

## Patterns of Interpersonal Problems among Adults with Major Depressive Disorder (MDD): A Clinical Study

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### Abstract

One of the main characteristics of Major Depressive Disorder (MDD) is interpersonal dysfunction. Interpersonal deficit is strongly connected with the severity of symptoms, impairment of functioning, and treatment results. Although increasing attention is being paid to the interpersonal aspect of depression, there is a paucity of empirical data on this facet of depression among Indian clinical populations. The current research investigated the character and the intensity of interpersonal issues among adults with MDD in the Mysuru District, Karnataka State, India. A cross-sectional research design was used. Purposive sampling was applied to mental health environments of Mysuru District where adults with a clinical diagnosis of MDD were chosen according to the ICD 11 criteria. A standardized measure of interpersonal problems was used to measure interpersonal functioning. The analysis of data was performed through descriptive statistics and comparisons of domains. The respondents were found to experience high levels of interpersonal distress in various areas. The notable challenges that were witnessed were social withdrawal, non-assertiveness, overdependence, and sensitivity to interpersonal rejection. Such interpersonal issues implied the occurrence of deprived relational functioning that can be linked to depression symptomology. The results highlight the importance of interpersonal dysfunction in MDD in an Indian clinical setting. Interpersonal interventions and assessment can be introduced into the standard clinical practice in order to expand the effectiveness of the treatment and psychosocial recovery.

**Keywords:** Major Depressive Disorder, interpersonal problems, depression, clinical psychology, IIP-C, QIDS-SR.

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### Introduction

Major Depressive Disorder (MDD) is one of the main causes of disability across the globe and it is a significant hindrance to emotional, cognitive, and social performance (World Health Organization, 2023). Although it has been widely researched that depressive symptomatology, interpersonal problems have been emerging as a core and enduring component of depression, impacting depression development and prognosis (Hames et al., 2013).

Social withdrawal, lack of assertiveness, excessive reassurance, dependency, and interpersonal hostility are some of the common interpersonal problems in MDD (Joiner and Timmons, 2009). These patterns may undermine social support systems, reinforce the negative self-schemas and also help in the chronicity and reoccurrence of the depressive episodes. Interpersonal dysfunction is another predictor that has been found out to be associated with low response to treatment and increase relapse (Cuijpers et al., 2016).

The interpersonal theory of depression assumes a reciprocal association amid depressive symptoms and maladaptive interpersonal

behaviors (Coyne, 1976). Such actions can arouse rejection or less responsiveness by other people, and it confirms their worthlessness and hopelessness. This has made interpersonal functioning an extremely important intervention focus in the evidence-based interventions like Interpersonal Psychotherapy (IPT).

Interpersonal dysfunction is one of the symptoms and one of the perpetuating mechanisms of major depressive disorder. The process which links mode thinking and communal engagement is turning out to be an increasingly significant concept in depression theories. Studies indicate that attachment in security man adaptive behaviour and interpersonal stresses all contribute to how chronic and recurrent depression is, thus assessment and treatment of interpersonal functioning is vital to depression treatment. by incorporating interpersonal Framework such as through attachment informed therapy CBT adaptation or IPT therapy outcome will improve and reduce chances of relapse.

Social withdrawal Reliance conflict avoidance and interpersonal sensitivity are just some of the numerous interpersonal problems that

individuals with MDD pass through as empirical research keeps unveiling. These difficulties manifest themselves in diverse situations such as family of friends and work (Weissman et al., 2001 Vittengl et al., 2003)

Results of the Inventory of interpersonal problems (IIP; Horowitz et al., 2000) demonstrate that individuals with MDD tend to report high scores on sub-scales of non-assertive socially inhabited and over accommodating non-assertive relationships often result in unsatisfactory relationships.

