Kiesler, 1996; Leary, 1957). Likewise, the interpersonal situation as represented in **Figure 2** is meant to be highly flexible so as to serve and connect a range of clinical functions. The model can be simplified in the form of the IPC, or elaborated to account for different levels of interpersonal functioning or time. Contemporary interpersonal assessment enables the elaboration of the interpersonal situation across three levels of functioning: interpersonal dynamics that occur across levels of interpersonal functioning within the person, patterns of interaction across situations, and patterns of interaction within situations (Pincus et al., 2014).

To better understand and integrate different *levels of interpersonal functioning* (Leary, 1957), David agreed to complete a battery of IPC questionnaires (**Figure 4**), including the *Inventory of Interpersonal Problems-Short Circumplex* (IIP-SC; Horowitz et al., 1988; Soldz et al., 1995), the *Circumplex Scales of Interpersonal Values* (CSIV; Locke, 2000); the *Personality Assessment Inventory* Interpersonal trait scales (Morey, 1991), and the *Interpersonal Sensitivities Circumplex* (ISC, Hopwood et al., 2011). Jenna also rated him on the IIP-SC.

David and Jenna also agreed to rate interpersonal situations every day (**Table 1**) for two weeks to assess *patterns of interaction across interpersonal situations*. David rated 29 total interactions across a variety of relationships, 10 of which were focused on interactions with Jenna. Jenna also rated 10 interactions with David. They both rated 5 variables for each interaction: self warmth, self dominance, other warmth, other dominance, and positive vs. negative affective valence for self on a 1-7 scale.

Finally, *patterns within therapy sessions* were assessed by trained coders who rated the clinician's and David's warmth and dominance during the first, second, and third sessions using a computer-based momentary interpersonal coding system (**Table 2**) (Lizdek et al., 2012; Sadler et al., 2009) that records a data point for each dimension every half second. These data can be used to examine moment-to-moment interactions that occur within a particular interpersonal situation,

including therapy sessions (Thomas et al., 2014; Tracey et al., 2014). At the conclusion of session 4, David was trained to use the procedure by the clinician, which included observation and practice. David then coded 5 minutes and 50 seconds of an interaction during session 2 (**Table 3**). Below, we integrate these assessments using the interpersonal situation to develop a clinically useful formulation of David's personality and difficulties.

Field Dysregulation. When asked to describe the events leading up to his suicidal gesture, David reported being stressed by being a parent and husband. He felt like a failure because he had been unemployed and wasn't doing enough to help Jenna. David described playing online video games as his "only release", but Jenna criticized him for playing video games while she was taking care of their son, cleaning the house, etc. He basically agreed with her, but this criticism set off an avalanche of self-blame and hopelessness. The day of his gesture, David said he "just couldn't take it, and didn't know what to do". David's tendency to withdraw conflicted with his desire to be close to his son and to his wife, to be helpful and connected, and to do the "right thing". He resented Jenna for her criticism and wanted her to be more gentle, but also readily sympathized with her position. David wanted to be able to be there for Jenna when she needed him, but also to find ways to take a break when things got too stressful, and wanted to figure out what was making that difficult. David and the clinician agreed that one goal of the assessment would be to answer the question: *How can I manage closeness and distance?*

Questionnaire data indicated that David's predominant interpersonal trait and problem disposition was to be cold and submissive, whereas he was most sensitive to others' closeness (**Figure 4**). Jenna rated him as relatively cold and submissive (**Table 1**), which was consistent with the average of the trained coders' momentary ratings (**Table 2**). In the initial three clinical sessions, David exhibited below average warmth, which was highly discrepant (Cohen's $d > 2.0$) from the clinician's behavior in these same sessions. These data converged in suggesting that David's characteristic interpersonal style is to be cold and detached, with limited flexibility around that set point.

However, this portrait belies appreciable complexity. First, while David did report being too cold on the IIP-SC, he also reported problems being too warm (**Figure 4**). Second, in contrast to scores on dispositional IPC measures, David reported being warm and assertive in most interactions, including when interacting with Jenna (**Table 1**). Thus, across assessment methods discrepancies emerged, suggesting that it is possible that there are important times when David does not withdraw. Perhaps he is experiencing an inner conflict related to closeness with others, or it is possible that David held a distorted perception of his interpersonal patterns. We discuss each of these possibilities more below.

We also examined David's unique interpersonal structure (i.e., the within-person correlations between warmth and dominance across time) in both the interactions and momentary coded data (Tables 1 and 2). In the interaction-level data, David reported that when he is dominant, he is also warm, whereas when he is submissive, he is cold. Observers' momentary ratings revealed an opposite pattern, as did Jenna's report of their mutual interactions. Overall, these complex patterns suggest that a) David's withdrawal is connected to dominance and submission in interpersonal situations and b) his perception of his own behavior is likely distorted in important ways that relate to his withdrawal.

Self Dysregulation. David reported valuing being both cold-dominant and submissive in relationships (**Figure 4**). As with his self-reported problems, the existence of two non-adjacent elevations in the dispositional values profile could reflect an internal conflict between his desire to put himself first and his desire to comply with the wishes of others. Remarkably, his general interpersonal style, cold-submissive withdrawal, was his least valued interpersonal orientation (**Figure 4**). This pattern, in which David views himself as being the way he least values, suggests self-loathing and an experience of failure in interpersonal situations, in that the person he would like to be and the person he is are very different from one another. These patterns betray inner conflicts with regard to identity and self-worth, and raise the possibility that interpersonal withdrawal serves a defensive function, helping him regulate these inner conflicts.

