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INTERPERSONAL PROBLEMATIC AREAS IN LIAISON PSYCHIATRY: A FEASIBILITY STUDY

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Abstract

Objective: Interpersonal Psychotherapy (IPT) model, with its four problematic areas of grief, deficit, role transition and role dispute, provides a useful frame of reference for a quick case formulation. We aimed at applying the IPT problematic areas assessment in a sample of patients from a liaison psychiatry setting.

Methods: One-hundred and twenty-nine hospitalized patients of both sexes, aged between 18 and 80 years were interviewed. The 'Interpersonal Problem Areas Rating Scale' (IPARS) was used to detect the interpersonal focuses.

Results: IPARS problematic areas were identified in the 76% of the sample (n=98). Grief and role transition, interpersonal deficits and role disputes were, respectively, the most frequently (43.4 and 42.6%, respectively) and the less frequently described focuses (14 and 11.6%). Moreover, 31 patients (24%) showed no problem areas related to current symptomatology.

Conclusions: The IPT model has proved to be an easy-to-use tool, able to guide the psychological interview and allowing the collection of information from an interpersonal perspective in a short time, although no specific focuses were detected as related to current psychological distress in around 25% of the sample.

Key words: IPT, depression; liaison psychiatry, IPARS, psychosomatic

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Introduction

Patients admitted to the hospital for physical symptoms and requiring an assessment for psychological/psychopathological conditions are usually referred to consultation-liaison Psychiatry (CLP). Within this heterogeneous patients' population, CLP professionals could evaluate any type of patient presenting a possible discomfort potentially related to psychological distress or full-blown psychiatric disorders. Literature indicated that a series of reasons could be involved in referral to CLP, including patients with chronic physical illnesses and psychiatric comorbidities, patients awaiting surgery, those who develop anxiety or mood symptoms as a response to the stress of physical illnesses, or patients already followed-up for a psychiatric disorder. Leentjies et al. (2011) carried out a systematic classification of the potential patients evaluated in CLP settings by adding patients with *'medically unexplained symptoms'* (MUS), subjects with a history of suicide attempts or with a family loading for psychiatric disorders and/or suicide attempts, and subjects who might oppose, in a delusional way, to treatment choices of the medical team.

Consultant may find difficulties when operating in settings not suitable for the psychological/psychopathological interview, trying to obtain patient's collaboration or to find clinical elements for a reliable diagnosis formulation in the charts. Frequently, differential diagnosis is obscuring case formulation. In this way, the biomedical model makes it difficult to complete an adequate assessment according to the bio-psychosocial model encompassing the interpersonal network and the psychosocial functioning of a given patient (Kusnanto et al., 2018). The Interpersonal Psychotherapy (IPT) model by Klerman et al. (1996) could be useful to provide a *'frame of reference'* and to facilitate patient's assessment according to a bio-psychosocial approach. The basic assumption of IPT is that depression (as well as other psychiatric disorders) has a biological substrate, but it is triggered and maintained by interpersonal difficulties (Klerman et al., 1996). Although the IPT model has a wide number of studies demonstrating its effectiveness in psychiatric patients, its use in CLP is rather limited, with the exception of psycho-oncology and HIV settings (Heckman et al., 2018; Blanco et al., 2019).

In this feasibility study, we aimed at assessing the presence/absence of the four IPT interpersonal problematic areas (grief, interpersonal distrust, role

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transition, interpersonal deficit), in a sample of patients hospitalized for physical diseases or surgery, evaluated in a CLP setting. Our hypothesis was that the IPT problematic areas could be part of clinical routine in CLP*,* and could integrate the psychopathological assessment in a setting that usually is not focused on the collection of interpersonal difficulties. We hypothesized that the problematic areas assessment specifically targeting four prominent components to psychological distress might have a clinically meaningful effect in helping the consultant to understand which aspects of the patient's interpersonal relationships might have contributed to the presence of current symptomatology or psychological distress. For this purpose, we utilized the Interpersonal Problematic Areas Rating Scale (IPARS) constructed and validated in two studies by Markowitz et al. (2000), and Andrade et al. (2008) that, however, did not enroll patients in CLP settings.

