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Pincus and Hopwood have provided a definitive summary of interpersonal theory, including a comprehensive understanding of the broad areas of clinical practice—psychopathology, assessment, and intervention. These domains of clinical practice are often taught as separate courses and procedures for patient contacts (e.g., first assessment, then interventions), but this text provides a meaningful integration under a single theoretical approach. While transdiagnostic models and common factor approaches have challenged these traditional boundaries, Pincus and Hopwood explain how this unified interpersonal approach can also be sophisticated and adaptable for multiple situations.

—**Timothy Anderson, PhD**, Professor of Psychology, Ohio University, Athens

This book is a well-written, comprehensive, and engaging overview of contemporary integrative interpersonal theory (CIIT) that will broadly appeal to clinicians, academics, and students. Drs. Pincus and Hopwood, experts in interpersonal theory and research, succinctly summarize over 70 years of theory and research and provide a step-by-step primer for how to integrate CIIT seamlessly into clinical practice. In fact, their excellent clinical examples, including four cases followed in-depth throughout the book, truly bring the material to life for the reader. I have no doubt that it will become the go-to book for anyone interested in learning more about CIIT.

—**Nicole M. Cain, PhD**, Associate Professor, Clinical Psychology, Rutgers University, New Brunswick, NJ

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The field of clinical assessment and intervention has undergone drastic changes in the last few decades, as clinicians and scholars alike have recognized the substantial limitations of categorical diagnostic models when describing and treating mental health disorders. Clinical formulations that rely wholly on psychiatric symptoms and generalized distress typically fail to capture the complex ways that mental health challenges impact individuals in their efforts to build and maintain lives of meaning, connection, and value. Contemporary integrative interpersonal theory (CIIT) represents a synthesis of clinical, theoretical, and empirical work from the past century aimed at challenging reductionistic models of mental health, offering new transdiagnostic frameworks that carry greater utility and more direct salience and value to both practitioners and patients. This book provides a comprehensive overview of the historical roots and central tenets of CIIT and offers immediate practical value to readers through the inclusion of evocative clinical case examples, guidelines for applying CIIT concepts in both clinical assessment and intervention, and free assessment and training resources for readers looking to incorporate CIIT into their work. This book offers readers an opportunity to not only expand their fundamental formulations of psychopathology and personality as abstract concepts, but also deepen their understanding of the real and heartfelt complexities of navigating relationships across both joyful and challenging moments in everyday life.

—**Katie C. Lewis, PhD**, Director of Research, the Austen Riggs Center, Stockbridge, MA

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# 1 INTRODUCTION TO THE INTERPERSONAL PERSPECTIVE

Imagine an important moment in your life. Any moment will do; just go with the first one that comes to mind. What matters is that it was important to you. What was the situation? What were you doing, thinking, and feeling? What did you want, and what did you see? If there were other people around, what were they doing, and what do you think they wanted, were thinking, and were feeling? Thinking back on it now, were you and others perceiving the situation similarly and/or accurately at the time? Why was the moment important to you?

We have asked thousands of students and workshop attendees this question over the years and have received a wide variety of answers. Some are positive, such as a graduation or a marriage. Others are negative, such as the loss of a close loved one or a personal trauma. Some are intense, like a near accident, whereas others are calm, like a relaxing moment on vacation. Some are focused on self-achievement, such as a promotion. Others are focused on relationships with others, such as making love for the first time.

What they all have in common is that they are *interpersonal*. Some explicitly refer to interactions with other people, usually important moments with loved

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<https://doi.org/10.1037/0000467-001>

*The Interpersonal Situation: Contemporary Integrative Interpersonal Theory, Assessment, and Psychotherapy*, by A. L. Pincus and C. J. Hopwood

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ones. Winning a championship with your team or being with your partner as she gives birth to your child are common examples. Others refer to interactions between different aspects of oneself, such as feeling proud or ashamed of oneself. In both cases, there is a self and an other. Whether the other is a single person, a group of people, an imagined or remembered person, or an aspect of yourself, it is the feelings, desires, and thoughts that are shared between the self and the other that make the moment important and memorable. Marriages are important because they express love between two people. Divorces are important because they express the loss of love. Personal accomplishments are memorable because a person feels proud of themselves, and failures are memorable because a person feels shame, a self-conscious emotion. All of these examples are interpersonal situations because they reflect how a self interacts with an other.

