THE INTERPERSONAL CORE OF PERSONALITY PATHOLOGY

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The purpose of this article is to demonstrate that personality pathology is, at its core, fundamentally interpersonal. The authors review the proposed *DSM-5* Section 3 redefinition of personality pathology involving self and interpersonal dysfunction, which they regard as a substantial improvement over the *DSM-IV* (and Section 2) definition. They note similarities between the proposed scheme and contemporary interpersonal theory and interpret the Section 3 definition using the underlying assumptions and evidence base of the interpersonal paradigm in clinical psychology. The authors describe how grounding the proposed Section 3 definition in interpersonal theory, and in particular a focus on the "interpersonal situation," adds to its theoretical texture, empirical support, and clinical utility. They provide a clinical example that demonstrates the ability of contemporary interpersonal theory to augment the definition of personality pathology. The authors conclude with directions for further research that could clarify the core of personality pathology, and how interpersonal theory can inform research aimed at enhancing the Section 3 proposal and ultimately justify its migration to Section 2.

Several authors have stressed the clinical value of assessing both (a) the general features that define *personality pathology* and distinguish people with and without personality disorder diagnoses and (b) the specific features that distinguish individuals with *personality disorders* (PDs) from one another (Bender, Morey, & Skodol, 2011; Bornstein, 1998, 2006, 2011; Hopwood, 2011; Hopwood et al., 2011; Kernberg, 1984; Livesley, 1998; Parker et al., 2004; Pincus, 2005, 2011; Pincus & Hopwood, 2012; Rutter, 1987; Trull, 2005; Wakefield, 2008; Widiger & Trull, 2007). Clinically, general features indicate the presence and severity of a PD, and the specific features indicate how the PD is likely to vary in its manifestation, contribute to dysfunction, and provide a basis for hypotheses about differential therapeutics.

The distinction between the presence of personality pathology and the style of PD is explicit but underdeveloped in the third and fourth editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association [APA], 1980, 1994). In that model, a general definition provides the rationale for the "Axis II" classification of personality pathology, whereas a series of categorical diagnoses characterize stylistic variants of PDs. However, according to a subset of the Personality and Personality Disorder Work Group, "the *DSM-IV* conceptualization of PD is largely uninformative on PD commonalities," is "difficult to operationalize effectively," and is "nonspecific regarding the nature of personality dysfunctions" (Morey et al., 2011, p. 347). Thus, "neither the *DSM-IV* general severity specifiers nor the Axis V GAF scale, which confounds symptoms and maladaptive functioning, have sufficient specificity for personality psychopathology to be useful as personality functioning measures" (Bender et al., 2011, p. 332; see also Skodol, 2012).

The Work Group therefore proposed a more specific and quantifiable definition of personality pathology involving dysfunction of the self (goal-directedness and identity) and in relation to others (empathy and intimacy). Although the Work Group's proposed definition of personality pathology offers a more coherent rationale for distinguishing personality pathology from mood, anxiety, neurodevelopmental, psychotic, and other kinds of disorders than that of the *DSM-IV*, the American Psychiatric Association's Board of Trustees voted to retain as unchanged the *DSM-IV* PD system in Section 2 of (recognized and official categorical mental disorders). The proposal will appear in Section 3 (Emerging Measures and Models). This creates an important impetus to critically evaluate the Section 3 proposal (henceforth "the proposal") in order to improve upon it and empirically justify its migration to the official section of future diagnostic manuals. We assert that one way to approach this involves connecting key aspects of the proposal to contemporary evidence-based theoretical models of interpersonal functioning. Doing so would provide a clinically useful model of pathological behavior that can be linked to intervention hypotheses, adjoined to basic and clinical research, and which provides a validated system of assessment tools.

In this article, we interpret the *DSM-5* proposal from the perspective of contemporary interpersonal theory (Benjamin, 1996, 2003; Benjamin & Karpiak, 2001; Horowitz, 2004; Horowitz et al., 2006; Pincus, 2005; Pincus & Ansell, 2012; Wiggins, 1991, 1996) in order to more fully develop the *DSM-5* proposal to defining personality pathology. We conclude that the proposed system is broadly consistent with the interpersonal approach in terms of its focus on mental representations of self and others in interpersonal situations. We thus reconceptualize the proposed *DSM-5* model in interpersonal terms and demonstrate how it can be augmented using interpersonal constructs and principles.

**THE PROPOSED *DSM-5* DEFINITION
OF PERSONALITY PATHOLOGY**

The *DSM-5* Personality and Personality Disorder Work Group set out, with
the limitations of the *DSM-IV* for defining general aspects of PDs in mind,
to develop a quantitative index of personality pathology (Bender et al.,
2011; Skodol, 2012). In order to articulate its core features, Morey and
colleagues (2011) analyzed specific items from personality functioning
measures (Livesley, 2006; Verheul et al., 2008) to identify those that reli-
ably discriminated among patients' levels of personality pathology as de-
fined by diagnostic status, the number of PD diagnoses met, and symp-
toms present. The content of the most discriminating items appeared to
involve identity confusion and lack of goal directedness as well as difficul-
ties developing and maintaining relationships.

Although Morey et al. (2011) focused on what these items had in com-
mon, their diversity of content as well as factor analyses suggested multi-
dimensionality. This is not surprising because the parent measures were
designed to have multiple dimensions. Furthermore, although single di-
mensions of personality pathology are clinically useful (Bornstein, 1998,
2006, 2011; Hopwood et al., 2011; Tyrer & Johnson, 1996), multiple un-
derlying dimensions of personality pathology have been theorized (Beck,
Freeman, Davis, & Associates, 2004; Kernberg, 1984; Livesley, 1998; Luy-
ten & Blatt, 2011; Pincus & Hopwood, 2012) and identified empirically
(Berghuis, Kamphuis, Verheul, Larstone, & Livesley, in press; Parker et
al., 2004). The features of personality pathology most often parse into two
broad factors, one reflecting self-concept, agentic behavior, and the ability
"to get ahead," and the other reflecting interpersonal relatedness, commu-
nal behavior, and the ability "to get along."

The *DSM-5* Personality and Personality Disorder Work Group accord-
ingly proposed to define personality pathology in terms of "self" and "inter-
personal" functioning (Skodol, 2012) and noted that "impairment in self
and interpersonal functioning has been recognized by reviewers of the
proposed *DSM-5* model to be consistent with multiple theories of PD"
(Bender et al., 2011, p. 341). Because the specific elements of these "sub-
strates of personality psychopathology" (APA, 2010) involve how individu-
als think about themselves and others and how they relate to others, the
proposal implies that the core features of personality pathology are *inter-
personal*. Somewhat more explicitly, the *DSM-5* website identifies "social
processes" (Sanislow et al., 2010) as the most relevant broad domain of
research for personality pathology.