Materials and methods

a) Participants

The sample consisted of 129 patients (76 men, 58.9%; 53 women, 41.1%), aged ≥ 18 years (mean age: 61.0±16.4; age range: 18-96) hospitalized for acute physical diseases or waiting for surgery. The assessment of the presence/absence of IPT problematic areas was part of a broader research project, whose appropriate procedures (including written informed consent), were followed in accordance with the ethical standards of the responsible committee on human experimentation, and approved by the local Ethics Committee (protocol # 15627). The interpersonal assessment was carried out independently from the patient's psychiatric management that was entrusted to other specialists. No inclusion/exclusion criteria were adopted. Thus, the IPARS assessment was included in the routine of the liaison psychiatry service active for patients hospitalized for physical diseases or surgery. Psychiatric evaluation was performed on demand, after a formal request by the specialists who were the patients' case manager, and who considered clinically relevant a psychiatric assessment for their patients. As a consequence, we evaluated a sample characterized by a huge heterogeneity of physical diseases, as follows: 27 patients (20.9%) with an oncologic disease, 19 (14.7%) with a gastro-intestinal disease, 15 (11.6%) with a respiratory disease, 14 (10.8%) with a cardiovascular disease, 8 (6.2%) with diabetes, 7 (5.4%) with traumatism, 6 (4.6%) with vascular diseases, 6 (4.6%) with neurological syndromes, 4 (3.1%) with muscular diseases, 2 (1.5%) with liver diseases, 2 (1.5%) with kidney diseases, 1 (0.75%) with a iatrogenic disease, 1 (0.75%) with an infectious disease, 1 (0.75%) with an acute intoxication. Sixteen patients (12.4%) did not received a formal diagnosis at the time of the liaison psychiatry consultation.

b) Assessment

Demographics derived from the chart review. Clinical diagnoses regarding the presence of Axis I psychiatric disorders were clinically made following the Diagnostic and Statistical Manual for Psychiatric Disorders-Fifth Edition (DSM-5, APA, 2013) criteria. The definition of the problematic area associated with current symptomatology was carried out with the '*Interpersonal Problem Areas Rating Scale*' (IPARS) (Markowitz et al., 2000).

IPARS is the assessment scale used in IPT to guide the choice of the most represented multiple problematic areas in patients with unipolar depression (MDE). The four problematic areas (grief, interpersonal distrust, role transition and interpersonal deficit) are scored separately, and are not mutually exclusive. For each area, the presence/absence must be established first; if the area is present, it is characterized by specific questions, as follows:

- *Grief*: if present, the criterion for *'complicated'* or *'uncomplicated'* grief is defined. Other information is also considered relevant: a) the deceased person, b) the relationship between the deceased and the patient, c) the date of death, d) the number of months between death and the onset of depression.
- *Interpersonal Distrust*: If present, the following are specified: a) other significant aspects of the relationship, b) conflict in '*impasse*'; c) most relevant theme of the conflict (authority/domination, dependence, sexual problems, raising children, marriage/separation, and transgression). Moreover, the approximate duration of the conflict is indicated in months.
- *Role transition*: a transition related to: a) a diagnosis of dysthymic disorder; b) changes in work/living places; c) wedding/cohabitation; d) separation/divorce; e) degree/new job; f) loss of a work/retirement; g) somatic diseases; h) other (specify). If more than one item has been selected, the most relevant one is decided by the rater. The number of months between the SLE and the onset of depressive symptoms is requested.
- *Interpersonal deficit*: If present, an attempt is made to characterize the patient's personality: a) avoidant; b) employee; c) masochist; d) borderline; e) schizoid; f) paranoid; g) lack of social skills; h) other (specify). If more than one choice is indicated, the most relevant one is specified.

Then, the rater formulates his/her own hierarchical evaluation, by the assignment of a score to the areas: 1) = most important area, 2) = area of secondary importance, 3) = least important area. The area scored '1' is proposed to the patient as the focus of the intervention.

c) Statistical Analyses

Patients were compared using chi-square test for categorical variables, Mann-Whitney and t-test for ordinal level and continuous variables, when appropriate. All analyses were performed using SPSS, version 20.

Results

a) Demographic Characteristics

The age in the total sample had a normal distribution, as demonstrated by the Kolmoronov-Smirnov test (Z =.970; p =.304), with no statistically significant differences between men (59.9 ± 14.2) and women (62.6 ± 19.0) (df = 56; $\chi2$ =.093). Only two statistically significant differences were found in demographics between genders, namely the number of patients working (significantly higher in male gender; M = 35 vs. F = 13; $\chi2$ = 7.429; df = 2; p = .024), and a higher education level in men than in women (M = 14 vs. F = 3; $\chi2$ = 8,369; df = 3; p = .03) (**table 1**).