Variations on this question include “Imagine what you will be thinking about during the last moment of your life” and “What is the last dream you remember?” People respond with a range of situations, feelings, and outcomes, but every answer is interpersonal, meaning that it involves a self and an other. Why is every answer to these kinds of questions interpersonal? We believe it is because humans evolved as a social species. We rely on our attachment relationships to grow, and we rely on one another to create societies. In fact, we find our deepest meaning in relationships with others and with ourselves. Interpersonal patterns are the scripts for how we organize our experiences and how we tell our life stories. We understand ourselves through our relationships with others, and we understand others through our relationships with ourselves. When we need help, we turn to others, and when others turn to us—that is, those of us in the mental health community—for help, we try our best to help them. Just like our important memories, dreams, and final thoughts, mental health care is a fundamentally interpersonal endeavor (Cain et al., 2024).

As we will describe in significant detail later, the model we use to account for what happens in interpersonal situations comprises what a self and an other want, feel, and do, and how they perceive and understand themselves and one another. From an interpersonal perspective, these are not only the basic building blocks of relationships but also the central variables of personality, psychopathology, and psychotherapy.

Contemporary integrative interpersonal theory (CIIT) begins with the premise that what is ultimately most fundamental and important in people’s lives is interpersonal. As we hope to show, beginning with this premise leads to a highly generative, practical, and useful model for understanding and helping people with mental health problems that cuts through the complexity

(and inaccuracy) of diagnostic labels and is applicable across therapeutic orientations. It does so by asking more basic questions about what is really happening when two people encounter one another and how one person can be helpful to the other.

FOUR CASE EXAMPLES

Throughout this book, we illustrate various points with the cases of Daniel, Ruth, Mei, and Mehmet, each of whom we briefly introduce next and summarize in Table 1.1. Please note that these cases are fictional amalgams based on past clients and clinical experiences.

“I Hate You; Don’t Leave Me!”: The Case of Daniel

Daniel (he, him) is a 28-year-old homosexual European American man. He grew up in an intact household but described both of his parents as old-fashioned and unsupportive. Daniel believed that they always liked his older sister better than him. Although he has occasional contact with his sister, he rarely speaks to his parents, having moved away at age 18 from the “boring” small town in which he grew up to attend college. He completed 2 years of college but dropped out because he believed he could make more money in the service industry, where he worked various jobs in restaurants, hotels, and clubs. Daniel has lived in multiple apartments, often squatting with friends or boyfriends, and has a large but relatively superficial social network. He is

TABLE 1.1. Four Cases

|                   | Daniel                                    | Ruth                       | Mei                               | Mehmet              |
|-------------------|-------------------------------------------|----------------------------|-----------------------------------|---------------------|
| Age               | 28                                        | 36                         | 46                                | 55                  |
| Gender            | Man                                       | Woman                      | Nonbinary                         | Man                 |
| Attracted to      | Men                                       | Men                        | Men                               | Women               |
| Pronouns          | He, him                                   | She, her                   | They, them                        | He, him             |
| Race/ethnicity    | White                                     | Black                      | Asian                             | Turkish             |
| Country           | Canada                                    | USA                        | USA                               | Germany             |
| Primary diagnosis | Personality disorder                      | Delusional disorder        | Depression                        | Generalized anxiety |
| Treatment         | Psychodynamic therapy<br>DBT skills group | Cognitive behavior therapy | Acceptance and commitment therapy | Behavior therapy    |

Note. DBT = dialectical behavior therapy.

a night owl who likes to party, regularly drinks alcohol and uses other drugs, and often engages in casual sexual relationships. He has had several close romantic relationships, but none that lasted more than a year. Most of his relationships ended because of infidelity on the part of himself, his partner, or both. In nonromantic relationships, Daniel is attractive and charming, so he is able to make friends easily. However, he tends to burn bridges because of his mood swings, self-absorption, occasionally aggressive behavior, and willingness to be dishonest and exploit others to get what he wants.