The interpersonal stress as a major projector of the onset and reference of depression based on the longitudinal studies research (Hammen, 2006; Stroud et al., 2011). The more through maladaptive behaviours such as avoidance and reassurance seeking even people with MDD can be strongly triggered by events such as loss of role changes or relationship difficulties which are depressive episodes according to meta-analytic data (Dagan et al., 2018). Liu et al. (2014) state that depressed individuals often experience a high degree of rejection sensitivity that is prone to interpret social signals in the lens of anticipated rejection of Criticism. social support systems of their undermined by the prejudice that leads to people being Sun intimacy or more hostile towards relationships. Interpersonal relations, in Indian sociocultural perspective, are incorporated in collectivistic values, interdependence in the family and socially defined roles. Additional complications of interpersonal functioning can be depression-related stigma and poor mental health literacy. Even though the burden of depression is high in India, there is limited empirical research regarding interpersonal issues among MDD patients in regions.

The Karnataka State, Mysuru District, has a distinctive sociocultural and clinical environment, which includes urban, semi-urban, and rural communities. The analysis of interpersonal issues in the given context would add to the culturally based clinical knowledge and make contextually relevant interventions.

**Objectives:** To determine the patterns of interpersonal issues among adults with Major Depressive Disorder.

To understand the prevailing areas of interpersonal dysfunction and the symptoms of depression among adults with Major Depressive Disorder.

To investigate the relationship between the symptoms of depression and interpersonal dysfunction using an Indian clinical population.

### **Method**

#### **Participants**

The research study encompassed 51 adult participants in the age range of 18 to 60 years and with a confirmed clinical diagnosis of a Major Depressive Disorder according to the ICD 11 criteria. The data collection was done in Krishna Rajendera Hospital of Mysuru District, Karnataka State. Subjects with serious comorbid psychiatric issues, neurological disorders or intellectual disability were not included.

#### **Sampling Technique**

Purposive sampling was applied to make sure that clinically diagnosed persons that fit into the study criteria were included.

#### **Measures**

Sociodemographic and Clinical Data Sheet: Data gathered in terms of age, gender, education, marital status, and clinical history.

#### **Inventory of Interpersonal Problems (IIP)**

The *Inventory of Interpersonal Problems (IIP)* was originally developed by Horowitz, L. M., Alden, L. E., Wiggins, J. S., and Pincus, A. L. (2000). The IIP is a widely used self-report instrument designed to assess distress associated with interpersonal difficulties. Grounded in interpersonal theory, the scale evaluates multiple domains of interpersonal functioning, including non-assertiveness, social inhibition, dependency, interpersonal sensitivity, and other maladaptive relational patterns.

The instrument has demonstrated strong psychometric properties, including good internal consistency and construct validity across both clinical and non-clinical populations. It is frequently used in research examining interpersonal dysfunction in mood disorders, particularly Major Depressive Disorder.

#### **Quick Inventory of Depressive Symptomatology–Self-Report (QIDS-SR).**

The Quick Inventory of Depressive Symptomatology–Self-Report (QIDS-SR) is a 16-item self-report measure developed to assess the severity of depressive symptoms over the preceding seven days, consistent with DSM criteria for Major Depressive Disorder. The instrument evaluates nine core symptom domains: depressed mood, sleep disturbance,

appetite/weight change, concentration/decision-making difficulties, self-criticism or guilt, suicidal ideation, loss of interest, reduced energy/fatigue, and psychomotor changes. Each domain is rated on a 4-point scale (0–3), yielding a total score ranging from 0 to 27, with higher scores indicating greater symptom severity. Severity classifications are as follows: 0–5 (no depression), 6–10 (mild), 11–15 (moderate), 16–20 (severe), and 21–27 (very severe). The QIDS-SR has demonstrated good reliability, strong convergent validity, and sensitivity to treatment-related changes, making it suitable for both clinical practice and research applications.

**Procedure**

The ethical approval was obtained by University of Mysore Human Ethics committee and the ethical committee of Mysore medical college and Research institute. Later data was collected in Krishna Rajendra Hospital,

Mysore. All participants gave informed consent in written. The data collection was done individually in a clinical setting with the consideration of confidentiality and non-violation of ethical considerations described in the Declaration form.