Table 1. *Demographic Characteristics of the sample (n=129)*

	Overall Sample (n=129)	Males (n=76)	Females (n=53)
Age (mean/SD)	61.0±16.4	59.9±14.2	62.6±19
Marital status	**n/%**	**n/%**	**n/%**
- Single	21 (16.2)	12 (15.8)	9 (17)
- Married/partner	108 (83.8)	64 (84.2)	44 (83)
Occupation	**n/%**	**n/%**	**n/%**
- Unemployed/retired	79 (61.2)	41 (53.9)	38 (71.6)
- Employed	32 (24.8)	21 (27.6)	11 (20.7)
- Professional	7 (5.4)	6 (7.8)	1 (1.8)
- Kraft and related works	4 (3.1)	3 (3.9)	1 (1.8)
- Services/sales worker	3 (2.3)	3 (3.9)	-
- Student	3 (2.3)	1 (1.3)	2 (3.7)
- Manager	1 (0.8)	1 (1.3)	-
Education	**n/%**	**n/%**	**n/%**
- Primary education	16 (12.4)	7 (9.2)	9 (16.9)
- Lower secondary	42 (32.5)	20 (26.3)	22 (41.5)
- Upper secondary	54 (41.8)	35 (46)	19 (35.8)
- Degree	17 (13.1)	14 (18.4)	3 (5.6)

b) Clinical features of Axis I disorder

As shown in **table 2**, the most frequent Axis I diagnosis was unipolar depression (MDE) (n=91; 70.5%)

c) Assessment of personality traits with IPARS

Although not allowing a formal evaluation of comorbidity for personality disorders, IPARS indicated that some personality traits were associated with interpersonal focuses and the absence of *'social skills'* (**table 2**).

d) Interpersonal problematic areas assessed with IPARS

Table 3 indicates that *'Grief'* was diagnosed in 43.4% of the sample (n = 56), *'role transition'* in 42.6% (n = 55), *'interpersonal distrust'* in 11.6% (n = 15) and *'interpersonal deficit'* in 14.0% (n = 18). No statistically significant differences were found in the distribution of problematic areas by gender. *'Grief'* was diagnosed in 30 males and 26 females ($\chi2$ = 1,167; df = 1; p = .280); *'role transition'* in 31 males and 24 females ($\chi2$ = 0.258; df = 1; p = .612); *'interpersonal distrust'* in 7 males and 8 females ($\chi2$ = 1.052; df = 1; p = .305); *'interpersonal*

Table 2. *Axis I and Personality Assessment (n=129)*

	Overall sample (n=129)	Males (n=76)	Females (n=53)
Axis I Diagnosis (DSM-5)	**n/%**	**n/%**	**n/%**
MDE	91 (70.5)	56 (73.6)	35 (66.0)
BP-I	15 (11.6)	7 (9.2)	8 (15.0)
GAD	12 (9.3)	8 (10.5)	4 (7.5)
BP-II	4 (3.1)	1 (1.3)	3 (5.6)
Panic Disorder	2 (1.6)	2 (2.6)	-
Delirium	2 (1.6)	1 (1.3)	1(1.8)
AN-R	2 (1.6)	-	2 (3.6)
Schizoaffective Disorders	1 (0.8)	1	-
IPARS Personality Traits	**n/%**	**n/%**	**n/%**
Avoidant	2 (1.6)	1 (1.3)	1 (1.8)
Dependent	4 (3.2)	3 (3.9)	1 (1.8)
Masochistic	1 (0.8)	1 (1.3)	-
Borderline	6 (4.7)	1 (1.3)	5 (9.0)
Schizoid	1 (0.8)	-	1 (1.8)
Paranoid	-	-	-
No social skills	1 (0.8)	1 (1.3)	-
Other interpersonal difficulties	1 (0.8)	1 (1.3)	-

deficit' in 10 males and 8 females ($\chi2$ = 0.098; df = 1; p = .755).