Alignment of the *DSM-5* with integrative, clinically rich, evidence-based
models of personality dysfunction would arm clinicians with a much more
useful system for distinguishing patients with PD from those without than
was offered by the *DSM-IV* (Pincus, 2011; Zimmermann et al., 2010). Like-
wise, the potential to maximize the utility of the *DSM-5* proposal is less
likely to be fulfilled to the extent that specific links between the proposed
DSM-5 definition and contemporary evidence-based models of pathologi-

cal interpersonal functioning have not been thoroughly developed. In what follows, we draw upon a contemporary interpersonal theory of personality and psychopathology to further develop the clinical utility (e.g., Anchin & Pincus, 2010; Cain & Pincus, in press), evidentiary basis (e.g., Hopwood, Koonce, & Morey, 2009; Monsen, Hagtvet, Havik, & Eilersten, 2006; Wright et al., 2012), and theoretical coherence (e.g., Pincus, 2005; Pincus & Hopwood, 2012; Pincus, Lukowitsky, & Wright, 2010) of the *DSM-5* proposal for defining personality pathology.

AN INTERPERSONAL APPROACH TO DEFINING PERSONALITY PATHOLOGY

Fundamentally, personality pathology irritates and complicates day-to-day interpersonal situations and, over time, relationships. Although this impairment is pervasive and arises across situations and relationships, it is of central importance as it manifests clinically. For example, it is evident in the countertherapeutic behaviors of personality disordered patients (Anchin & Pincus, 2010; Maltsberger & Buie, 1974; Strauss et al., 2006), which contribute to the pessimistic attitudes of professional psychiatric staff (Bowers & Allan, 2006, p. 241) and in turn negatively impact the effective delivery of psychiatric treatments (Barber, Connolly, Crits-Cristoph, Gladis, & Siqueland, 2009; Barnicot et al., 2012; Hilsenroth, Holdwick, Castlebury, & Blais, 1998; Kuyken, Kurzer, DeRubeis, Beck, & Brown, 2001; Reich & Green, 1991; Safran & Muran, 1996; Saxon & Barkham, 2012; Shea et al., 1990).

Accordingly, the therapeutic relationship represents a central focus in most treatments designed for individuals with PDs (e.g., Anchin & Pincus, 2010; Beck et al., 2004; Benjamin, 1996, 2003; Cain & Pincus, in press; Clarkin, Yeomans, & Kernberg, 2006; Fonagy & Bateman, 2006; Linehan, 1993; Luborsky, 1984). Innovative treatment developers have even made accommodations that challenge theoretical dogma in order to address the interpersonal complications that come with treating individuals with PDs. For instance, although Linehan (1993) sought to develop a cognitive-behavioral treatment for borderline PD, and although such treatments historically have not emphasized the interpersonal nuances of treatment delivery, considerable efforts are made in Dialectical Behavior Therapy (DBT) to leverage the relationship with the therapist as a primary contingency in highly articulated behavioral plans:

> The patient is frequently like a dancer twirling out of control. The therapist has to move in quickly with a counterforce to stop the patient from moving off the dance floor. "Dancing" with the patient often requires the therapist to move quickly from strategy to strategy, alternating acceptance with change, control with letting go, confrontation with support, the carrot with the stick, a hard edge with softness, and so on in rapid succession. (Linehan, 1993, p. 203)

Although interpersonal dysfunction is recognized as central to personality pathology across distinct theoretical models, interpersonal theory is

unique in that it originated with the assumption that one should focus on interpersonal processes in order to understand pathological behavior (Leary, 1957; McLemore & Benjamin, 1979; Pincus & Wright, 2011; Sullivan, 1953). This assumption and the associated model of interpersonal structure and processes lead to concrete benefits for clinical conceptualization. For instance, interpersonal theory can augment Linehan's extensively validated approach to treatment by providing the DBT clinician with a coherent conceptual model for understanding when and how the patient "twirls out of control" (Pincus & Hopwood, 2012), specific recommendations for how the therapist should "counterforce" (Anchin & Pincus, 2010; Hopwood, 2010), and validated assessment tools for measuring interpersonal dispositions, dynamics, and outcomes (Locke, 2011). In the following sections, we describe the basic elements of contemporary interpersonal theory as they apply to the definition of personality pathology.

THE INTERPERSONAL SITUATION

It follows from Harry Stack Sullivan's (1953) definition of personality as "the relatively enduring pattern of recurrent interpersonal situations which characterize a human life" (pp. 110–111) that the "interpersonal situation" is the fundamental unit of analysis in interpersonal theory. Interpersonal situations are events involving a self and other and associated with an affective experience. It is important to clarify that from an interpersonal perspective the term *interpersonal* refers to what happens between actual people as well as to what happens between mental representations of self and others (Blatt, Auerbach, & Levy, 1997; Lukowitsky & Pincus, 2011; Pincus & Ansell, 2012; Sullivan, 1953). In either case, 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 needs are frustrated, it is unpleasant, prompting dysregulation and distress and a need to cope and adapt. These basic motivational concepts conceptually align with interpersonal (security) and self (self-esteem) functioning as described in the *DSM-5* proposal.

Sullivan (1953) proposed that patterns of interpersonal situations—called dynamisms—develop through age-appropriate social learning. Dynamisms vary in their adaptivity and health, with some characterized by satisfaction of motives for security and self-esteem and others associated with frustrated motives, which can manifest as distress, dysregulation, distortions, and, in severe cases, dissociation. These attributes reflect the specific aspects of dysfunction (Wakefield, 2008; Wright, 2011) that define personality pathology from an interpersonal perspective. Similar to the *DSM-5* proposal to partition self-dysfunction and interpersonal dysfunction, a basic assumption of interpersonal theory is that these elements can be most effectively organized by the metaconcepts Agency and Communion.

AGENCY AND COMMUNION

Wiggins (1991, 2003) extended Sullivan's model by integrating the concepts of security and self-esteem with the broader metaconcepts of agency and communion (Bakan, 1966). Agency refers to the condition of being a differentiated individual, as manifested in strivings for power and mastery that can enhance and protect one's differentiation. Communion refers to the condition of being part of a larger social entity, and is manifested in strivings for intimacy, union, and solidarity with the larger entity. The general similarity between agency and communion and the "Self" and "Interpersonal" concepts of the *DSM-5* definition of personality pathology provides a useful theoretical parallelism (Pincus, 2011).