The analysis of data was done with the help of IBM SPSS 25 statistical software.

**Results**

The data analysis involved both descriptive and inferential statistics wherein the interpersonal problems overall and those specific to domains were investigated in terms of descriptive statistics (means and standard deviations). Inferential analyses were done where necessary to investigate patterns in the data.

One-sample t tests were applied to the sample size of 51 in order to test the strength of interpersonal difficulties, sleep disturbance, and depressive symptomatology, and the test value was set at zero.

**Table 1**

*One-Sample Descriptive Statistics and One-Sample t Tests for Interpersonal Problems and Depressive Symptoms (N = 51)*

Measure	M	SD	t	df	p	95% CI
Domineering–Controlling	9.92	3.03	23.37	50	< .001	[9.07, 10.77]
Vindictive–Self-Centered	9.88	2.85	24.79	50	< .001	[9.08, 10.68]
Cold–Distant	10.82	2.07	37.41	50	< .001	[10.24, 11.40]
Socially Inhibited	10.82	2.27	34.07	50	< .001	[10.19, 11.46]
Nonassertive	10.14	3.11	23.32	50	< .001	[9.26, 11.01]
Overly Accommodating	10.16	2.49	29.19	50	< .001	[9.46, 10.86]
Self-Sacrificing	8.82	3.24	19.44	50	< .001	[7.91, 9.74]
Intrusive–Needy	7.24	3.65	14.02	49	< .001	[6.20, 8.28]
IIP Total	67.94	13.77	35.25	50	< .001	[64.07, 71.81]
QIDS Total	22.92	2.58	63.36	50	< .001	[22.19, 23.65]
Sleep	2.84	0.37	55.28	50	< .001	[2.74, 2.95]
Mood	2.78	0.42	47.87	50	< .001	[2.67, 2.90]
Appetite	2.43	0.50	34.71	50	< .001	[2.29, 2.57]
Concentration	2.49	0.51	35.22	50	< .001	[2.35, 2.63]
Self-View	2.43	0.54	32.23	50	< .001	[2.28, 2.58]
Suicidal Ideation	2.41	0.61	28.43	50	< .001	[2.24, 2.58]
General Interest	2.49	0.51	35.22	50	< .001	[2.35, 2.63]
Energy Level	2.51	0.51	35.50	50	< .001	[2.37, 2.65]
Agitation/Retardation	2.53	0.50	35.83	50	< .001	[2.39, 2.67]

Note. One-sample t tests were conducted using a test value of 0. IIP = Inventory of

Interpersonal Problems; QIDS = Quick Inventory of Depressive Symptomatology. All tests were two-tailed.

The findings showed that the participants had recorded a high score in all the domains measured and the *t* values of each were statistically significant and the confidence intervals were not intersecting the value of one thus showing strong deviation with the reference value.

Regarding interpersonal issues, the mean scores on the subscales of the Inventory of Interpersonal Problems (IIP) showed that there were wide-spread troubles in a variety of interpersonal styles. The Cold-Distant and Socially Inhibited dimensions showed the greatest mean scores (both  $M = 10.82$ ) indicating a high level of withdrawal, lack of emotion, and avoidance of people. High scores were also observed in Non-assertive ( $M = 10.14$ ) and Overly Accommodating ( $M = 10.16$ ) patterns as an expression of the inability to express personal needs and the overcompliance at relationships. Domineering-Controlling ( $M = 9.92$ ) and Vindictive-Self-Centered ( $M = 9.88$ ) dimensions were rated moderately high, whilst Self-Sacrificing ( $M = 8.82$ ) and Intrusive-Needy ( $M = 7.24$ ) dimensions, but more comparatively lower, were significantly high. The general IIP mean total score was high ( $M = 67.94$ ,  $SD = 13.77$ ) which proved significant and general interpersonal dysfunction in the sample.

