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Are none, some, or all disorders interpersonal?

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ABSTRACT. – The objective of this paper is to analyze three different hypotheses on the role of the interpersonal domain in psychopathology: specifically, whether none, some, or all disorders should be considered interpersonal. In evaluating these three theoretical positions, I present a general thesis and an antithesis for each, aiming to bolster an interpersonal perspective in psychotherapy. This perspective draws on principles formulated almost a century ago by Harry Stack Sullivan. Finally, I discuss an evolutionarily informed synthesis of all these theses and antitheses. My proposed conclusion is that the history of our species, general human functioning, and thus mental health and psychopathology, have always and distinctly evolved socially. Implications for conceptualization and treatment are discussed.

Key words: diagnostic classification, interpersonal disorders, personality disorders, psychopathology, social brain.

A brief historical premise

In the last twenty-five years, several scholars have questioned the standard diagnostic classification based on symptoms and categories (Blaney *et al.*, 2015; Millon *et al.*, 2010). The comorbidity between symptoms and diagnoses, the heterogeneity within specific formulations, and the lack of evidence supporting a variety of possible therapeutic mechanisms have fueled this debate. The expectation of a substantial reform of diagnostic systems, however, was dashed by the release of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5; Zachar *et al.*, 2019). This new manual, born from numerous discussions and reconsiderations, included decisions that proved unpopular with many clinicians. Two may exemplify the sense of "restoration" that followed the work of the American Psychiatric Association task forces between the late 1990s and the manual's publication in 2013.

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First, in the multi-axial model of the DSM-IV-TR, clinicians were required to consider not only the complex – and often problematic – coexistence of different disorders on different axes, but also to formulate a comprehensive assessment of functioning that transcended this heterogeneity. The Global Assessment of Functioning (GAF) Scale offered an important way to think about the patient as a whole (Aas, 2010). This scale is consistent with what clinicians usually do in the first sessions with a patient: they try to understand what the patient's resources are, what the multifaceted functioning is, and the general level of severity. In the DSM-5, there are no longer tools or frameworks – such as the GAF – to integrate different formulations.

Second, what was initially intended to be a comprehensive reform of personality disorders (PDs) diagnosis was relegated to a potential future line of research shortly before the DSM-5's publication (Alternative Model of Personality Disorders; AMPD). The original decision was to officially adopt the new dimensional system, which included a general criterion of functioning (consistent with the GAF) and a specific criterion of maladaptive traits (Skodol, 2012). This new framework is now in Section III, "Emerging Measures and Models", while the official diagnosis of PDs remains unchanged.

This debate was further fueled by the formulation of the Hierarchical Taxonomy of Psychopathology (HiTOP; Kotov *et al.*, 2017) and the new International Classification of Diseases (ICD-11; Oltmanns & Widiger, 2019). HiTOP sought to integrate – through meta-analytic or psychometric procedures – data on symptoms, maladaptive, and nonclinical traits to formulate superordinate spectra, while the ICD-11 reformed its categorical diagnostic model for PDs, introducing a dimensional one (similar to the AMPD). Both of these models are based on a dimensional perspective, which assumes that an integration of an understanding of general intra- and interpersonal functioning with particular attention to stable personality traits is necessary for a proper assessment and treatment plan formulation. This dimensional framework is undoubtedly consistent with theoretical studies such as those by Caspi on a general factor of psychopathology (p-factor; Caspi *et al.*, 2014) and by Cicchetti on two spectra (internalizing *vs.* externalizing) corresponding to developmental trajectories (Cicchetti & Toth, 1991).

More recently, the ongoing debate on the differential utility of AMPD Criterion A and B (general functioning and maladaptive traits, respectively) has been fueled by Wright, Hopwood, and Pincus's (2022) provocative proposal to replace PDs with "interpersonal disorders". This proposal, critically addressed by Zavlis and Fonagy (2024), suggests the need to consider PDs as psychopathologies exclusively rooted in the interpersonal domain. What the data seem to suggest is that both Criterion A and Criterion B are clinically useful and that nearly all PD treatment protocols focus conceptualization on maladaptive interpersonal patterns, cycles, and dynamics.

In this paper, I propose to review three general hypotheses on the relationship between interpersonal experience and psychopathology. For each of these hypotheses, I present a coherent thesis and then an antithesis that aims to explore the centrality of the interpersonal dimension in our species (Table 1). I then formulate an evolutionarily-informed synthesis that supports the radical idea that all psychopathology and human functioning must always be considered socially evolved (Cheli, 2018, 2026; Cheli & Brüne, 2025). Finally, I discuss possible implications for clinical practice.