David related a story that occurred while he was being trained for a new job in a factory. One element of the training required him to hear a subtle signal which he could not hear because of tinnitus. However, he hesitated to tell his manager about his disability, creating some confusion. When a co-worker explained the situation, David's manager was understanding, and in fact expressed relief, saying "I thought you were just dumb!" David became quite anxious and self-critical in response to this half-joke, and his self-critical rumination became so severe that evening and that he called in sick the next day. He reported an inner monologue as follows: "Of course it would be ok, it is not my fault, but why did I need someone else to stand up for me? I am just weak and worthless". He reported often feeling in a similar position with respect to his wife, whom he perceived as more effective at parenting, managing their finances, and keeping the house organized, and whom he experienced as critical and demanding. David and the assessor agreed that a second question was: "*How can I assert myself effectively?*"

In talking further with David, it became clear that inner conflicts related to self-worth and value typically preceded withdrawal. Within the interpersonal situation, then, the detached behavior that is most commonly observed by others seems to be connected to an inner identity of worthlessness and incompetence. Others' criticism is presumed implicitly, to some degree independent of the proximal others' reaction in interpersonal fields, and it connects easily with his inner critic. The connection between dysregulation in the self-system and interpersonal withdrawal raises questions about the developmental origins of this pattern, the role of parataxic distortion, and his affective experience of this interpersonal sequence.

Affect Dysregulation. As described above, David reported limited distress in general across self-report instruments. His IIP-SC elevation was in the normal range, suggesting average levels of interpersonal distress. The affective valence of his interaction ratings were also quite positive, in that they were consistently above the midpoint of the scale and significantly higher than Jenna's affect ratings (**Table 1**).

In discussing the interaction ratings, David was struck by how well things actually seemed to be going for him. He emphasized that things only go bad once in a while; generally his interactions are good. If anything, he felt he was even more warm and assertive, and felt better, when interacting with Jenna. He understood the discrepancy between his ratings and Jenna's in terms of her dissatisfaction, which he attributed to his incompetence. "She's unhappy with me, it is not so much that I am unhappy", he said. This stance was in contrast to some of the things that he said earlier about the inner experiences precipitating his suicidal gesture. When asked about this discrepancy, David said that things were bad then but had gotten better now that he had moved home. However, Jenna was not reporting significant changes in his behavior, casting some doubt on his report. It would appear that David was somewhat closed off to his negative emotions.

An interesting clue about David's affect system emerged in his ratings of his interaction with the clinician (**Table 3**). The scene that David coded for momentary behavior involves David telling the therapist about the time that his colleague told his boss about David's hearing difficulty. This scene picks up following the clinician asking him to describe a situation in which he had a difficult time asserting himself. Although there was not significant evidence of distortion in David's ratings, the time series data from David's momentary assessment were substantially more variable than those of the coders. The clinician identified areas of David's time series where there were intense shifts in their warmth levels and inquired with David about his experience of those moments. In one instance, he rated both the clinician and himself as increasing sharply on warmth. It was after the clinician said "that really does sound intense" about David's inner experience of his colleague talking to his boss. When asked, he said "I really felt that you understood what I was saying, and I guess that felt good". In another instance, the clinician's time series had a sharp downward spike on affiliation, during a time when David was saying how embarrassed he felt. When asked about this, David reported that "I just felt like I was being so annoying, you must have been bored".

Further probing made it clear that David's emotional experiences were, in fact, quite intense. However, he disavowed them immediately and automatically. Following a discussion of these experiences, David and the clinician agreed that these are the kinds of experiences he was withdrawing from the day of his suicide gesture, and that this pattern is similar to what happens routinely with Jenna. It is not Jenna that he was withdrawing from, but when interpersonal situations lead to affective disruption, her presence in those situations blocks his most trusted defensive patterns. To get away from the feelings, he has to remove himself from the situation, which means moving away from her. David agreed that this pattern would be difficult for her to see, as it was for the clinician to see given his report of limited distress on the questionnaires. David also acknowledged that he often did not see it so clearly himself.

Distortion. Assessment data consistently suggested the importance of distortion in understanding David's problems in living. To start with, Jenna reported that he has significantly more problems than he himself reported on the IIP-SC. This difference was corroborated in mean values in the interaction ratings, in which Jenna rated David's warmth, David's dominance, her own warmth, and affective valence all significantly ($p < .05$) lower than did David (effect sizes ranged from .96 to 1.91). Every direct comparison indicated that Jenna was significantly less satisfied than David in their interactions than he reported, consistent with the possibility that he was not fully aware of the extent of his interpersonal difficulties.

A more nuanced difference in their perceptions involved within-person correlations between David's dominance and warmth across situations (**Table 1**). As discussed above, correlations between David's self-reported dominance and warmth scores were .62 in general and .42 in interactions with Jenna. He saw himself as vacillating somewhat between a position of warm dominance in which he feels effective and connected (correlations with positive affect in his data were .87 for warmth and .56 for dominance) to a position in which he is withdrawn, self-critical, and hopeless. In contrast, Jenna saw

David's dominance and warmth as strongly negatively correlated (-.48). From her perspective, he vacillates between asserting himself in a manner that is hostile and cold to withdrawing via compliance and ingratiation.