'Role transition' (n = 55) was subjectively related to health problems in almost all cases (53/55; 96.3%). In two patients, the onset of depressive symptoms was related to retirement and to a moving house. Multiple *'role transitions'* were described in 20/55 patients (36.3%) with 17/55 patients (30.9%) who described two simultaneous transitions, and 3/55 that described three role transitions (5.4%). *'Interpersonal distrust'* involved as *'significant other one'* the partner (10/15; 66.6%), the mother (3/15; 20%) or a son/daughter (2/15; 13.3%). Distrust was in impasse for more than 70% of the selected problematic area (11/15; 73.3%). In 46.6% of cases (7/15) distrust was related to transgressions; 26.6% (4/15) derived from an excessive dependence from others; 20% (3/15) was perceived as a problem of role's authority; 2/15 (13.3%) derived from distrust in the children education; 13.3% (2/15) of cases accounted for sexual problems with the partner.

The number of problematic areas detected by IPARS in the total sample varied significantly. In 24% of the sample (n = 31), with the assessment carried out in the CLP context, it was not possible to identify any interpersonal problematic area. The 48.1% of the sample (n = 62) reported a problematic area, 22.5% (n = 29) two areas, 3.1% (n = 4) 3 areas, and 2.3% (n = 3) 4 areas. The number of diagnosed problem areas did not differ statistically significantly between genders ($\chi2$ = 5,884; df = 4; p = .208).

The small sample size, did not allow statistical comparison between patients grouped by physical disease.

Discussion

as far as we know, this is the first study assessing interpersonal problematic areas, as part of the clinical routine, in a CLP setting. Studies are available on IPT in its various forms (Brief-IPT, IPT, IPT-C) administered to patients with cancer, irritable bowel syndrome or HIV (Heckman et al., 2018; Blanco et al., 2014; Blanco et al., 2019; Hetterich & Stengel, 2020), but with no formal assessment with the IPARS. Conversely, two studies with IPARS did not enroll patients from CLP settings (Markovitz et al., 2000; Andrade et al., 2008). The main result of our study was the identification of at least one interpersonal problematic area related to the onset/maintenance of psychiatric symptoms or psychological distress in 76% of the sample, thus confirming the validity of the approach proposed by the IPT model, even in an *'atypical'* setting.

IPARS has proved to be an easy-to-use tool, able to guide the psychological/psychopathological interview and to allow the collection of information from an interpersonal perspective in a short time, in the context of a first contact with patients presenting conditions of significant psychological and physical suffering, in uncomfortable settings. However, the 24% of the sample did not show any correlation between interpersonal problematic areas and psychiatric symptoms. This subgroup of *'focus free'* patients fulfilled several Axis I diagnoses, such as MDE, bipolar spectrum disorder (BP-I and BP-II), schizophrenia spectrum disorders, and GAD. We could hypothesize problems in the psychological interview and in the assessment of problematic areas both for patients with bipolar spectrum disorders and for patients diagnosed with schizoaffective disorder, due to the severity of clinical presentations. Less understandable is the absence of interpersonal areas in patients diagnosed with MDE or GAD. However, in this case we could hypothesize some difficulties in finding a problem area specifically related to current MDE after only one session of IPT assessment, as already described (Levenson et al., 2010) in a study on depressed patients in a psychiatric setting, where they were unable to find a focus during the first two sessions. Similarly, for patients diagnosed with GAD, the reliability of IPT focuses might decrease significantly, as patients with GAD describe themselves

Table 3. *IPARS Interpersonal Problematic Areas in the overall sample (n=129)*

	Overall Sample (n=129)	Males (n=76)	Females (n=53)
Number of Problematic Areas	**n/%**	**n/%**	**n/%**
No problematic areas detected	36 (27.9)	25 (32.8)	11 (20.7)
1 PA	57 (44.1)	31 (40.7)	26 (49.0)
2 PAs	29 (22.5)	17 (22.3)	12 (22.6)
3 PAs	4 (3.1)	3 (3.9)	1 (1.8)
4 PAs	3 (2.3)	-	3 (5.6)
Grief	56 (43.4)	30 (39.4)	26 (49)
Role Transition*	55 (42.6)	31 (40.8)	24 (42.9)
- Geographic move	7 (5.4)	4 (5.2)	3 (5.6)
- Marriage/cohabitation/dating	-	-	-
- Separation/divorce	5 (3.8)	2 (2.6)	3 (5.6)
- Job Problems	3 (2.3)	-	3 (5.6)
- Retirement	13 (5.4)	7 (9.2)	6 (11.2)
- Health Issues	53 (41.0)	30 (39.4)	23 (43.3)
Deficit	18 (14)	10 (13.2)	8 (14.2)
Role Distrust*	15 (11.6)	7 (9.2)	8 (15.0)
- Empasse	12 (9.3)	4 (5.2)	8 (15.0)
- Authority	3 (2.3)	2 (2.6)	1 (1.8)
- Dependence	4 (3.1)	2 (2.6)	2 (3.6)
- Sexual problems	1 (0.7)	1 (1.3)	-
- Educational issues	2 (3.0)	-	2 (3.6)
- Transgression	6 (4.6)	2 (2.6)	4 (7.2)