Null hypothesis: no disorder

Modern psychopathology has been profoundly influenced by Sigmund Freud. His first metapsychology theory defines a dynamic system in which it is precisely this dynamism that gives rise to an intrapsychic conflict between drives (Freud, 1916; Laplanche & Pontalis, 1967). The Freudian model presents the human psyche as constantly striving for equilibrium, which, as in any complex system, is never fully achieved or stable (Prigogine, 1977). This search, while consistent with a common Western cultural perspective, is solely defined as an intrapsychic experience – a challenge faced by the individual within the self. Undoubtedly, a tradition that extends from ancient philosophical models such as the Stoic one to the moral function of reason in Immanuel Kant and to the most recent developments in Cognitive Behavioral Therapy (CBT), places the search for well-being in the capacity for intrapsychic regulation. Nevertheless, studies in social psychology and cultural anthropology

Table 1. The interpersonal domain in psychopathology.

	Null hypothesis	**Quasi-interpersonal hypothesis**	**Fully interpersonal hypothesis**
General formulation	The disorders do have an intrapersonal origin	Personality disorders are only understandable within interpersonal situations	General functioning is an intersection between intra- and interpersonal functioning
Thesis	No psychopathological disorder is interpersonal	Only personality disorders are properly interpersonal	Only a domain of general functioning is interpersonal
Antithesis	All psychopathology arises from the intersection between the individual and the social	There is no specific dynamic (extreme, rigid, etc.) of personality traits that is pathological *per se*	There is no specific or general functioning that is non-interpersonal environment

have highlighted how the individualistic formulation of constructs such as the self, agency and mental health is culturally determined: in Western societies the self is understood as an independent experience and psychological well-being as self-affirmation, in contrast with cultural frameworks more focused on interdependence and connectedness (Hamamura *et al.*, 2018; Markus & Kitayama, 1991; Nisbett, 2010).

The choice of technical words and the theoretical organization underlying the most common diagnostic classifications, such as the DSM and the ICD, seem to refer to individualistic assumptions in the explicit or implicit conceptualization of the psyche and psychopathological disorders. For example, depressive disorders are defined in terms of internal emotional and cognitive experiences that compromise the ability to function. Even disorders often associated with interpersonal problems, such as PDs, refer to stable patterns of inner experience and behavior. Understandably, classifications and taxonomies born within a given cultural context are both shaped by it and aim to be easily understood by its members. At the same time, it is interesting to note how many psychopathological models – primarily Western ones – convey a sort of implicit assumption that all disorders are intrapersonal or none are truly interpersonal.

This thesis, if made explicit and considered valid, is, however, disconfirmed by a large amount of data available in the psychopathological field and beyond. Meta-analyses conducted in recent years have highlighted how interpersonal problems play a central role in psychological distress and well-being. Interpersonal problems show a moderate association with a variety of indicators of psychopathology and mental health (Liu *et al.*, 2019; Zhang *et al.*, 2022), and a small – albeit robust – association with indicators of the effectiveness of psychotherapy (Gómez Penedo & Flückinger, 2023; Iovoli *et al.*, 2024). Surprisingly, a psychopathological model that assumes the null hypothesis that no psychopathological disorder is interpersonal negates all the most common explanatory models in psychological sciences formulated at least since the 1970s (*e.g.*, the bio-psycho-social model). In psychology and psychopathology, it is extremely rare – if not impossible – to identify a linear causal relationship between two factors. Furthermore, even fields considered more akin to hard science, such as neuroscience, highlight the need to abandon simplistic linear causation (Potter & Mitchell, 2025). If interpersonal problems are covariates, then intrapersonal regulation skills are also covariates. Indeed, all psychopathology arises from the intersection between the individual and the social environment. It is only the interpretative choices in problem formulation that can alternatively highlight either the intra- or interpersonal component, just as belonging to either individualistic or collectivistic cultures predicts self-representations and corresponding neurophysiological activations consistent with those cultures (Chiao *et al.*, 2009).