The levels of depressive symptomatology are to be discussed, with the QIDS total score being rather high ( $M = 22.92$ ,  $SD = 2.58$ ), which is related to the severe range of depression. Research on each domain of symptoms revealed a steady high mean score in sleep disturbance (2.41), depressed mood (2.84), change in appetite (2.45), problems in concentration (2.45), negative self-view (2.84), suicidal ideation (2.45), lack of interest (2.45), loss of energy (2.45), and psychomotor agitation or retardation (2.45). These findings reveal that depressive symptoms were not localized but were wide-based and intense and

### Table 3

*Subscales of Interpersonal Problems and Depressive Symptom Relationship matrix.*

touched on emotional, cognitive, behavioural, and somatic functioning.

In general, the trend of the results proves that the sample had severe interpersonal problems, high levels of depressive symptoms severity, and significant sleep disturbance. The application of both high interpersonal dysfunction and high levels of depressive and sleep-related symptoms to one of the main clinical issues illustrates the complicated and multidimensional clinical picture of the participants of the current study, which explains why integrative and interpersonal-oriented intervention is relevant.

To understand the relationship between interpersonal problems and depressive symptoms Pearson's product-moment correlation analysis was done.

### Table 2

*Pearson Correlation Between Interpersonal Problems and Depressive Symptoms*

Measure	1	2
1. IIP	—	.295*
2. QIDS	.295*	—

Note.  $p < .05$  (two-tailed).

### Relationship Between Interpersonal Problems and Depressive Symptoms

Pearson's product-moment correlation analysis revealed a **statistically significant positive association** between interpersonal problems and depressive symptoms,  $r(49) = .30$ ,  $p = .036$ . This indicates that higher levels of interpersonal difficulties were moderately associated with greater severity of depressive symptoms.

Descriptive statistics indicate slightly higher mean scores for depressive symptoms and interpersonal problems in Gender Rank 1 compared to Gender Rank 2; however, these differences were small and required inferential testing.

A **significant positive correlation** was observed between interpersonal problems and depressive symptoms, indicating that greater interpersonal difficulties were associated with higher depression severity.

IIP Dimension	Sleep	Mood	Appetite	Concentration	Self-View	Suicidal Ideation	General Interest	Energy Level	Agitation / Retardation	QIDS Total
Domineering–Controlling	-.10	-.03	-.11	.01	.12	-.04	.07	.00	.03	-.00
Vindictive–Self-Cantered	-.10	.08	.14	.08	-.03	-.15	.06	.03	.04	.03
Cold–Distant	.07	.17	.23	.09	.05	-.10	.14	.28*	.02	.17
Socially Inhibited	.16	.13	.39**	.18	-.04	.10	.06	.12	-.00	.20
Non-assertive	.11	.04	.28*	.15	.11	.23	-.02	.11	-.01	.20
Overly Accommodating	.09	.13	.25	.32*	.17	.14	.08	.30*	-.04	.28*
Self-Sacrificing	-.02	.06	.15	.36**	.40*	.29*	.16	.22	.14	.36*
Intrusive–Needy	-.00	-.10	.04	.30*	.04	-.01	.17	.03	.06	.11
IIP Total	.05	.09	.31*	.34*	.16	.12	.16	.23	.06	.30*

### Interpersonal Problems and Depressive Symptom Relationships.

The relationships between interpersonal problem scale dimensions (IIP subscales and total score) and the domains of depressive symptoms, such as overall depressive severity (QIDS total score) were tested using Pearson product-moment correlations in adults with major depressive disorder (N = 51).

On the indexed interpersonal distress measure of IIP total score, overall interpersonal distress was significantly and positively correlated with overall depressive severity,  $r(49) = .30$ ,  $p < .05$ . At the symptom-domain level, a positive relationship between higher IIP total scores and increased appetite disturbance,  $r(49) = .31$ ,  $p < .05$ , and increased concentration difficulties,  $r(49) = .34$ ,  $p < .05$  were found significant. The correlations between IIP total scores and sleep disturbance, mood disturbance, self-view, suicidal ideation, general interest, energy level, and psychomotor agitation/retardation were not significant, which demonstrates the selective, but not the global, nature of the relationship between IIP total scores and symptoms.