as *'chronic worries'* who remember to *'have always been anxious'*, regardless of a specific SLE (Mauri et al., 2016).

Grief and role transition were the most frequently diagnosed problematic areas. Role transition was mainly related to physical condition, in agreement with finding from other studies in psychosomatic settings, such as in psycho-oncology (Blanco et al., 2019). *'Interpersonal distrust'* was less frequent in our sample. Interestingly, distrust was frequently described by patients in '*impasse*', therefore characterized by scarce possibility of change. *'Interpersonal deficit'* was found in 14% of the sample. According to literature, this interpersonal area is related to the least favorable outcome (Frank et al., 2009) *'Interpersonal deficit'* is often diagnosed in patients with chronic depressive spectrum symptomatology, or in subjects with social phobia. Frequently, patients with interpersonal deficits might show an extensive area of residual symptoms that occur for a long time after a depressive episode, or in the course of bipolar disorder and that are neither recognized nor, sometimes, adequately treated. Several studies showed how residual symptoms of the mood spectrum have a significant impact on quality of life (QoL) on levels of psychosocial functioning and on the increased risk of relapses or recurrences (Cassano et al., 2009; Miniati et al., 2009; Rucci et al., 2011).

We could hypothesize that in CLP settings patient's psychological suffering might derive, to a large extent, from the perception of a compromised QoL due to physical disease and to the hospitalization traumatic experience. From this point of view, it would be interesting to investigate, as a future line of research, how much of the role transition perceived by hospitalized patients can be related to the individual perception of a '*dignity loss*'. The individual perception of dignity derives from the integration, on several levels, of psychological elements considered as *'subjectively relevant order of values'* (Hack et al., 2010). Subjective dignity is based on the perception of merits acquisition, as a consequence of virtuous actions that have moral, cultural, or even aesthetic significance in a collective evaluation system (Hack et al., 2010). In *'borderline'* conditions, such as hospitalization, individual dignity can be *'hurt'* or compromised. The need that each individual has to be *'recognized'*, *'respected'*, *'interpreted'* in gestures, behaviors and words can be in dissonance with environments, contexts, conditions in which this expectation is partially or completely disregarded (Cochinov et al., 2002). The diagnosis and the implementation of treatments of '*life threatening'* pathologies, such as diseases that lead to hospitalization, can be subjectively perceived as a moment of threat not only to physical integrity, but also to individual dignity (Cochinov et al., 2002). Several studies, mainly in psycho-oncology, explored which strategies could be applied to enhance a global approach to the personal needs related to the subjective dignity perception. An adequate management of physical pain, targeted interventions on psychological suffering, proximity and support from caregivers, might have a positive impact on the hospitalized patient's QoL (Monin & Shulz, 2009). On the other hand, failure to consider these aspects at the time of the diagnostic-therapeutic process can result in subjective suffering. The need to perform analyses and to receive a diagnosis predominates over the rest. The role of a psychiatrist or of a psychologist in a liaison setting must include an approach that considers relevant not only the differential diagnosis, but also other aspects most closely related to a *'role transition'* that might be perceived by the patient as a loss of psycho-social functioning, (Frank et al., 2009) or an acute impairment of individual dignity (Cochinov et al., 2002).

Study limitations

The main limitation of the study was the one-point cross-sectional assessment, with no follow-up. A second limitation was the adoption of an unstructured clinical evaluation of the Axis I diagnosis, according to DSM-5 criteria. However, settings in which the consultations took place did not allow patients and consultants to a formal evaluation that would request a longer time. A third limitation was the wide age range of the sample, but again, this was a consequence of the feasibility design, with no exclusion/inclusion criteria. Finally, the small sample did not allow statistical comparison between patients grouped by physical disease.

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