Quasi-interpersonal hypothesis: some disorders

Undoubtedly, the thesis that no disorder is interpersonal does not rely on evidence. On the contrary, the antithesis has been extensively validated and, therefore, is more valid than the thesis: all psychopathology arises from the intersection between the individual and the social environment. This is presumably the foundation of modern approaches to psychopathology and part of a wider conceptualization of mental health that overcomes unifactorial models and simplistic causal explanations. This also may justify different hypotheses that further specify the role of the interpersonal domain in psychopathology. For the sake of clarity, I suggest two broad alternatives: a quasi-interpersonal hypothesis about the existence of specifically identified disorders that are, by their nature, interpersonal; and a fully dimensional hypothesis that supports that all disorders are intrinsically interpersonal.

The distinction I make here between a quasi-interpersonal and a fully interpersonal perspective corresponds, I believe, to a distinction that can be discerned in postwar interpretations of Harry Stack Sullivan's work (1946): a conservative and a radical one, respectively. Sullivan outlined – through a variety of disparate publications rather than a single, definitive manual – a profoundly interpersonal view of psychopathology and psychotherapy. In his view, clinical and social psychology are two disciplines that need to work closely together to overcome a recurring bias that corresponds precisely to an individualistic perspective on mental health (Sullivan, 1964). Sullivan (1953) proposed a revision of Freud's intrapsychic conflict, suggesting that anxiety – understood as a generic clinical suffering in response to psychosocial challenges – always has an interpersonal origin. Similarly, personality would correspond to a process of "de-individuation", in which the person emerges as an agent within the social context, rather than socializing their innate individuality within it. This perspective was not dissimilar from that of Lev Semenovich Vygotsky (1978), who in the same years suggested that the origin of higher psychological functions emerged through a process of internalization of what was experienced in interpersonal relationships.

Since Leary's (1957) circumplex model, Sullivan's work has been used to justify almost exclusively an interpersonal perspective on personality and its disorders. The circumplex model, which is organized along the two dimensions of agency (along the dominant-submissive *continuum*) and communion (along the hostile-friendly *continuum*), has become a cornerstone of many theoretical and clinical perspectives. Recently, Contemporary Integrative Interpersonal Theory (CIIT) has attempted to use the circumplex model to suggest an interpersonal perspective on personality and psychopathology (Pincus, 2005). While this perspective

remains primarily focused on personality assessment, its developers emphasize the usefulness of understanding interpersonal situations and dynamics for predicting human behavior and psychopathology more broadly (Hopwood *et al.*, 2023).

At the same time, CIIT has been used to propose a substantial revision of the diagnosis of PDs in terms of interpersonal disorders (Wright *et al.*, 2022). The authors highlight two criticisms related to Criterion A and B of the AMPD, respectively. On the one hand, an analysis of intra- and interpersonal functioning (Criterion A) would be unable to distinguish PDs from other disorders. On the other hand, maladaptive personality traits (Criterion B) would be descriptive of psychopathology as a whole rather than of PDs alone. The interpretation of these criticisms is that the modern diagnosis of PDs is unreliable, while an analysis of interpersonal situations and dynamics based on the circumplex model would offer a specific assessment of personality disorders as, precisely, interpersonal disorders. This argument may be easily integrated with the one suggested by Zavlis and Fonagy (2024), according to which, if we do not think of PDs in terms of interpersonal disorders, then PDs would not exist at all. Here, the criticism of a trait-based perspective – also present in the work of Wright *et al.* (2022) – is taken to a final end. If we believe that PDs emerge from extreme scores on specific traits, then it no longer makes sense to distinguish them from other disorders, and the diagnosis of PDs should be abandoned. The conclusion is once again to consider PDs as interpersonal disorders, where in this case, the suggested model is that of mentalization (the ability to understand intentions and mental states) and epistemic trust (the ability to trust the other as a source of knowledge), formulated by Fonagy and colleagues (Zavlis *et al.*, 2025).