However, when David coded his own session, his correlations between his dominance and warmth were similar to observers. Specifically, dominance and warmth were correlated negatively, as the coders and Jenna had reported (albeit his ratings had a smaller correlation than the observer ratings). After the task, David described feeling "blown away" by how differently he looks on the outside than he feels on the inside. He said: "When I see myself talk I just want to turn the other way; I'm so negative even when I don't think I'm being that way. No wonder Jenna doesn't think I care enough." This highlights the utility of engaging a patient in the task of perspective taking, which is aided by a concrete and readily accessible assessment data. Further, it shows that David has the capacity for accurately encoding his own behavior, even though this becomes derailed in affectively charged situations in the real world.

As is often the case in collaborative interpersonal assessment (Finn, 2006; Hopwood, 2010), this "perception test" had actually served as a powerful intervention, providing David with insights regarding how he comes across to others. That proved to be an important moment for David, because it helped him understand Jenna's experience of him and how different it is from how he feels. During the times when he feels warm and dominant on the inside (self-system: effective and caring husband), he actually comes across as cold and brooding (field system: aloof and self-centered). Although his affect and self-systems are highly sensitive to interpersonal dynamics, as indicated by his experience of significant variability over time, his behavior is relatively flat due to his characteristic avoidance of negative emotions, making him seem unaffected. It was likely very difficult for Jenna (or David) to know when or why he was upset. Likewise, his perceptions of others' behavior are colored by his expectation of

judgment and criticism, and his perceptions of his own behavior. These distortions had been supporting a pattern, rooted in development, which had become a core theme in David's interpersonal dysfunction.

Formulation

The goal of personality assessment is to conceptualize all aspects of patient functioning into a coherent and parsimonious formulation that answers specific referral questions. An initial sub-goal involves characterizing the individual's general configuration of personality traits that indicate areas of dysfunction in interpersonal situations, as shown by the black symbols in **Figure 5**. David's affective experience is constrained to low arousal and low valence. His interpersonal behavior is withdrawn, and there is an inverse correlation between dominance and warmth in his behavior (at least as experienced by others). He has identity conflicts related to power vs. weakness that are strongly connected to his affects, although this connection is only partially in David's awareness. Finally, he has significantly distorted perceptions of both his own behaviors and others' perceptions of him. Likewise, others routinely fail to recognize his inner turmoil and thus misattribute the reasons for his withdrawal.

Although this rough portrait is useful in distinguishing David from other patients, in general, it fails to establish a connection between David's personality and his marital difficulties and suicidal behavior, or specify interventions that are likely to be effective. Understanding how these features play out in interpersonal situations helps establish those connections. The key task of the assessor is to *develop a formulation about when and how maladaptive patterns emerge*.

Interpersonal situations can be reconfigured as successive stages in order to understand how processes, such as the inner phenomena that lead David to withdraw, play out over time (Pincus & Hopwood, 2012). Such a model can be used to integrate interpersonal assessment data into a formulation of cyclical maladaptive patterns (see Anchin and Pincus, 2010; Luborsky, 1977; Strupp & Binder, 1984), as depicted in **Figure 6**. In the first stage, David sustains his sense of security with grandiose fantasies in which he finds himself in heroic roles such as "videogame grand champion",

“employee of the month”, and “husband of the year” (represented in the figure as a warm-dominant self-image, with parentheses indicating his inner experience as opposed to outer behavior), admired and entrusted by those around him (these inner objects are represented by the parenthesized warm-submissive other). The configuration of mental representations in stage 1 likely provides David with a sense of self-worth and shields him against deep feelings of failure and incompetence. However, it is highly fragile because it depends upon unreasonable expectations. In reality, David is not a hero, he is a “regular guy”. Yet because of the unreasonable expectations that stem from an inner world in which David sees himself as a hero, he experiences his actual behavior with a deep and automatic sense of falling short. At times, his actual behavior was less than it could be because of the dysregulation and distortion involved in bridging his inner fantasy with outer reality.

This gives way to a second stage in which David feels deflated and hopeless. He sees himself as incompetent (submissive self-image) and disconnected (cold self-image). Hostile and unforgiving internal objects (e.g., in the form of internal self-criticism) as indicated by his parenthesized self in **Figure 6** reinforce feelings of shame and worthlessness. These hostile critics, a powerful and automatic element of David’s inner experience for as long as he could remember, likely reflected internalized messages from his developmental environment (Benjamin, 1993). This configuration sets the stage for parataxic distortion, such that David’s behavior complements the inner self-critics but leads to strained interactions with proximal others in the interpersonal field (as was exhibited in his story about feeling incompetent at work due to hearing difficulties). For instance, during this stage David may come across to others as brooding and self-defeating (cold submissive) even when others are supportive and autonomy granting (warm submissive). This leads proximal others (e.g., Jenna or his boss) to become confused or frustrated and ultimately express genuine disappointment (i.e., become cold and dominant, as indicated in **Figure 6**), providing further fuel for self-criticism.

When confirmation of David's most intense insecurity in stage 2 leads to a level of self and affect dysregulation that is unbearable, he detaches himself from the stressful situations, creating a negative reinforcement loop which sustains the maladaptive pattern. In many situations, he could use minor withdrawals, such as ignoring the other person and retreating to inner fantasy, going for a walk, or playing video games. His suicidal gesture could be understood in this context as a more extreme behavior that was nevertheless the output of a generalizable interpersonal process, similar in function to withdrawal from his family to play video games.