In contemporary interpersonal theory, agency and communion undergird the structure that forms the basis of a clinically flexible and extensively validated model for organizing and assessing interpersonal functioning, the *Interpersonal Circumplex* (IPC; Fournier, Moskowitz, & Zuroff, 2011; Leary, 1957; Wiggins, 1996; Figure 1). At the level of behavior, agency and communion vary along dominance–submission and warmth–coldness, respectively. A unique feature of the IPC is that variance from the center of the circle outward and variance around perimeter of the circle are both informative. The distance of a behavior from the center of the circle indicates its extremity, or the intensity of an interpersonal behavior,
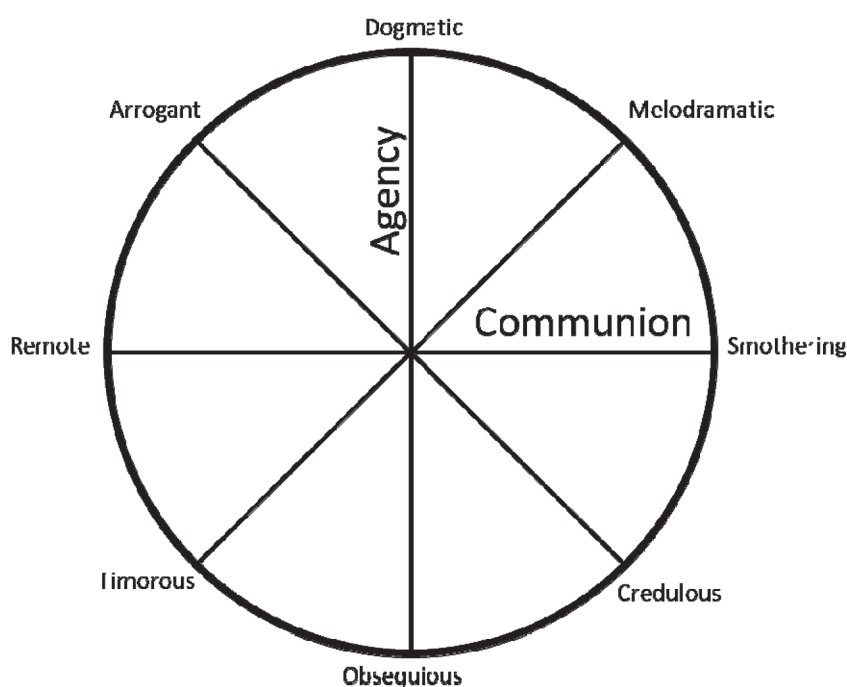

FIGURE 1. The Interpersonal Circumplex as an organizing structure for pathological interpersonal functioning.

motive, problem, or other feature. An extreme behavior is often pathological, as characterized by the kinds of behaviors arrayed around the circle in Figure 1. The placement of the behavior around the circle indicates its style, theme, or content. For instance, domineering persons may be dogmatic in their opinions whereas excessively warm persons may intrude on others' privacy. Thus, the IPC assesses both severity and style in a theoretically coordinated system (Gurtman, 1992): Individuals may vary in the extremity and adaptivity (as indicated by the distance from the center of the circle) of their behavior, and they may also vary in the kinds of behaviors they express (as indicated by the angular location in the circle).

Wiggins (1991, 2003) referred to agency and communion as propaedeutic metaconcepts because they can be found in dimensional taxonomies of human behavior throughout the social sciences. Within the study of personality functioning, they align with Freud's work and love (Erikson, 1950, p. 265), Bem's (1974) masculine and feminine, Five-Factor Model Extraversion and Agreeableness (McCrae & Costa, 1989), self and other concepts in attachment (Bartholomew & Horowitz, 1991), Blatt's model of self-definition and relatedness (Luyten & Blatt, 2011), and Beck and colleagues' (2004) autonomy and sociotropy model (Table 1). In this context, Sullivan's exposition of core motivations for security and self-esteem can be regarded as one expression of a more profound and universally identified truth about human nature (Bakan, 1966). It follows that to the extent that *DSM-5* "self" and "interpersonal" constructs also align with agency and communion, the move toward understanding personality functioning in terms of variation in these integrative dimensions carries with it signifi-

TABLE 1. Agency and Communion in Theoretical Models of Personality Functioning and Interpersonal Assessment

	Agency	**Communion**
Models of Personality Functioning		
DSM-5	Self Function vs. Dysfunction	Interpersonal Function vs. Dysfunction
Sullivan	Satisfied vs. Frustrated Self-Esteem	Satisfied vs. Frustrated Security
Freud	To Work vs. Not Work	To Love vs. Not Love
Blatt	Good vs. Poor Self-Definition	Good vs. Poor Relatedness
Beck	High vs. Low Autonomy	High vs. Low Sociotropy
Big Five	High vs. Low Extraversion	High vs. Low Agreeableness
Bem	High vs. Low Masculinity	High vs. Low Femininity
Attachment	Good vs. Bad Self	Good vs. Bad Other
IPC Measurement Surfaces		
Values/Goals/ Motives	Achievement vs. Deference	Connection vs. Independence
Traits/Behaviors	Dominant vs. Submissive	Warm vs. Cold
Problems	Controlling and Domineering vs. Passive and Nonassertive	Needy and Intrusive vs. Distant and Asocial
Strengths/Efficacies/ Capabilities	Ability to Lead vs. Ability to Follow	Ability to Love vs. Ability to be separate
Sensitivities	Sensitivity to Control vs. Sensitivity to Passivity	Sensitivity to Affection vs. Sensitivity to Indifference

cant potential for integrating psychiatric taxonomy with broader personality and social science research (Bender et al., 2011).

An implication of the metaconceptual status of agency and communion is that they could not logically be measured as a single set of manifest behavioral tendencies. Rather, they reflect a common structure for individual differences across a host of interpersonal constructs represented by distinct "IPC surfaces" (Table 1). Validated IPC instruments assess interpersonal surfaces, including values, goals, traits, behaviors, problems, efficacies, capabilities, strengths, impacts, and sensitivities (Locke, 2011). Certain configurations of these various IPC attributes can suggest the degree to which basic agentic and communal motives are satisfied (Pincus et al., in press). For instance, a person who reports valuing dominance a great deal, but who also reports feeling incapable and ineffective at enacting dominant behavior, is perhaps communicating impairment in satisfying his or her agentic motives. Such configurations may also indicate the nature of any dysregulation and distortion associated with frustrated motives, such as when a person with extreme trait warmth reports problems related to being too warm as well as strong sensitivities to others' remoteness. Notably, assessment methods have also been developed to assess dynamics in interpersonal functioning as they play out within (Sadler, Ethier, Gunn, Duong, & Woody, 2009; Thomas, Hopwood, Ethier, & Sadler, in review) and across (Moskowitz, 1994; Russell, Moskowitz, Zuroff, Sookman, & Paris, 2007) interactions over time. Thus, interpersonal theory provides a system for assessing interpersonal functioning across psychological domains and at different levels of temporal resolution (Pincus et al., in press). Overall, Table 1 highlights the flexibility, range, and integrative potential of the IPC for conceptualizing personality pathology.

We next describe the interpersonal dynamics that define personality pathology: dysregulation and parataxic distortion.

