



The relationship between the premorbid personality traits and the behavioral and psychological symptoms of Alzheimer disease



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ABSTRACT

Aim: In this study, we have aimed to investigate the relationship between the premorbid personality traits and the behavioral and psychological symptoms of Alzheimer disease.

Method: 147 dementia patients who have attended to Geriatric Psychiatry Department of Istanbul University Cerrahpaşa Medical Faculty have been selected randomly. Out of these patients, 45 Alzheimer type dementia patients whose family members or a relative could be reached are included in the study. Relatives of each patient have been asked to fill in the Munich Personality Test (MPT) – relatives form for the purpose of assessment of premorbid personality traits of the subjects.

Results: It could be stated that high level of premorbid isolation tendency and schizoidia scores are the predictors of hallucinations and aggression. Low level of premorbid frustration tolerance is found to be associated with the present anxiety and the higher Behave-AD general assessment scores.

Conclusion: We conclude that certain premorbid personality traits could be a risk factor for the later development of behavioral and psychological symptoms in Alzheimer's disease or that psychopathologic symptoms could actually be exaggerations or morbid distortions of lifelong behavioral tendencies, and it may also be explained by reflection of neuropathological processes occurring in brain in dementia onto clinic practice, in reliance upon detection of similar findings in studies conducted on different types of dementia and in different cultures. Advanced studies conducted on a sufficient number of subjects in prospective design within a biopsychosociocultural model are needed.

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1. Introduction

Alzheimer's disease (AD) is defined clinically by a gradual decline in memory and other cognitive functions and neuropathologically by gross atrophy of the brain and the accumulation of extracellular amyloid plaques and intracellular neurofibrillary tangles (Karch, Cruchaga, & Goate, 2014). The term "behavioral and psychological symptoms of dementia" is a concept used in definition of psychological reactions, psychiatric symptoms and behaviors of a dementia patient (Finkel, Burns, & Cohen, 2000). Various different studies have been conducted on neurochemical, neuropathological, environmental and social factors and premorbid personality traits towards etiology of behavioral and

psychological symptoms. The previous studies suggest that personality changes in dementia are associated with distortion of biological foundation constituting the personality traits, and are specific to disease, and are universal. However, evidences obtained from different cultures about their specificity are limited (Torrente et al., 2014). Personality traits do not only shape the response of an individual to normal aging process, but also determine the degree of his response to age-related stress and brain diseases (von Zerssen, Pfister, & Koeller, 1988).

Premorbid personality traits become more and more important day by day in research of predisposition to mental diseases. "Do the premorbid personality traits increase the predisposition to development of behavioral and psychological symptoms in Alzheimer's Disease?" question has also become a point of discussion in the recent years (Meins, 2000). However, till date, only a few studies have been conducted to study the effects of premorbid personality traits of patient on his psychological symptoms and behavioral pathologies in AD.

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In a study performed by Brandt et al. (1998), it is argued that certain premorbid personality traits constitute a risk factor for specific psychiatric symptoms subsequently developing in Alzheimer patients, or psychopathologic symptoms can actually be exaggerations or morbid distortions of lifelong behavioral tendencies (Brandt et al., 1998). In a study performed by Meins, Frey, and Thiesemann (1998), some evidences indicating that premorbid personality traits are associated with an increase in the risk of behavioral and psychological symptoms in AD have been obtained. A relation has been detected between a low level of premorbid frustration tolerance on one hand and depressive findings and symptoms on the other hand, and between a high level of premorbid emotional inconsistency on one hand and disturbing behavioral and personality changes on the other hand (Meins et al., 1998).

In a study, Chatterjee, Strauss, Smyth, and Whitehouse (1992) have determined that patients developing paranoid deliria in the progress of AD are more hostile pre-morbidly, and patients developing hallucinations in the progress of AD are open to live imaginations and fantasies pre-morbidly (Chatterjee et al., 1992). Low, Brodaty, and Draper (2002) have studied premorbid personality traits in Alzheimer patients, and have reported that higher neuroticism scores are a precursor of high delirium scores; and higher agreeableness scores are a precursor of hallucinations, aggression, affective disorder and an increase in total Behave-AD scores; and higher openness to experiences scores are a precursor of an increase in affective disorder in Behave-AD (Low et al., 2002).