Intervention

By depicting core areas of David's dysfunction and the dynamics of a cyclical maladaptive pattern, this formulation leads to specific transtheoretical and transdiagnostic treatment recommendations. It can be helpful to connect specific strategies to particular aspects of the interpersonal situation, in order to integrate interventions and demarcate areas for specific assessments of change. Below, we describe several treatment recommendations designed to affect certain aspects of David's interpersonal situations, as depicted in **Figure 7**.

How can I manage closeness and distance? Three strategies were recommended for helping David manage closeness and distance (**Figure 7**). First, David agreed to a behavioral plan in which he would engage in five concrete behaviors per week involving closeness to his wife. These behaviors would be monitored in weekly meetings with the clinician and follow-up data would be collected from David and Jenna regarding the reduction in his withdrawal behavior. Second, the clinician was consistently warm during the sessions, in order to increase David's warmth (see Tracey, 2002) in the therapeutic relationship and model how to stay connected during moments of inner turmoil. **Table 2** shows both the stability of the clinician's warmth and the increasing levels of David's warmth during the early stages of their interactions. Finally, couples therapy was recommended to improve communication and address problematic relational patterns directly via clarifying perceptual disconnections between

David and Jenna. In particular, it would be important for David to help Jenna understand that his withdrawal was in response to intense and painful inner feelings, and for them to develop strategies for communicating during those moments of intensity that do not leave him feeling overwhelmed and her feeling abandoned.

How can I assert myself more effectively? David agreed to a behavior plan in which he practiced asserting himself in increasingly anxiety-provoking situations. Improvement was assessed based on his behavior and experience of each situation, as well as overall changes in IPC follow-along measures. In addition to increasing the frequency of effective self-assertion, it was hoped that this practice might have the additional benefit of helping David integrate his unrealistic aspirations with a more realistic sense of his strengths and how they might help him achieve his goals. This would, in turn, reduce his experience of failure and disrupt his cyclical maladaptive pattern in general. A better understanding of the developmental origins of agentic conflicts would further facilitate insight, which could contribute to improved regulation in David's self system, and a loosened connection between identity disruption and dysregulated affect. Insight could be developed in a psychotherapy focused upon connecting here-and-now interaction patterns with developmental experiences, and which also leveraged aspects of the interpersonal process itself (e.g., Anchin & Pincus, 2010; Hill & Knox, 2009). Specifically, by occupying a warm and submissive position in the therapeutic interaction, the clinician would invite David to be warm and dominant, and by maintaining a clear distinction between warmth and dominance, the clinician could model a more normative interpersonal stance than characterized by David's behavior in which assertion is usually done in a brooding, negativistic manner, and compliance is conflated with connection.

Summary

Contemporary psychiatric diagnosis is mostly disconnected from clinical practice because it does not provide the kind of information clinicians need to help their patients. Organizing clinical data in

terms of the structure and processes of personality provides a framework that connects assessment to individual lives and specific interventions (Krueger, 2013; Millon, 1969; Sullivan, 1954). The interpersonal situation offers a system that can build upon DSM-5 assessment, buttressed by the clinically rich principles of CIIT, decades of empirical research, and a suite of clinically sensitive assessment tools, to provide a powerful framework for personality assessment.

By integrating personality *structure* and *process*, CIIT and the interpersonal situation satisfy all of the requirements of a useful system for conceptualizing cases laid out at the beginning of this chapter. The interpersonal situation (**Figure 2**) covers the range of characteristics and difficulties that are likely to be of clinical interest in most cases. The elements of the interpersonal situation conform to an evidence-based structure of individual differences (i.e., the interpersonal and affective circles, which themselves can be connected to general trait models). The interpersonal situation affords a means for describing what a person is like in general, variability around these general characteristics, and specific contextualized dynamic patterns. It can integrate diverse evidence-based models of psychopathology, personality, and intervention, exemplified by the use of techniques from a variety of orientations in the case demonstration. It provides a framework for integrating multimethod assessment data (Hopwood & Bornstein, 2014), as shown in the case above in which informant, self-report, performance, and observational methods were used to provide a comprehensive portrait of David's interpersonal situations. Perhaps most importantly, the case demonstrated how the interpersonal situation can connect assessment, formulation, and intervention.

An ongoing challenge in CIIT and personality assessment in general has to do with portability. Although interpersonal assessment is highly elegant and parsimonious, day-to-day clinicians do not have the resources to conduct some elements of the assessment described in this chapter. Furthermore, only the most simplistic analyses are presented here; but in fact intensive repeated measures in particular open the clinician and researcher to an array of powerful analytic techniques which have the advantage

of making more use of these kinds of data, with the disadvantage of being intimidating and difficult to automate for the practicing clinician. Our hope is that, with advancing technology, such techniques will become increasingly viable, and it will become routine to assess patients over time and across different levels of personality, time, and informant (Roche et al., 2014). To successfully accomplish this, researchers and clinicians will need a model for integrating these various sources of information. The interpersonal situation provides an evidence-based model that is well-suited to that purpose.

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Table 1. Results of Repeated Assessments of Interpersonal Situations from David and Jenna.