A number of different patterns came up at the interpersonal style level. The interpersonal style that was most strongly associated with a depressive symptomatology and consistent was the Self-Sacrificing type. Self-Sacrificing

scores were very closely related to concentration problems,  $r(49) = .36$ ,  $p < .01$ , negative self-view,  $r(49) = .40$ ,  $p < .01$ , suicidal ideation,  $r(49) = .29$ ,  $p < .05$ , and the overall measure of depressive severity,  $r(49) = .36$ ,  $p < .01$ . These results indicate that both cognitive and affective aspects of depression are highly correlated with a tendency towards excessive self-denial and overinvestment in other people. Overly Accommodating interpersonal style was also greatly linked with problems with concentration,  $r(49) = .32$ ,  $p < .05$ , low level of energy,  $r(49) = .30$ ,  $p < .05$ , and general severity of depression,  $r(49) = .28$ ,  $p < .05$ . Equally, the Nonassertive style showed a strong positive relation with the disturbance in appetite,  $r(49) = .28$ ,  $p = .05$ , but was not found to be strongly related with the general depressive severity.

Socially Inhibited interpersonal style was found to have a strong correlation with the domain of appetite disturbance  $r(49) = .39$ ,  $p < .01$ , but was not significantly correlated with other domains of depressive symptoms or total QIDS scores. Conversely, the Cold-Distant interpersonal style was also associated with less but significant energy levels,  $r(49) = .28$ ,  $p = .05$ , although the other relationships with the symptoms domains and the general severity of the depression were not significant.

Intrusive-Needy, Domineering-Controlling, and Vindictive-Self-Centered interpersonal styles did not show significant relations with overall depressive severity or any symptom domain, thus suggesting that the interpersonal patterns can be less centrally related to the expression of depressive symptoms in the current sample.

Overall, interpersonal problems defined by excessive self-sacrifice, accommodation, and inhibition have stronger correlation with the severity of depressive symptoms and with the domain of particular symptoms, as opposed to the presence of hostile or controlling interpersonal styles. This trend endorses interpersonal theories of depression by highlighting the effectiveness of submissive and self-effacing relational patterns in the continuation and phenomenology of major depressive disorder.

### Discussion

The current results are in line with global literature that places interpersonal dysfunction as a fundamental feature of Major Depressive Disorder (Hames et al., 2013; Joiner and Timmons, 2009). High social withdrawal and non-assertiveness imply that MDD sufferers might find it difficult to have a reciprocal social interaction hence restricting their access to social support.

Cultural rules that promote emotional restraint and role conformity in the Indian setting could worsen interpersonal inhibition in depressed individuals. Moreover, the stigma of mental illness can help avoid any social contact and the unwillingness to report emotional distress.

The results confirm interpersonal theories of depression, and they prove the necessity to work with the relational patterns in addition to reducing symptoms. Interpersonal-oriented therapy like IPT can be of special use in enhancing social functioning and decreasing the severity of the depressive symptoms in Indian clinical environments.

### Clinical Implications

The research study emphasises the clinical evaluations of MDD which should include routine evaluation of interpersonal functioning. Further the psychotherapeutic methods that engage interpersonal focus could improve the outcome of the treatment. Henceforth relational roles and family dynamics interventions that are culturally sensitive are suggested through the current study.

### Limitations and Future Directions

The present research study employs cross-sectional design that limits causal inference. Further the use of purposive sampling restricts generalizability. However future studies can employ longitudinal designs, larger samples, and comparative groups to examine changes in interpersonal functioning across treatment and recovery phases.

### Conclusion

Major Depressive Disorder in adults in Mysuru District is associated with major problems in interpersonal relationships that negatively impact social functioning. These issues of interpersonal concern should be tackled to achieve a comprehensive and effective treatment. The research provides region-specific data to the world literature in clinical psychology and justifies the incorporation of interpersonal paradigms in depression treatment.

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