DYSREGULATION

The failure to achieve security and self-esteem in interpersonal situations causes dysregulation that, when chronic and extreme, reflects personality pathology. In contemporary interpersonal theory, it is assumed that dysregulation can occur in one of three psychological domains: self, affect, and the interpersonal field (Pincus, 2005; Pincus et al., 2010). *Self-regulation* involves the ability to effectively manage one's social cognition and self-concept, or how one thinks about oneself in interpersonal situations. *DSM-5* elements of self–dysfunction, such as difficulties differentiating self from others, incoherent sense of self, lack of goal-directedness, unstable self-esteem, and difficulties with self-reflection, all represent aspects of self-dysregulation. *Affect regulation* involves the ability to modulate one's inner emotional states and affective expression (Gratz & Roemer, 2004; Gratz, Rosenthal, Tull, Lejuez, & Gunderson, 2006), or how one feels in

interpersonal situations. Variability in the kinds of affects that can be dys-regulated can also be described by two-dimensional models with circum-plex properties (Posner, Russell, & Peterson, 2005). These models are or-ganized by arousal/positive affectivity and valence/negative affectivity dimensions. Characteristics listed in the proposed *DSM-5* criteria for self-functioning—such as difficulties experiencing a range of emotions and regulating those emotions when experienced—reflect affective dysregula-tion. *Field regulation* involves modulating the processes by which one re-lates to others in interpersonal transactions, or how one behaves and im-pacts others' behavior in interpersonal situations (Wiggins & Trobst, 1999). Evidence of field dysregulation would include proposed *DSM-5* in-terpersonal functioning criteria such as the difficulties developing feelings of intimacy and mutuality of regard for others. 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.

These constructs, when coupled with the logic of the IPC, provide an ef-fective means for distinguishing personality pathology from personality disorder that is missing in places in the *DSM-5* proposal. For instance, the proposed *DSM-5* criteria for intimacy primarily involve deficits in interper-sonally warm behaviors. From an interpersonal perspective, both warm and cold behaviors can be pathological, depending on one's capacity for affect and field regulation. It is the capacity to be either effectively warm or cold, as the situation indicates, that indicates health, not a preference for or tendency to exhibit one or the other. Indeed, being too warm can interfere with the development of intimacy when the extremity of warmth is experienced as needy, intrusive, or smothering by others.

PARATAXIC DISTORTIONS

Sullivan (1953) proposed the concept of "parataxic distortion" to describe the influence of internal subjective interpersonal situations on observable interpersonal behavior. He suggested that distortions occur "when, beside the interpersonal situation as defined within the awareness of the speak-er, there is a concomitant interpersonal situation quite different as to its principle integrating tendencies, of which the speaker is more or less com-pletely unaware" (p. 92). In other words, a parataxic distortion occurs when one's mental representation of an interpersonal situation does not match an objective interpretation of the situation. The effects of distor-tions on interpersonal relations can take several forms, including chronic distortions of new interpersonal experiences, generation of rigid, extreme, and/or chronically nonnormative interpersonal behavior, and the domi-nance of self-protective motives (Horowitz et al., 2006) leading to the dis-connection of interpersonal "input and output" (Pincus & Hopwood, 2012). The kinds of distortions common in personality pathology often lead to increasing distress in self and/or others. Often the distortion involves a

feared outcome (e.g., abandonment, criticism) that leaves the individual feeling threatened, distressed, and needing to protect the self via defensive behavior. Thus, the distortion contributes to self (e.g., need to protect), affect (e.g., fear), and interpersonal field (e.g., defensive behavior) dysregulation. 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, which points to a clear target for intervention.

Healthy personality functioning can be defined in part by the capacity to organize and elaborate the data of interpersonal situations without distortions. Accurate social cognition promotes the mutual satisfaction of agentic and communal needs for both self and others. This is hypothesized to be most likely to occur when the individual's mental representation of the interpersonal situation aligns with a more objective assessment of the interaction. In contrast, when individuals have chronically distorted representations of self and others, failures to satisfy their basic psychological needs are common. Such individuals tend to bring these representations into new interpersonal situations (Beck et al., 2004; Benjamin, 1993; Caligor & Clarkin, 2010; Pincus & Hopwood, 2012), disturbing their ability to interact successfully with others.

THE STRUCTURE OF INTERPERSONAL SITUATIONS

The interpersonal concepts agency and communion, regulation, and distortion comprise the basic elements that structure interpersonal situations, as depicted in Figure 2. The self includes both the self and affect systems. 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, 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 in Figure 2. 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 (self and affect systems) and others, who are perceived in terms of their agentic and communal behaviors and impacts. The specific "input and output" within the field is indicated by the bidirectional arrows between self and other in Figure 2, but in a sense the contours of the interpersonal field are captured by the entirety of the interpersonal situation as indicated by the box outlining Figure 2. Perceptual processes moderate the
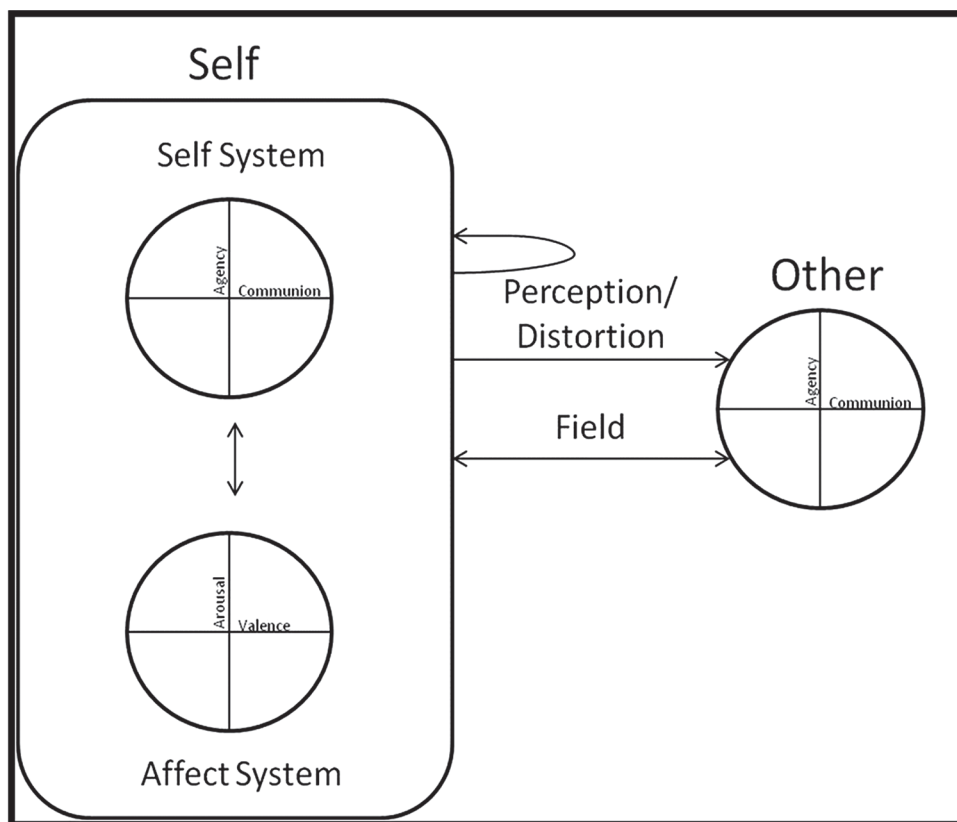
FIGURE 2. The Structure of Interpersonal Situations.

functioning of the self, affective, and field regulatory systems. Distortions are like dysregulation in that the form they take will tend to be systematically colored by past experiences and regulatory motives. The nature of distortions is thus predictable by the nature of self, affect, and field dysregulation. That is, dysregulation and distortion generally present as coordinated indicators of personality pathology.