While the thesis that PDs are prominently interpersonal disorders is easily sustainable, doubts remain about the specificity, or rather exclusivity, of the interpersonal definition of PDs. First, an explanation based on a principle of parsimony, such as Occam's razor, perhaps suggests alternative explanations for the limited reliability of PDs. If the diagnostic criteria of dimensional models (*e.g.*, AMPD) can lead to the indistinguishability of PDs from other disorders, perhaps this distinction is less reliable than assumed. And perhaps the limited efficacy of therapeutic protocols for PD and other disorders, which are effective but in a minority of patients, is indicative of interventions that are not specific to the patient's experience (Harrer *et al.*, 2025). That is, we are offering the same treatments, such as CBT for depression, to extremely heterogeneous manifestations and developmental trajectories of symptoms (Fried *et al.*, 2016). Second, the proposed alternative models for conceptualizing the redefined interpersonal disorders – namely, mentalizing and the circumplex model – do not appear to show sufficient reliability to preclude criticism of models such as the

AMPD. Both mentalization and the circumplex model have also been used in disorders other than PDs and have not been shown to effectively supplant alternative models such as metacognition, interpersonal schemas and cycles, modes, and so on. They are therefore not specific and reliable enough to fully replace the various other models (*e.g.*, AMPD; ICD-11, etc.) which, however imperfect, have their own empirical evidence.

Finally, there is an alternative hypothesis – or antithesis – that seems consistent with what has been said about modern perspectives on psychopathology, which disproves the null hypothesis that no disorder is interpersonal. There is no specific dynamic (extreme, rigid, etc.) of personality traits that is pathological *per se*; rather, it is the interaction between the individual and the social environment that determines the emergence of what we call psychopathology over time. A patient I treated as a therapist worked in a criminal environment (Cheli *et al.*, 2021). In that environment, his distinctive tendency toward suspiciousness had been of great help to him. Only when he chose a healthier job and new, equally healthy relationships did his suspiciousness become maladaptive, to the point of meeting the criteria for a diagnosis of paranoid personality disorder and then major depression. It's perhaps not the trait itself or the elevation of its scores that define whether it is pathological, but rather the interaction over time between the patient's whole personality and his social network. And this explanatory model applies to both PD and a symptomatic disorder.

Fully interpersonal hypothesis: all disorders

There are some clinicians who have drawn direct inspiration from Sullivan, offering us a radical interpretation of his thinking, which in my opinion is more coherent with the original formulation than many other models discussed so far. Frieda From-Reichman's intensive psychotherapy and Jeremy Safran's relational psychotherapy are two clear examples of this radical interpretation. From-Reichmann (1950) fully appreciated Sullivan's idea that patients do what they do to try to maintain their relationships, and that it is through rebuilding a sense of relational safety that therapy becomes effective. Safran integrated Sullivan's conceptualization of paratactic distortions with the most recent developments in cognitive science, suggesting that it is the repetition of relational experiences that crystallize patterns that then channel one's view of the world and others, as well as the maintenance of painful self-to-other patterns (Safran & Segal, 1991). Both of these clinical perspectives implicitly suggest that understanding interpersonal experience and functioning underpins clinical action. And this clinical action is geared toward comprehending the patient and their history, rather than formulating an "exact" diagnosis. This statement is not meant to suggest that

it is not useful to empirically validate assessment and therapy models, but rather to remind us that a clinical model is useful to the extent that it facilitates the achievement of objectives shared with the patient.

If we seek to test a radical interpretation of Sullivan's theory, consisting of a fully dimensional hypothesis, we must perhaps start with a limited thesis. We can therefore ask whether only one of the domains of general functioning is interpersonal, regardless of the fact, or valorizing the very fact, that the understanding of general functioning may be a non-specific criterion as highlighted by Wright *et al.* (2022). Paradoxically, one of the criticisms that have supported an interpersonal perspective on PDs (the non-specificity of Criterion A) equally supports the usefulness of general functioning across disorders and therefore also of interpersonal functioning. Consistently, Interpersonal Psychotherapy (IPT) – a psychodynamically oriented intervention that focuses on social and interpersonal functions – has been reported in a meta-analysis to have a significant effect on reducing specific symptoms, such as depressive symptoms (Bian *et al.*, 2023). Thus, targeting interpersonal functioning improves mental health, whether the patient is diagnosed with PDs or not.

At the same time, many of the studies I have cited to invalidate the null hypothesis seem to suggest that it is not a personality trait per se that is pathological, but the interaction between the person as a whole, defined by many traits, and his or her social environment over time. Not all children who are extroverted, low in conscientiousness, or high in reward sensitivity will manifest internalizing spectrum disorders (see Cicchetti & Toth, 1991). On the other hand, even an effective treatment targeting poor interpersonal functioning and specific maladaptive traits in patients diagnosed with PDs will not change the prominent personality or interpersonal style (Cheli *et al.*, 2025). Therefore, there is no specific or general functioning that is non-interpersonal. And an effective therapy is maybe the one capable of valuing the patient's interpersonal functioning regardless of a specific diagnosis.