	David's Report of Interactions across 2 Weeks (k = 29)	David's Report of Interactions with Jenna (k = 10)	Jenna's Report of Interactions with David (k = 10)
Mean (SD)			
David Warmth	4.55 (1.52)	5.10 (1.20)	3.30 (1.25)
David Dominance	4.41 (1.59)	5.10 (1.37)	2.60 (1.26)
Other Warmth	5.10 (1.35)	5.40 (1.17)	4.20 (1.32)
Other Dominance	3.86 (1.48)	3.70 (1.63)	3.50 (1.51)
Self Positive vs. Negative Affect	4.62 (1.54)	4.90 (1.45)	3.44 (1.26)
Cross Correlations			
Warm Complementarity	.78	.84	.90
Dominance Complementarity	-.43	-.43	.06
David Dominance-Warmth	.62	.42	-.48
Other Dominance-Warmth	.34	.20	.00

Note. All variables were rated on a 1-7 scale for each interaction and then averaged across interactions, with high scores indicated by the term in the column (e.g., high scores on David dominance mean that David was more dominant than submissive). Cross correlations were computed between variables (e.g., warm complementarity = correlation between self and other warmth across interactions).

Table 2. Momentary Dynamics across Sessions.

	Session 1	Session 2	Session 3
Mean (SD)			
David Warmth	-163 (86)	-76 (57)	-23 (57)
David Dominance	118 (251)	-13 (262)	25 (262)
Clinician Warmth	94 (45)	117 (30)	88 (36)
Clinician Dominance	-74 (270)	89 (225)	-20 (266)
Cross Correlations			
Warm Complementarity	.25	-.14	-.05
Dominance Complementarity	-.96	-.93	-.94
David Dominance-Warmth	-.76	-.67	-.55
Clinician Dominance-Warmth	.25	.55	-.09

Note. Momentary scores range from -1000 to 1000. All correlations were computed after covarying time. The average correlations among the time series of individual raters for both dimensions across sessions was .73.

Table 3. Momentary Aspects of a Clip from Session 2 from Observer and Patient Perspectives.

	Trained	
	Observer	Patient
Mean (SD)		
David Warmth	-139 (49)	-391 (483)
David Dominance	187 (189)	78 (445)
Clinician Warmth	129 (13)	-38 (495)
Clinician Dominance	13 (177)	-350 (510)
Cross Correlations		
Warm Complementarity	-.06	.25
Dominance Complementarity	-.95	-.76
David Dominance-Warmth	-.61	-.36
Clinician Dominance-Warmth	.01	.23

Note. Momentary scores range from -1000 to 1000. All correlations were computed after covarying time.

Figure 1. Agency and Communion metaframework (Top); Interpersonal Circumplex (Bottom).

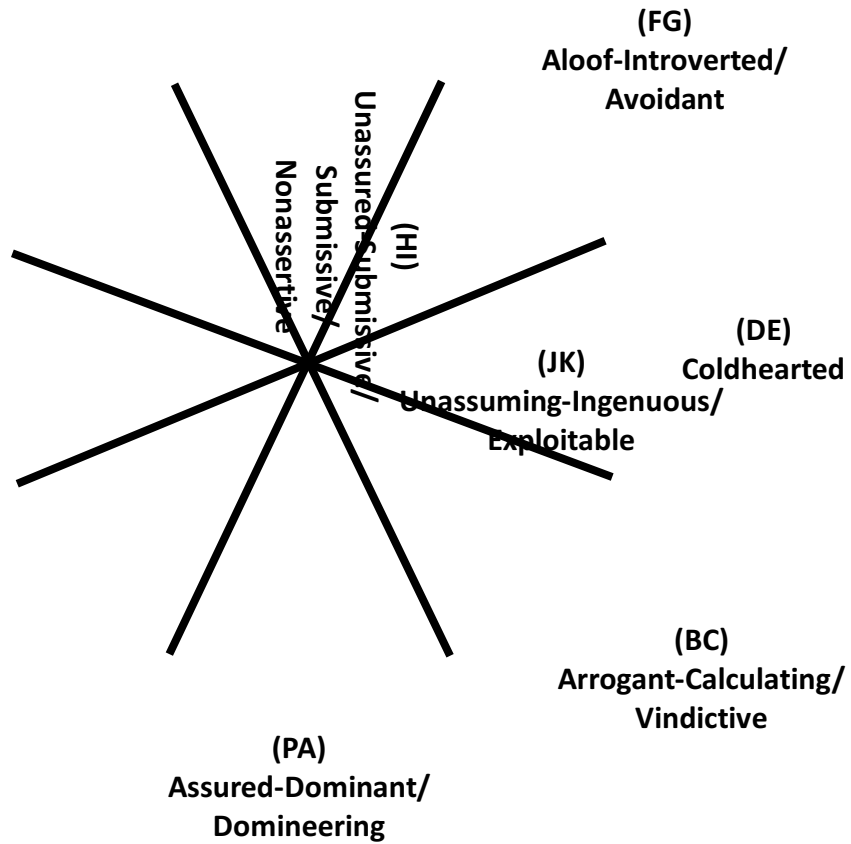
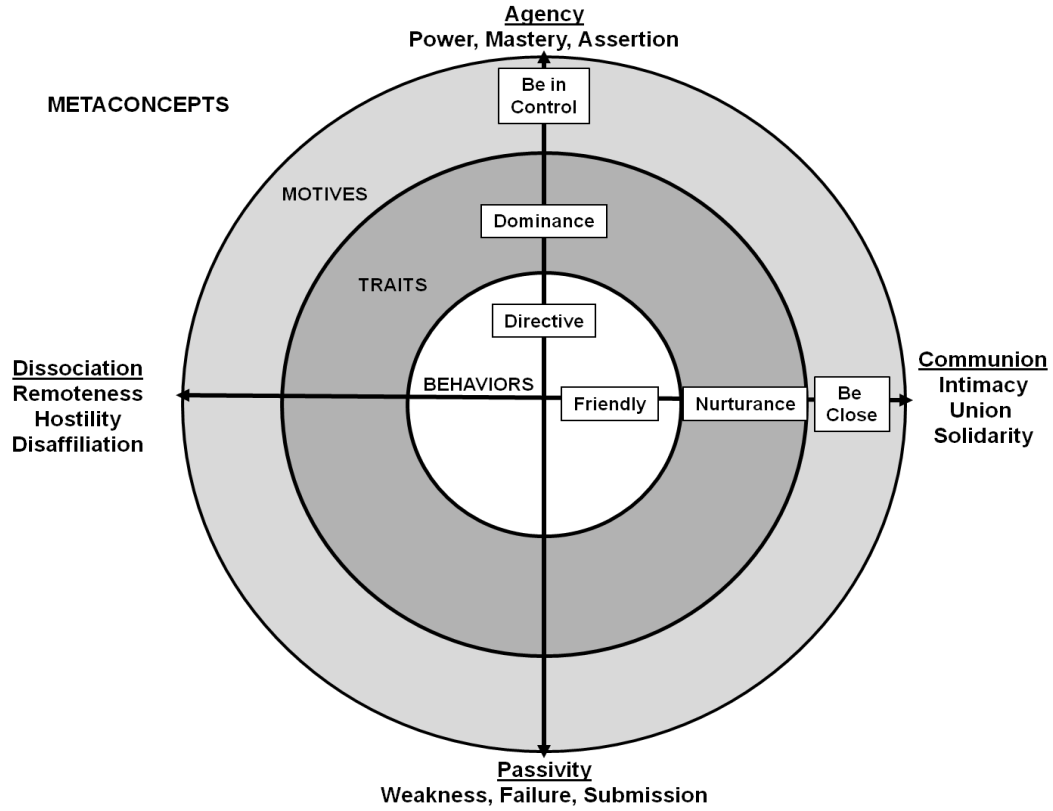