Broadly speaking, behavioral transactions occur as a sequence of inputs from others in the interpersonal field in terms of agentic and communal behavior, colored by perception, which are mediated by internal processes related to goal satisfaction and affective regulation, leading to interpersonal output that may or may not be adaptive. In specific interpersonal situations, interpersonal motives lead to the pursuit of proximal goals via particular patterns of agentic and communal cognition and behavior. This interpersonal behavior occurs within a field cocreated with another person, who may be physically proximal or mentally construed. The other's patterns of response vary in the degree to which they satisfy interpersonal motives, and this variance contributes to different affective experiences. When motives are satisfied, affects are generally positive and

well regulated, whereas when they are not, affects are generally negative and dysregulated.

Dysregulated or negative affects in interpersonal situations signal a disruption in the overall system, potentially leading to a number of consequences. Such affects can be regulated via the interpersonal field, such as when people feel better by being kind and helping others whom they know to be distressed, or similarly when someone who is distressed turns to another for succor and support. Affective disruption can also be regulated via the self, either through mature adaptation and learning or, conversely, through pathological misperception and misattribution. Individuals with adaptive personalities are mostly able to regulate themselves and achieve their proximal agentic and communal goals, regulate their affects during times when their motives are frustrated, regulate their interactions with others, and perceive themselves and others more or less accurately. In contrast, individuals with personality pathology have a disturbed behavioral repertoire. Their behavior is not normatively contingent or adaptive because it is extreme, inflexible, oscillating, or based on misperceptions. Due to disordered social learning and pathological temperament, they tend to distort interpersonal input, often feel threatened or insecure in interpersonal situations, and commonly enact self-protective defensive behaviors. Because their basic motives for agency and communion are routinely unmet, they experience vulnerable and unstable self-states and negative affects, and engage in maladaptive interpersonal behavior. As personality pathology increases, pathological interpersonal signatures develop as compromises between actual social contingencies and the desire to satisfy internal motives (Cain & Pincus, in press), and these signatures characterize the distinct expressions of PD (Pincus & Hopwood, 2012; Sullivan, 1953).

INTERPERSONAL DYNAMISMS

Interpersonal theory's focus on the interpersonal situation distinguishes it from other personality models in two specific ways that are useful for depicting personality pathology. First, interpersonal situations occur between people, even if the people are confined to one person's mental representations or are different aspects of the same person. Second, interpersonal situations exist in dynamic "recurrent patterns" (Sullivan, 1953, p. 111). That is, from an interpersonal perspective, *personality functioning is not what someone is, it is what someone does.* It is in these interactions—what people do with others—that personality pathology is most poignantly expressed.

Interpersonal *complementarity* (Carson, 1969; Kiesler, 1983) is the most basic dynamic pattern in interpersonal theory. Complementarity occurs when there is a match between the interpersonal motives of each person and reflects the baseline pattern for proximal interactions. Carson (1969) first proposed that complementarity could be defined based on the social

exchange of status (agency) and love (communion) as reflected in reciprocity for the vertical dimension of the IPC (i.e., dominance pulls for submission; submission pulls for dominance) and correspondence for the horizontal dimension (friendliness pulls for friendliness; remoteness pulls for remoteness) (see also Kiesler, 1983). For example, submissive interpersonal behavior (e.g., "Can you help me") communicates a bid for support (e.g., "I am unable to help myself") that impacts the other in ways that elicit either complementary (e.g., "Yes, I can do that for you") or noncomplementary (e.g., "You should try to do it yourself") responses. Although complementarity is neither the only reciprocal interpersonal pattern that can be described by the IPC nor proposed as a universal law of interaction, empirical studies consistently find support for it probabilistically (e.g., Sadler et al., 2009; Sadler, Ethier, & Woody, 2011).

Establishing this normative baseline is critical for interpersonal diagnosis, because deviations from complementarity signal maladaptive interpersonal functioning and potential personality pathology (Ansell, Kurtz, & Markey, 2008; Cain & Pincus, in press; Fournier, Moskowitz, & Zuroff, 2009; Pincus, 2005; Pincus, Lukowitsky, Wright, & Eichler, 2009; Roche, Pincus, Conroy, Hyde, & Ram, in press). Any form of dysregulation or parataxic distortion would tend to contribute to noncomplementary behavior (Kiesler, 1991; Safran, 1992). For instance, a narcissistic individual might exhibit extremely arrogant (dominant) behavior rooted in the motive to self-enhance and reinforce the self-concept. However, this strategy could backfire when others stand up to the person (i.e., exhibit noncomplementary dominance). If the other person "wins" this power struggle (field dysregulation), then the narcissistic individual may experience shame (affect dysregulation) and a diminished self-concept (self-dysregulation) (Kealy & Rasmussen, 2011; Roche, Pincus, Lukowitsky, Ménard, & Conroy, in press). Patterns (i.e., interpersonal dynamisms) that are chronic and pervasive will be associated with significant self and interpersonal dysregulation to the degree that the individual can be diagnosed with personality pathology.

SUMMARY

We have outlined the fundamental assumptions and constructs of contemporary interpersonal theory as they apply to the definition of personality pathology. In so doing, we suggest that two interrelated points can inform research aimed at enhancing the *DSM-5* proposal and ultimately justifying its migration to *DSM-5,* Section 2. First, there is considerable congruence between the assumptions and constructs of contemporary interpersonal theory and those of the *DSM-5* proposal for personality pathology. Second, understanding personality pathology from an interpersonal perspective, and particularly in terms of the structure and dynamics of the interpersonal situation, has the potential to significantly enhance the clinical utility of the *DSM-5* proposal. The following clinical example is in-

tended to demonstrate the value of focusing on the interpersonal situation for understanding personality pathology.