Perhaps there is an epistemological bias that – even if we start from premises consistent with a systemic and complex *weltanschauung* – inevitably leads us to choose those hypotheses that are most easily explained in terms of linear and individualistic causation. Richard Bernstein (1983) defined this bias as a Cartesian anxiety that forces us to choose between dogmatism and indefiniteness. And to reduce our sense of uncertainty, we might then indulge in different forms of dogmatism. An alternative, presumably, is to recognize that if we affirm that human experience is given by a within-person complexity of traits and a between-person heterogeneity of interaction trajectories with the social world, then it will be difficult to find completely mechanistic or time-invariant explanations. Any explanation must account for a high degree of complexity and heterogeneity.

An evolutionarily informed synthesis

In this section, I propose a synthesis of all the theses and antitheses discussed. In doing so, I refer to an evolutionarily informed framework that I assume is consistent with a radical interpretation of Sullivan's thought (Table 2). The assumption from which I begin and which I seek to justify is that an evolutionarily informed perspective on the so-called social brain offers empirical support in two directions:

i) It justifies a radical view in which all human psychopathology is interpersonal;
ii) It supports the development of new hypotheses based on the integration of what is known about the interpersonal dimension in psychopathology.

The theory of evolution was formulated by Charles Darwin (1859, 1871) more than 150 years ago, and it has found infinite empirical confirmations and a variety of applications in fields such as psychology and psychopathology. Although many things may be said about this fascinating scientific paradigm, two topics are of great interest for the present paper. First, the theory of evolution was born to investigate the major problem in psychopathology: heterogeneity. Although this dimension was originally studied in interspecific terms, it was then progressively applied to interindividual variability within a single species. Models such as Life History Theory (LHT), initially designed to investigate interspecific differences, were later applied to intraspecific differences (Stearns, 1992). The primary goal was to understand how a species invests more in somatic development (*i.e.*, slow strategy; *e.g.*, elephant) or in sexual reproduction (*i.e.*, fast strategy; *e.g.*, mouse). LHT was subsequently applied to understand how human traits are associated with either slow (*e.g.*, autism) or fast (*e.g.*, borderline personality disorder) strategies (Martínez *et al.*, 2024). In doing so, evolutionary psychologists have increasingly attempted to integrate a pure evolutionary perspective on understanding the phylogenetic development of a trait with a behavioral ecology perspective on the ontogenetic development of the same trait (Tinbergen, 1963). In short, the theory of evolution has the theoretical and empirical tools to support an under-

Table 2. A tentative synthesis.

	Socially evolved functioning
General formulation	Human functioning, whether maladaptive or adaptive, is always socially evolved
High-order synthesis	Human functioning is defined – phylogenetically and ontogenetically – within a social domain
Low-order synthesis	Human fitness originates from social parameters and in turn gives rise to what we define as psychopathology or mental health

standing of a species characterized by high complexity and heterogeneity, such as *Homo sapiens*.

Second, some of the most interesting and convincing applications of evolutionary theory to clinical psychology and beyond concern the role of the interpersonal domain in humans. The empirically-validated hypothesis on the phylogenetic growth of the neocortex – the area of the human brain that is ultimately distinctive from both an anatomical and functional point of view – is the Social Brain Hypothesis (SBH; Dunbar, 1998). The data suggest that humans "needed" such a large and complex device to cope with the quantitative and qualitative complexity of our social life. Apes, and humans in particular, have invested in the development of a neuroarchitecture capable of exploiting the social resources present within their packs. This has led to cognitive skills that allow them to refine their understanding of their own and others' mental states, both for competition and collaboration. These skills have three relevant characteristics: i) in *Homo sapiens*, they require enormous parental and social investment, up to 25 years for the complete development of areas such as the prefrontal cortex (Galván, 2017); ii) they correspond to what clinical, developmental, and educational models describe as mentalization, metacognition, or social cognition (Fonagy & Luyten, 2018); iii) they are prominently compromised in PDs and schizophrenia, *i.e.*, disorders that appear to be exclusive to our species (Cheli, 2026).