Figure 2. The Interpersonal Situation.

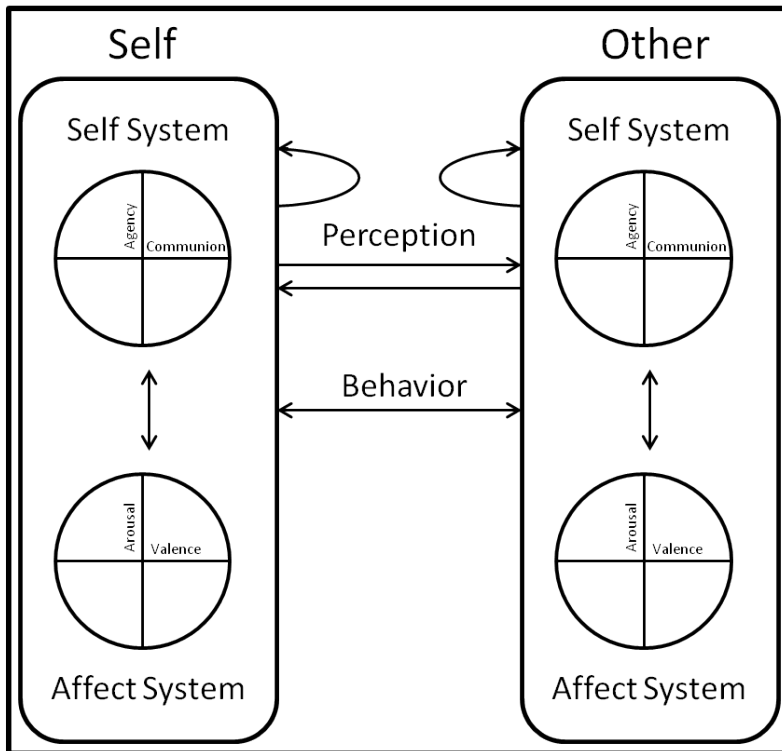


Figure 3. Personality Pathology as Dysregulation and Distortion in the Interpersonal Situation.