A CLINICAL EXAMPLE

Consider a patient who typically pays before every session based on a contractual agreement with his therapist, but who fails to pay before one particular session. When the therapist brings up the neglected payment, the patient becomes angry and accusatory. How is the clinician to understand this reaction? Clinically, this is a delicate moment because the clinician's surprise may increase the risk for countertherapeutic behavior, such as an aggressive response (maladaptive cold dominance) or breaking the contractual agreement to be paid before each session in order to avoid the anxiety of the moment (maladaptive warm submission). On the other hand, this is also an opportunity to understand the patient more deeply and accurately. Assuming the clinician was sensitive in broaching the subject, the patient's reaction might indicate underlying personality pathology. If the situation could be overcome, it could be used to further interpersonal learning and adjustment. From an interpersonal perspective, the best chance the clinician has for a positive outcome is to focus on the dynamics of the interpersonal situation.

Figure 3 depicts a potential pathway for the cascade of interpersonal events that might occur during this situation. The therapist has the best
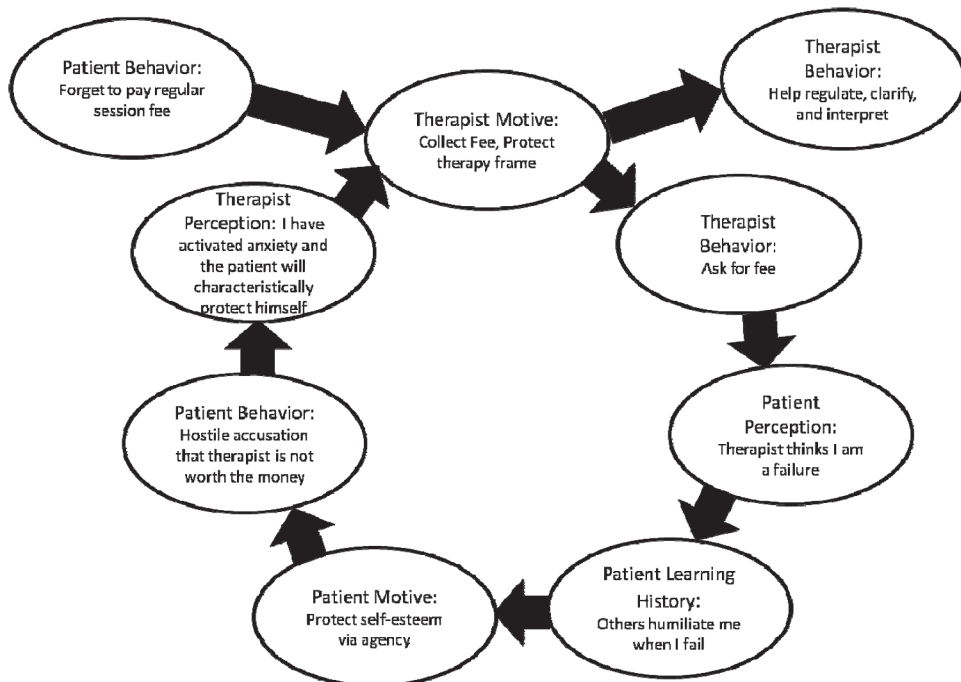

FIGURE 3. Maladaptive Transaction Cycle in Psychotherapy.

chance of protecting the contractual frame, receiving payment for her services, maintaining rapport, and avoiding shaming the patient if she can ask for the fee in a way that demonstrates warmth but also competence and control (adaptive warm dominance). However, given the patient's shame about not having paid, coupled with his history of learning that failure and incompetence were something to be ashamed about, and that one could get humiliated for, he implicitly connected the therapist's request for payment to his distorted internal model for understanding these kinds of interpersonal situations. He perceives the therapist as implying that he has failed—that he *is* a failure—and becomes anxious.

Note that in some respects the patient's objectivity is less relevant than the phenomenology of his experience, given *the functional equivalence of real and perceived humiliation* for his behavior in the current interpersonal situation. The therapist sees herself as warm-dominant and implicitly expects a warm-submissive response such as "Yes, sorry, I forgot to pay it and didn't bring my checkbook. Can I send you a check this afternoon?" In contrast, the patient finds himself in an inferior, cold-submissive position vis-à-vis an accusatory, cold-dominant therapist. The patient's anxiety may provoke a self-protective motive that overwhelms his capacity for reflection and regulation. He has learned that the most reliable way to avoid humiliation is to attack first. Because asserting cold-dominance raises the possibility of losing a power struggle, and thus furthering humiliation, he is ambivalent, and this further heightens his anxiety and dysregulation. He barks, "What have you done to earn that fee? I figured I'd take a break from paying you until I start to see some results."

The patient's response seems to come from nowhere and would be of the sort that would make nearly anyone anxious in a typical social interaction. The patient's comment might naturally provoke cold-submissive anxiety, cold-dominant anger, or warm-submissive capitulation, depending on the therapist's own characteristic interpersonal style. The therapist's task is to overcome any personal dispositions in order to mentalize the situation and choose the most therapeutic response (Anchin & Pincus, 2010; Cain & Pincus, in press; Hopwood, 2010). Ideally, the therapist's original motive to protect the therapy frame would hold, because accepting the patient's bid to engage in a pathological contest of wills could violate the parameters of the therapeutic situation and ultimately be countertherapeutic. However, the clinician's understanding of how to achieve the motive is now deeper, because there is a realization that this exchange has sensitized the patient's core personality pathology.

The therapist might try to help the patient regulate by slowing down her rate of speech and empathizing with his feelings of humiliation and anxiety. The goal would be to "cool down" the interpersonal situation to enable a discussion of the similarity of this pattern with other patterns from the patient's past or current relationships or their own relationship, and to gently challenge the patient to see and respond to the therapist's comment

as it was genuinely intended. That is, the warm-dominant therapist would try to move the patient from his anticomplementary cold-dominant response to the complementary, and healthy, warm-submissive response, in a manner that is effectively paced (see also Benjamin, 1996, 2003) so as to avoid further threatening his self-esteem. If successful, this series of events, which could have led to a rupture in the alliance, would end up being a valuable opportunity for interpersonal learning and alliance building.

Moreover, this event would tell the therapist that this dynamic is something to look out for in future interpersonal situations with this patient. This is the kind of situation that may go badly, even if the therapist handles it skillfully, and therefore it may need to be repaired or addressed at a later time. This valuable assessment information about the kinds of interpersonal situations in which the patient has difficulties, as well as the extent of the pathology, comes directly from participant observation of the interpersonal situation (Cain & Pincus, in press; Caligor, Kernberg, & Clarkin, 2007; Hopwood, 2010; Pincus & Cain, 2008). Making use of the data that emerge from the therapeutic relationship would prepare the therapist for future interactions like this via a more textured interpersonal formulation. Specifically, it could tell her the conditions under which the patient's personality pathology is most likely to be provoked, the pattern the pathology (i.e., distortion and dysregulation) will tend to take, the response the therapist will initially feel like taking but that may be countertherapeutic, and a more optimal therapeutic response.