In short, the traits associated with our social brain evolved to facilitate the adaptation of a species that has relied extensively on the ability to collaborate among conspecifics. This ability has seen exponential growth over the past five thousand years, reflecting primarily socio-cultural rather than biological changes. This sudden and complex development has perhaps exposed our species to significant risks. On the one hand, such complex abilities require subtle adaptations, even at the biological level. For example, vulnerability to emotional neglect appears to stem from an evolutionary mismatch between a species that for 300,000 years managed the rearing of its offspring in a tribal manner and the modern West's tendency over the past 100 years to maintain very small family units (Konner, 2010). On the other hand, ever-increasing intraspecific heterogeneity has led to complex evolutionary trade-offs between strategies that favor either the individual or the species. This variability exacerbates the more common trade-offs across different social environments and time periods. For example, when creativity is associated with difficulty in socializing one's ideas, it can represent a risk factor for even serious disorders such as those associated with psychosis (Cheli, 2023).

This brief summary of the theory of evolution and its applications in psychology supports the assertion that human functioning, whether maladaptive or adaptive, is always socially evolved. That is, it corresponds to a set of traits that are defined within a social domain, both phylogenetically and ontogenetically. Both the history of our species and the development of individuals are

shaped and constituted by socially evolved mechanisms and functions. Therefore, if we assume, consistently with almost all diagnostic systems, that psychopathology implies a non-specific criterion of difficulty adapting to one's context (work, family, etc.), psychopathology cannot be defined except in terms of social fitness. Fitness can be formulated as elevation on a tridimensional map, whose coordinates correspond to the interpersonal style of the individual and their social environment, respectively (Figure 1). This representation helps us see a snapshot of the adaptation process, which is dynamic, varying all the dimensions involved based on their possible configurations and the passage of time.

Practically speaking, transactions between social agents represent the stage on which individuals attempt to adapt by developing socially evolved processes that, in turn, establish a retrofeedback relationship between the individuals themselves and the social environment. This relationship is non-dualizing and follows a process of criterial causation, as defined by neuroscientist Peter Tse (2013): mental events can play a causal role even within biological constraints. Inevitably, both mental health and psychopathology are products of social transactions, or rather, they are the attempts of different systems (individual, family, community, cultural, etc.) to adapt by coexisting in an interconnected manner (Cheli, 2018). The distinction between symptomatic and personality disorders is secondary within this framework, just as the distinction between intra- and interpersonal functioning is a matter of convenience when analyzing an object of study.

Ultimately, psychotherapy becomes a sort of *ad hoc* system for simulating

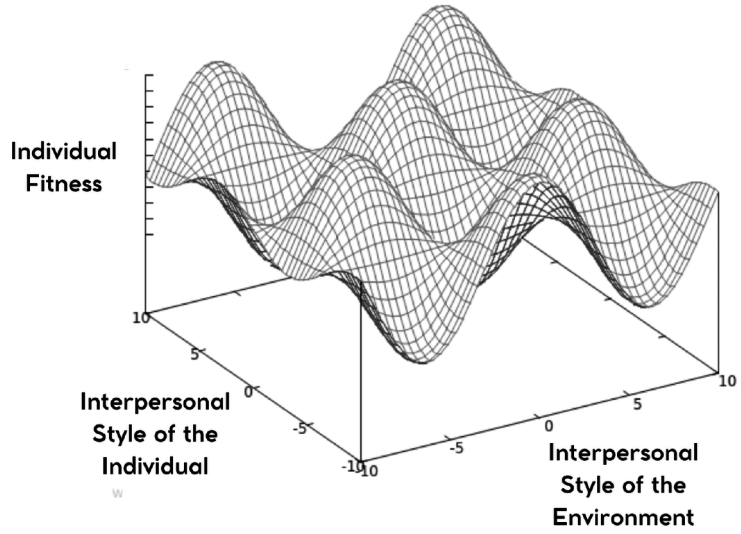

Figure 1. An interpersonal look at fitness.

these complex interactions. The relationship between patient and therapist is precisely this: a sort of hopefully intentional criterial causation that aims to facilitate the patient's experiential movement as they interact with their social environment. Consequently, the therapist cannot be seen as some kind of aseptic and detached instrument, but rather as a flexible one that must adapt to the interpersonal specificities of the patient and their social environment. Thus, the therapist, "as he listens to his informant, must realize that he is participating in speech behavior that pertains chiefly to the conceptual 'me' and 'you', with corresponding manifestation of the factors that have distorted and continue to complicate the interpersonal relations of the subject personality. As one who speaks, he is keenly aware that he is using linguistic processes in a configuration in which the hearer enters most significantly into the outcome of the attempt at communication" (Sullivan, 1947, p. 45).