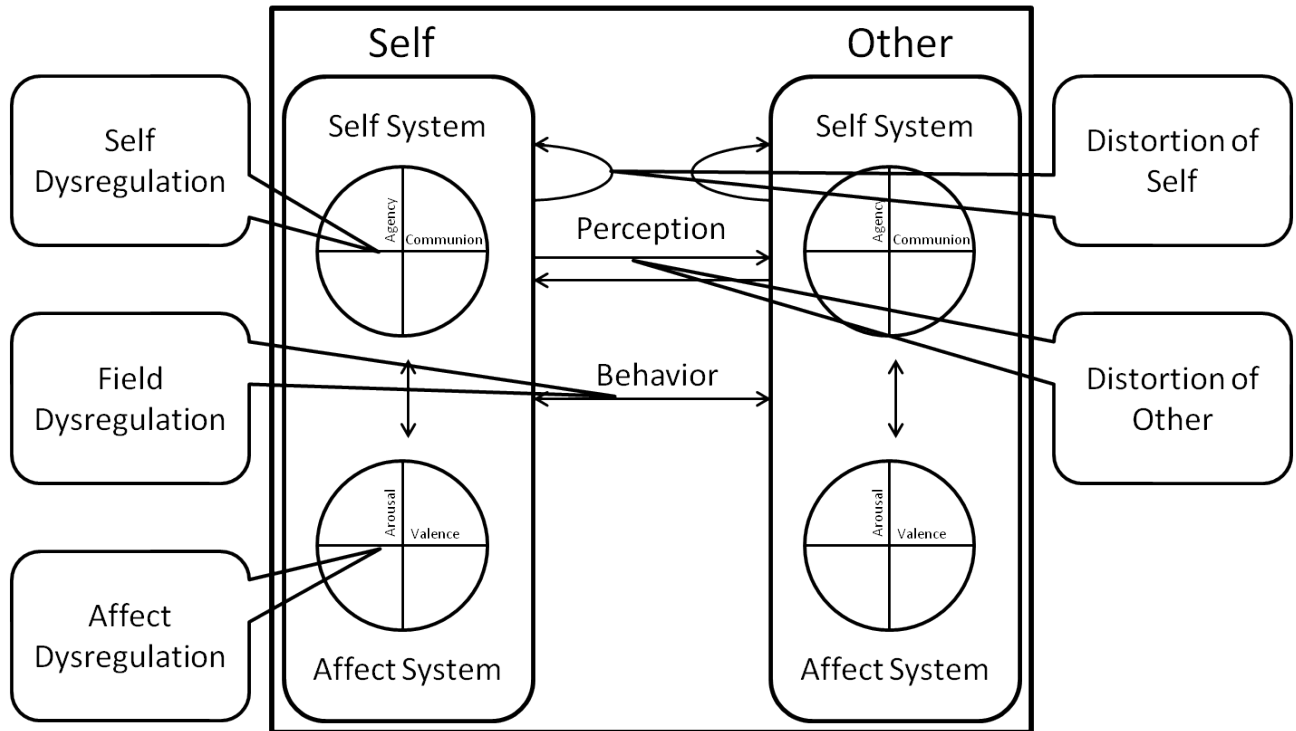
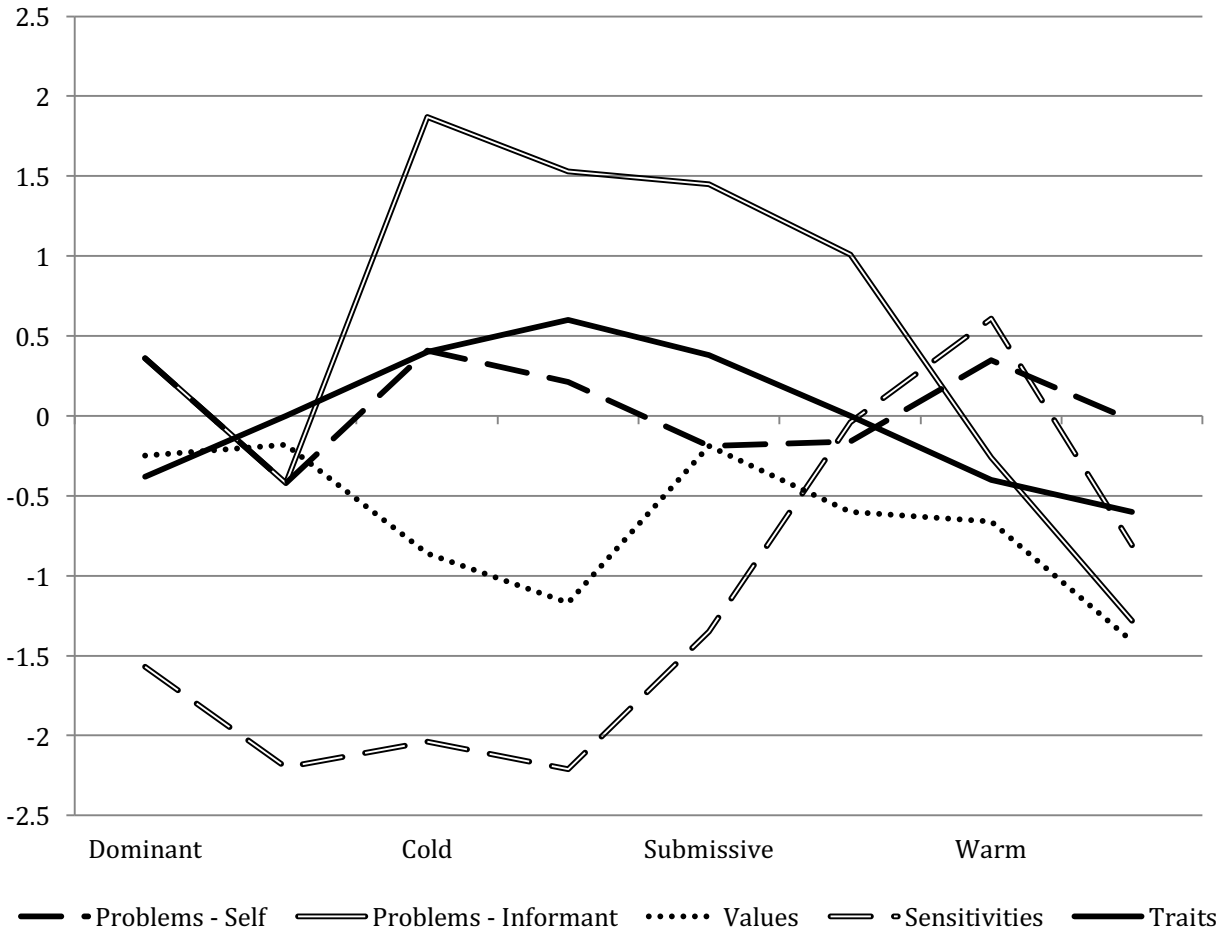
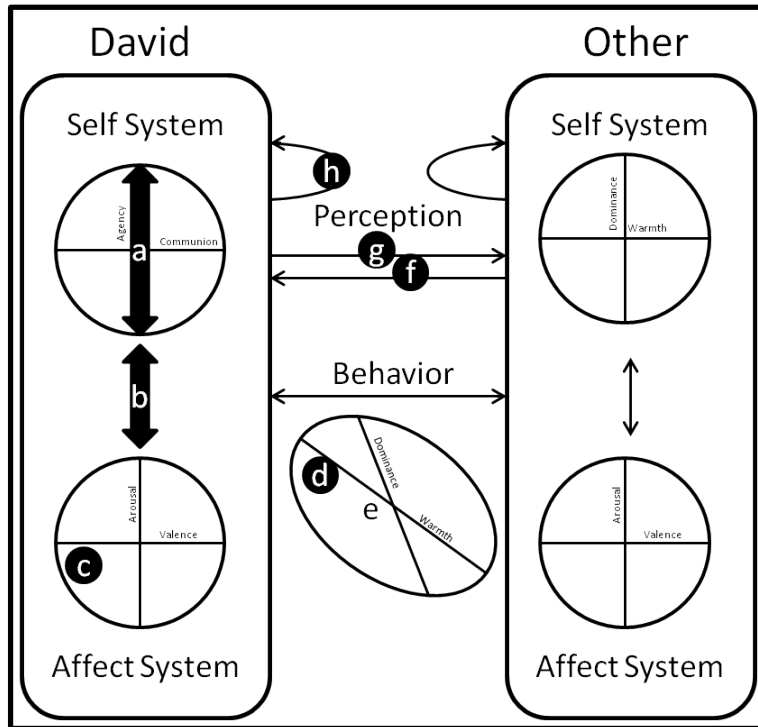