A core assumption of interpersonal theory is that personality plays out in interpersonal situations like this one, whose features recur across interactions. Personality dynamics related to maladaptive interpersonal patterns can be identified via IPC assessments (Pincus et al., in press). The overall pattern of IPC assessment data, coupled with the experience of interacting with this patient, can be used to develop a hypothesized formulation of the pathological pattern. Such a formulation is shown in Figure 4. The initial stages of this process are depicted in the first horizontal panel of interpersonal situations. First, the therapist (other) and patient (self) are warm to one another based on both the standard expectations of a professional relationship and the alliance they have developed over time. This is the baseline position in the interaction described previously, that is, the orientation immediately before the therapist asks the patient for the fee. In so doing, the therapist takes a dominant role, which the patient misperceives as domineering and threatening to his self-esteem. This distortion leads the patient to become anxious, because it has triggered past interpersonal situations in which he felt humiliated and ashamed. This moment is captured by the second stage in the first panel of Figure 4. In the third stage, he reacts to his perception of the therapist's cold-dominance rather than her objectively warm-dominant behavior.

The second and third panels depict potential countertherapeutic and therapeutic responses, respectively. In the second panel, the therapist
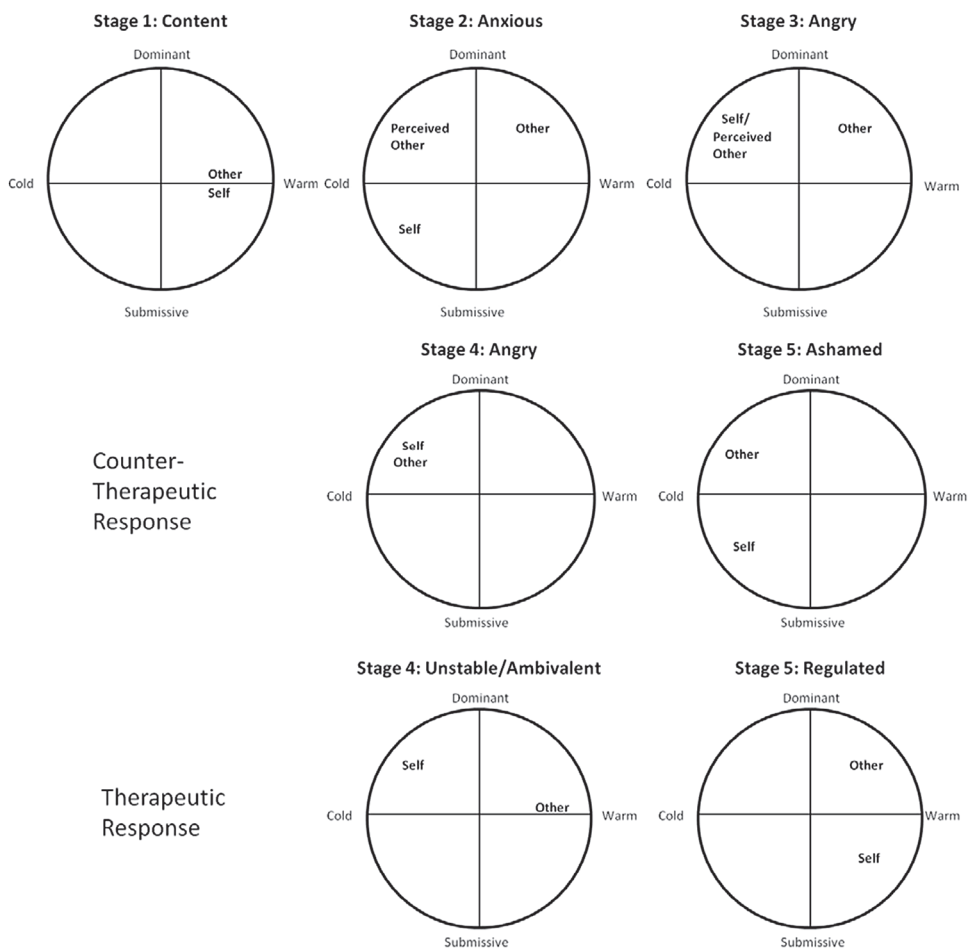
FIGURE 4. A Pathological Interpersonal Signature as States of Interpersonal Situations: Therapeutic and Countertherapeutic Responses.

may respond to the patient's accusation defensively. This would likely be the most typical response in other settings, such as if the patient had not paid his dry-cleaner or barista. The therapist may say, "Look, I am just doing my job. We agreed to this arrangement when we first met, so I expect you to pay and to not make a big deal out of it." In Stage 4, her dominance provokes a power struggle. Such power struggles can resolve in a number of different ways. This patient has learned that such struggles typically end in the other "winning" the struggle and the patient feeling ashamed. Indeed, this internal working model of the endgame of this interpersonal situation, particularly when coupled with the therapist's hierarchical status and motives to control the situation, may be a likely outcome in this particular interaction, as indicated by Stage 5 in the second panel.

   Conversely, the therapist may recognize that she has activated the pa-

tient's personality pathology and try to help him regulate so that they can make clinical use of the encounter. She may say, "You sound really angry. Is it something about the way I asked about the fee?" Her warm and non-defensive stance in Stage 4 of Panel 3 might encourage him to talk with her about his response, and perhaps during that process come to appreciate and own his distortion of her question, her actual intentions, and the role of his distortion in his dysregulation. With improved affect regulation, in Stage 5 he would be more likely to tolerate her assertion that regardless of his feelings about the interaction, he would need to pay for the session. That is, she would be able to assert dominance in a way that he could tolerate, in which case interpersonal learning would have occurred rather than the familiar experience of a humiliating loss of self-esteem.

The cascade of interpersonal situations described in Figures 3 and 4 represents a snippet of the kinds of situations that recur continuously in human experience and, together, constitute personality from an interpersonal perspective. It is in this cascade—due to frustrated motives, parataxic distortions, and dysregulation—that people come to make themselves and others feel anxious. Deviations from complementarity and negative emotions are moment-to-moment indicators that something about the interpersonal situation is awry. When this happens sufficiently often or intensely, it becomes clinically problematic enough to merit the diagnosis of personality pathology. That is, all individuals with personality pathology share the tendency to have maladaptive interpersonal signatures characterized by dysregulation and distortion that are rooted in social learning and generalize across various interactions.

The specific pattern of the cascade is diagnostic of the PD *species* (Pincus, 2011), which distinguishes individuals with different kinds of PD from each other. In this case, the patient's initial approach to payment suggests passive-aggression, his attribution of hostility on the part of the therapist suggests paranoia, and his quickly backing off from a power struggle suggests dependency or avoidance. That such patterns of distortion and dysregulation exist, that they tend to provoke maladaptive reactions and distress in self and others, and that they chronically recur, however, is a core definitional matter of the personality pathology *genus* (Pincus, 2011).