Clinical implications and examples

The psychotherapy setting is a highly specific relational experience, undoubtedly powerful but also potentially distorting. The therapist can fully leverage interpersonal transactions to explore cyclical patterns, their implications, and alternative strategies with the patient. This closeness allows for the dissection of the interpersonal process in a way that is rarely possible outside the therapy room. Consequently, the therapist and patient may have a misperception of the transferability and comprehensiveness of that experience. A session lasts about an hour and therefore (in a classic weekly session format) it is about 0.6% of the weekly time, or to put it another way, it is as if the therapist were physically present in the patient's life for approximately 8 minutes every day. Sometimes we therapists forget that the session is a hopefully significant experience, but only a drop in an ocean of relationships that shape the person's life.

A patient with a severe form of personality disorder associated with suicidal behaviors and visual hallucinations showed full recovery at the end of the treatment. The patient had a meaningful life, lived with her partner, had a job she loved, and had established the right distance from the family environment that had harmed her so much in the past. Following the COVID-19 pandemic, she and her partner lost their jobs and home and, for what was initially supposed to be a very short period, each returned to their respective families. When she contacted me again a couple of months later, most of her symptoms and suffering had returned. And I wondered if therapy had provided the time needed to consolidate her life as a couple, and if the relationship events had – understandably – trumped any work she had done with me, whether well or poorly. She returned to my office to tell me her story since we last saw each other. She wanted a space – temporarily – to talk about her current suffering.

She then asked me to respect her wish not to return to therapy and her desire to rebuild her relational life after recent events. She told me she would call me back if needed, thanked me for the chat, and said goodbye.

Some might say that this was a relational safety test, and they'd probably be right. But I think it was something else entirely. It was a search for confirmation that there were relationships in which her interpersonal style was welcomed and validated, recognizing its personal and generally adaptive significance. If, upon returning to her family, she'd had a diametrically opposed relational experience, now she wanted to remind herself that she could have a meaningful life while continuing to be herself in relationships.

As highlighted in Figure 1, fitness emerges from the intersection between the patient's interpersonal style and that of the social context in which they operate – here and now. Therefore, the therapist must explore and understand both of these coordinates. In one study, we attempted to test our psychotherapy model, Evolutionary Systems Therapy (EST), which integrates the interpersonal and evolutionarily informed perspectives (Cheli *et al.*, 2025). Beyond the individual therapeutic model – which may or may not interest the reader – I believe the interpersonal framework used may be of interest. Patients' conceptualizations were organized according to three interpersonal styles, which we assumed corresponded to the three common psychopathological spectra on which different symptoms and disorders saturate (Ringwald *et al.*, 2023). The perfectionistic-affiliative style corresponds to an evolved strategy of managing relationships by considering others as a sort of validator of oneself and one's value and is associated with the internalizing spectrum (Hewitt *et al.*, 2017). The schizotypal-defensive style corresponds to an evolved strategy of managing relationships by considering others as a potential threat, even physical, and is associated with the psychosis or schizotypy spectrum (Cheli & Lysaker, 2023). The antagonistic-distancing style corresponds to an evolved strategy of managing relationships by viewing others as obstacles to achieving one's own well-being or value and it is associated with the externalizing spectrum (Miller & Lynam, 2019). The entire treatment plan was aimed at understanding the interpersonal style not as pathological but as distinctive of the patients, as well as understanding the interpersonal styles of the social environments in which they lived.

The study highlighted some interesting results for the interpersonal perspective discussed here. First, the three styles were indeed associated with a greater likelihood of experiencing symptoms and disorders corresponding to the three spectra of modern psychopathology. Second, the intervention was effective, and this effectiveness corresponded to a reduction in distress in daily interactions with significant others. Third, although the intervention was effective at the end of treatment, the prominent interpersonal style before treatment was still the prominent one at the end of the treatment.

In light of this study, the reader may recognize that the patient described above corresponded to a schizotypal-defensive style, and the final session was more than a security test with me: it was a test of her security with respect to her social world. It was perhaps a search for reconfirmation that her suffering and, therefore, her well-being were not caused by herself or by the other, but rather by the intersection of these variables. "One achieves mental health to the extent that one becomes aware of one's interpersonal relations" (Sullivan, 1946, p. 102). If a person experiences different relational situations, positioning themselves differently – while others may do the same as well – then their mental health varies.

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