Figure 4. Interpersonal Assessment of David's Internal Dynamics.



Note. The X axis indicates variability around the 8 octants of the Interpersonal circumplex. Y axis indicates standard scores on IPC measures. In order to provide a common metric for comparing measurement surfaces, norms for all instruments are from college student samples, with the exception of the PAI, which was normed using a community sample. Trait estimates from the PAI are unlike other data in that the interpersonal profile is based on single scores for warmth and dominance, rather than eight octant scores (the other datapoints are inferred from these vectors).

Figure 5. Areas of Interpersonal Dysfunction implied by David's DSM-5 Section III Diagnosis.



Note. Bolded circles and arrows indicate particular areas of dysfunction, which include (in counterclockwise order starting at the top left): a) conflicts regarding agency and self-worth, b) a tight connection between his sense of self and his affects, c) predominantly negative, low arousal affects, d) cold, submissive behavior, e) conflation between warmth and dominance in self and others (as indicated by the oval shaped circle, as opposed to a black arrow or circle), f) others' misperception of him, g) misperception of others, and h) misperception of self.

Figure 6. Formulation of David's Core Maladaptive Pattern within Interpersonal Situations.

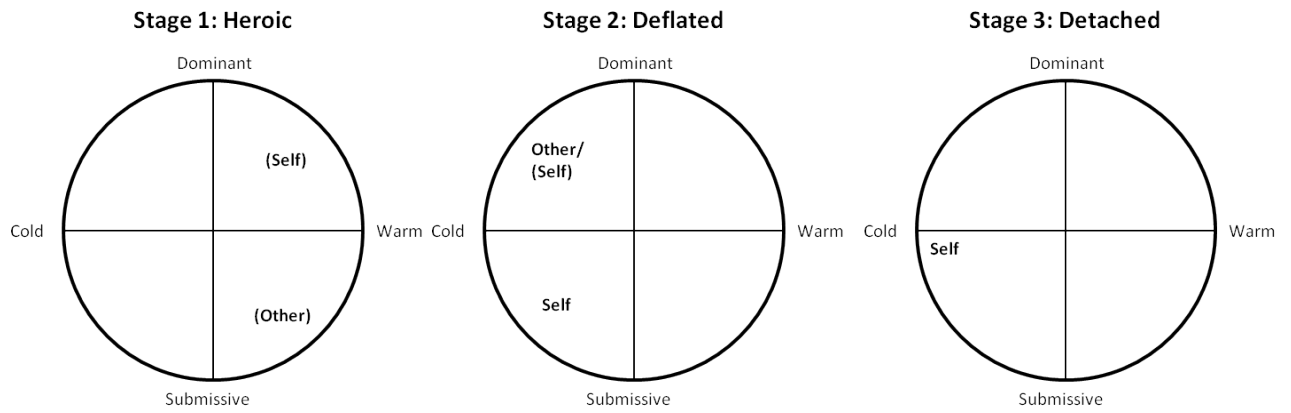


Figure 7. Connecting Treatment Strategies to Distortion and Dysregulation in David's Interpersonal Situations.