A RESEARCH AGENDA

The decision by the Board of Trustees of the American Psychiatric Association to retain the widely unpopular and empirically flawed *DSM-IV* model of personality disorders in Section 2 of the *DSM-5*, while placing the Personality and Personality Pathology Work Group proposal in Section 3, underscores the need for further research on the definition, description, and measurement of personality pathology. One of the most important innovations in the Work Group proposal is the recognition that personality is complex and must be broken down into clinically useful parts. Unlike

the *DSM-IV* model and *DSM-5,* Section 2, in which severity and style are conflated in diagnostic criteria, Section 3 has independent ratings of the defining aspects of personality pathology severity and the descriptive aspects of personality disorder style. This provides a rubric for clinicians to rate the severity of personality pathology separately from the stylistic expression of that pathology using evidence-based and clinically rich assessment models. This distinction is clinically useful in that it maps onto different kinds of clinical decisions, such as the level (e.g., inpatient vs. outpatient) versus type (e.g., insight-oriented vs. behavioral) of indicated treatment. A model with this level of clinical utility would stand in stark contrast to the Section 2 model, which has led to only a couple of evidence-based treatments for one of the 10 official disorders (borderline) since it was established in the *DSM-III* more than 30 years ago. Clearly, more research evaluating the clinical benefits of distinguishing PD severity and style is needed.

At a broader level, this division also maps onto a more fundamental diagnostic distinction between personality mechanisms (e.g., dysregulation and distortion) and individual difference structures (e.g., agency and communion). Structural models provide a map of the variables that are important for conceptualizing pathological behavior but do not describe the nature of that behavior; mechanistic variables that describe the nature of pathological behavior only become tangible with reference to the kinds of behaviors that are dysfunctional. Any system that focuses only on one set of these factors is necessarily limited. Thus, one possible positive outcome from the inclusion of the Work Group's proposal in *DSM-5*, Section 3, would be for psychopathology researchers to orient to this critical distinction and to thereby promote more clinically useful research.

The focus of this article has been on the potential for interpersonal theory to inform such research, particularly with respect to the definitional aspects of personality pathology. We have highlighted areas of congruence between the *DSM-5* Section 3 definition and the constructs and principles of contemporary interpersonal theory. Both models focus on a similar domain of behavior, which is organized around self (agentic) and interpersonal (communal) functioning. Furthermore, as shown in Table 2, the specific capacities asserted as defining personality pathology in the *DSM-5* Section 3 can also be understood as manifestations of parataxic distortion and interpersonal dysregulation. This congruence should be exploited in *DSM-5* era personality research.

Specifically, although future research on personality pathology would benefit from using the *DSM-5* Section 3 as a broad framework, clinically useful innovations will be most likely if research focuses on aspects of self and interpersonal dysfunction that occur in interpersonal situations. What is the person trying to do in terms of underlying motives for self-esteem and security? How is the person's behavior contextualized by the social environment and its dynamic influences? What is the interplay between the self, affects, and the interpersonal field? Many of the traditional

TABLE 2. *DSM-5* Section 3 Criteria for Personality Pathology as Interpersonal Dysregulation and Distortion

Interpersonal Dysfunction	*DSM-5* Section 3 Personality Functioning Criterion
Parataxic Distortion	*Self-Identity:* Accuracy of self-appraisal and self-esteem
	Self-Direction: Ability to productively self-reflect
	Interpersonal-Empathy: Comprehension of others' experiences
	Interpersonal-Empathy: Understanding social causality
	Interpersonal-Empathy: Comprehension of others' motivations
Self Dysregulation	*Self-Identity:* Experience of oneself as unique, with boundaries between self and others
	Self-Identity: Coherent sense of time and personal history
	Self-Identity: Stability of self-appraisal and self-esteem
	Self-Direction: Pursuit of coherent and meaningful short-term and life goals
Field Dysregulation	*Self-Direction:* Utilization of constructive and prosocial internal standards of behavior
	Interpersonal-Empathy: Understanding social causality
	Interpersonal-Empathy: Tolerance of others' different perspectives
	Interpersonal-Intimacy: Desire and capacity for closeness
	Interpersonal-Intimacy: Deep and durable connections with others
Affect Dysregulation	*Self-Identity:* Capacity for a range of emotional experience and its regulation
	Self-Identity: Capacity to regulate emotional experience

methods in personality disorder research (e.g., cross-sectional question-naire studies; comparative studies of diagnostic groups) are poorly suited to answer these kinds of questions. Fortunately, increasingly popular methodologies, such as experience-sampling, intensive repeated measures, and multimethod assessment designs hold considerable promise for developing insights about pathological personality mechanisms. These methods move beyond debates of the past, such as the validity of dimensional versus categorical models or the value of keeping or discarding certain disorder types, and offer the promise of developing clinically rich, experience-near, and empirically valid models of what people with personality pathology do in relationships with others. Our hope is that the *DSM-5* Section 3 orients the field to developing such models. We assert that contemporary interpersonal theory provides the focus, constructs, and tools with which to do so most effectively.

CONCLUSION

We have argued that the interpersonal situation is the psychological topography upon which the core features that define personality pathology play themselves out in daily life and in clinical interactions. Although many models attempt to cover this terrain, including the theoretical models that informed the *DSM-5* proposal, we have argued that contemporary interpersonal theory provides the best available map of this landscape. The parameters of interpersonal situations as described in this article reflect nomothetic dimensions that have been extensively validated by interpersonal research, but the focus of interpersonal theory with regard to defining personality is on interpersonal dynamisms as they occur in inter-

actions with others. This lens facilitates a bridge between diagnostic constructs and what occurs in the consulting room. Specifically, understanding personality pathology as fundamentally involving distortion of and dysregulation in both proximal and internal interpersonal situations provides a clinically useful and theoretically coherent means for demarcating personality pathology from disorders of mood, neurodevelopment, cognition, or impulse control. Interpersonal assessment provides a range of validated methods for assessing the core interpersonal characteristics of personality pathology as well as organizing assessment data from other methods (Hopwood, 2010; Locke, 2011; Pincus, 2010; Pincus et al., in press).

The promise of the *DSM-5* proposal for redefining personality pathology is therefore most likely to be realized to the degree that it is augmented with the evidence-based approaches to assessment and treatment found in contemporary interpersonal theory. The interpersonal paradigm in clinical psychology encompasses four generations of clinical scientists and practitioners, and includes a focus on theory, research, and treatment of personality pathology that spans 60 years. The *DSM-5* proposal moves the conceptualization of personality pathology more closely in line with this corpus of work. Further synthesis of the comprehensive scope of interpersonal dispositions, dynamics, distortion, and dysregulation found in contemporary interpersonal theory would provide an empirically valid and clinically useful basis for justifying the migration of a revised *DSM-5* proposal to Section 2 and replacing the untenable *DSM-IV* model.

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