Clinically, Daniel has a relatively high level of severity and carries a diagnosis of personality disorder. He experiences identity diffusion and extreme emotional variability, often swinging from anger to depression and back again. Sometimes he is grandiose and angry, becoming verbally aggressive and occasionally violent. Although he usually does not physically fight with other people, he sometimes breaks things and is often reckless regarding his own bodily safety. At other times, he is vulnerable and depressed, and contemplates suicide, which he has threatened numerous times. He has made suicide attempts involving drug overdoses and cutting, although in each case his intentions to die were unclear, even to him upon recall. Extreme emotional dysregulation has typically occurred in the context of romantic relationships. Daniel first tried psychological treatment in college after a suicide attempt that involved an overdose, which led to a hospital visit. He has begun and discontinued several mental health treatments since that time and is currently in individual psychodynamic psychotherapy and a dialectical behavior therapy skills training group, both of which meet weekly.

## **“Sometimes the Thoughts on the Inside Don’t Match the Outside”: The Case of Ruth**

Ruth (she, her) is a 36-year-old heterosexual African American woman. She comes from a large family, for whom she reports ambivalent feelings. She lives in the same small town in which she was raised, as do her two brothers and one of her two sisters—the other moved away to practice law. Her parents work various relatively low-paying jobs, and she grew up lower middle class. Her family is heavily involved in the church, and although Ruth considers herself a Christian, she is no longer involved with the church community, which is a source of stress between her and her family. She struggled to obtain a nursing degree at a local community college but developed transient paranoid concerns about the church, nursing instructors, town residents, and ultimately some of her family members. Although Ruth married a man she

went to high school with when she was 20, he left her for another woman when she was 27, and she has not dated since.

Ruth has experienced depression since adolescence, and although her depression is relatively chronic, there have been times when it was accompanied by paranoid fears that left her feeling insecure and confused about others' intentions and behaviors. Over time, Ruth's symptoms intensified. This left her unable to work, and she often did not leave the house unless accompanied by a family member. Her symptoms occasionally reached a level that required brief inpatient treatment, where she was given a diagnosis of delusional disorder. It was during one such episode, shortly after her divorce, that she sought mental health treatment in the context of the threat of losing her home if she did not establish the ability to live independently. She has tried various medications, group therapy, and individual behavioral and psychodynamic therapies and she is currently being treated with a cognitive behavioral approach. She has not experienced significant gains as a function of treatment.

Ruth has a mistrustful and isolating personality style, and she often prefers being alone, in part because she is afraid others might exploit or harm her. One clinical challenge with patients like Ruth is understanding her chronic mistrust not solely in terms of paranoid delusions but also in the context of actual experiences of racism and prejudice. She has never considered suicide because it is inconsistent with her religious beliefs, but she feels hopeless that things will improve.

## **"It's Always My Fault": The Case of Mei**

Mei (they, them) is a 46-year-old Asian American nonbinary individual who is attracted to men; has a diagnosis of depression; is hostile, withdrawn, and rejection-sensitive; and tends to negatively distort interpersonal information. Mei has been estranged from their family for most of their adult life, ever since the family expressed discomfort with their sexual identity. Mei has worked as a fifth-grade teacher at a local elementary school for nearly 20 years but struggles to keep up with the job demands. They are on speaking terms with colleagues, but they are not close with them and often feel they are unsupported and disliked by others. While Mei is currently living with their boyfriend of 3 years, they continue to have doubts about the relationship. These include self-critical judgments that they are unlovable and concerns that their boyfriend is growing uninterested and distant. Life seems limited to Mei as they try to keep up with classes and the discomfort experienced in work, family, and romantic relationships, as well as social adversity

related to their nonbinary status. They will be treated with acceptance and commitment therapy.

## **“I Need Your Help!”: The Case of Mehmet**

Mehmet (he, him) is a 55-year-old single, heterosexual Turkish man with generalized anxiety who is living in Germany, a transfer from his home country that was requested by his employer. Despite positive work reviews that landed him his new position as a manager for international shipping, Mehmet chronically views himself as incompetent and anxiously looks to others for help and support. His move to Germany heightened his anxiety as he tried to adapt and fit into a new culture and meet the expectations of his new position. To ensure others will like and support him, Mehmet tends to be very warm and very compliant with others and avoids assertion and conflict at all costs. However, he then feels taken advantage of, pushed around, or abandoned. He is treated with behavior therapy, including behavioral activation, exposure and response prevention, and skills training.

## **PLAN FOR THIS BOOK**

The interpersonal perspective on personality, psychopathology, and psychotherapy originated in the work of American psychiatrist Harry Stack Sullivan (1953) more than 70 years ago. The principles of CIIT, a theory rooted in the interpersonal framework, were formulated nearly 2 decades ago (Pincus, 2005) and recently augmented based on emerging evidence (Wright et al., 2023). Over the course of CIIT's development, a large body of empirical research, theoretical papers, and case studies has been published from this perspective. The goal of this book is to bring this work together in a single volume focused on applying the interpersonal approach to clinical practice with adult clients. While CIIT is also applicable to clinical practice with children, adolescents, and families (e.g., Di Blas et al., 2012; Meisel et al., 2022; Nilsen et al., 2015; Salekin et al., 2005; Sodano & Tracey, 2006; Trucco et al., 2013), this book will discuss our approach to adult case conceptualization, assessment, and intervention.

There are clinical approaches other than CIIT that emphasize an interpersonal perspective. Some of them are quite distinct, such as interpersonal psychotherapy (Weissman et al., 2017; Weissman & Mootz, 2024) and brief relational therapy (Safran & Muran, 2000; Zilcha-Mano et al., 2020), and some are overlapping, such as structural analysis of social behavior

(Benjamin, 2018; Critchfield & Benjamin, 2024). CIIT reflects the evolution in theory, assessment methods, and interventions that are characterized by (a) an expansion and integration of Sullivanian theory; (b) an emphasis on the impact of reciprocal social reinforcement in personality, psychopathology, and psychotherapy; (c) the use of the interpersonal circumplex (see Chapter 2) as the organizing model for describing and understanding interpersonal functioning; and (d) a pluralistic, integrative approach to psychotherapy (see Anchin, 1982; Pincus & Cain, 2008, for extended discussions). Importantly, CIIT and the interpersonal situation is not a specific and distinct intervention model; rather, it provides a meta-framework or lens through which all therapeutic approaches can be enhanced.

The first half of this book covers the underlying theoretical principles of CIIT. In Chapter 2, we review the history and central assumptions of CIIT. This will include a discussion of issues related to development, culture, and diversity. In Chapters 3 and 4, we describe how psychopathology and other common mental health constructs are understood from the perspective of CIIT. We will present a framework for interpersonal diagnosis and demonstrate how this approach is related to and different from other common approaches. Throughout, our emphasis will be on how CIIT provides not a new and different way to think about mental health problems but rather an integrative approach that is connected to many other common models.

The second half of this book describes how to implement CIIT in clinical practice. In Chapter 5, we describe how to use common interpersonal measures and interpret common assessment instruments from an interpersonal perspective. In Chapter 6, we articulate interpersonal principles for psychotherapy and show how those principles dovetail with intervention techniques from various specific orientations. In Chapter 7, we conclude with an emphasis on clinical integration and the transdiagnostic utility of our approach. Throughout, we use the case examples described in this chapter to make certain key points. Our hope is that this volume provides the reader with everything they need to understand how to use CIIT to enrich their clinical practice, regardless of the type of clients they work with or what kind of theoretical orientation they prefer.