Personality changes in Alzheimer patients frequently cover an increase in neuroticism, decrease in extraversion, openness to experiences and responsibility, and not much change in agreeableness (Siegler, Dawson, & Welsh, 1994). Alzheimer patients have been assessed by their spouses, and have been compared to the no-dementia period, and have been reported to be more fatherly, happier and more social before the beginning of disease (Meins and Dammast, 2000). Bauer, Stadtmüller, Qualmann, and Bauer (1995) have shown a relation between AD on one hand and premorbid inertia and spouse-dependency on the other hand (Bauer et al., 1995).

In this study, we aimed to study the relation between behavioral and psychological symptoms developing in AD and premorbid personality traits. In our country, no study has so far been performed specifically in this subject matter. We believe that this study will be a first step for the studies to be performed hereon in the future.

2. Materials and methods

We have randomly selected 147 inpatient dementia patients who have applied and attended to Geriatric Psychiatry Department of Istanbul University, Cerrahpaşa Medical Faculty. Dementia diagnosis, medical history, psychiatric examination (cognitive, psychiatric, behavioral, functional evaluation), neurological evaluation, laboratory tests (complete blood count, vitamin B12, folic acid, urea, creatinine, liver tests, thyroid function tests, HIV, Syphilis serology etc.), neuropsychological tests and brain imaging was based on the results. AD is diagnosed according to clinical properties, the Diagnostic and Statistical Manual of Mental Disorders, 4th ed, Text Revision (DSM-IV-TR) (American Psychiatric Association, 1994) and Neurological and Communicative Disorders and Stroke and the Alzheimer's disease and Related Disorders Association (NINCDS-ADRDA) criteria (McKhann et al., 1984). The diagnosis of AD can also be based on the criteria of DSM-IV-TR. The current diagnostic criteria are characterized by a two step procedure with: (i) the identification of a dementia syndrome; and (ii) the exclusion of other etiologies of a dementia syndrome,

using biological and neuroimaging exams. The diagnosis of AD has been based on the NINCDS-ADRDA criteria, according to which the diagnosis is classified as definite (clinical diagnosis with histological confirmation), probable (typical clinical syndrome without histological confirmation), or possible (atypical clinical features but no alternative diagnosis apparent; no histological confirmation) (Dubois, Picard, & Sarazin, 2009).

All patients have routinely been subject to Standardized Mini Mental Test (SMMT), behavioral pathology in dementia assessment scale (Behave-AD) and Global Destruction Scale (GDS) in clinical assessment. 45 patients who are diagnosed to be Alzheimer type dementia and whose family members or relatives may be reached are included in our study.

Data collection interviews are held preferably with relatives of first degree of the subjects, and in case of non-availability of relatives of first degree, with relatives who know the subject since long years (since at least 25 years). Patient relatives who are at least graduates of elementary school are included in the study. Two relatives of each patient are asked to fill in the Munich Personality Test – patient relatives form. We examined the correlation of total and sub-scores of Munich Personality Test, and determined that the test was sufficiently reliable. We particularly stated that in answering the scale, the patient's personality traits "of the period when the patient was physically and mentally healthy" should be described therein. That is why we believe that our study data and findings were reliable.

During the data collection process, we learned that five patients have died after the date of application to the clinic. However, as we had the required materials with respect to these patients, we included in the study their relatives who accepted to be included in the study. Clinically, we included in the study only patients who are at phase 4 according to the Global Destruction Scale. Other types of non-Alzheimer's dementias are (e.g. vascular dementia, frontotemporal dementia, Lewy-body dementia etc.) excluded since to reach more homogeneous data. Patients who have a past psychiatric disease history, and who are identified to be at phases before phase 4 according to the Global Destruction Scale, and who themselves and whose relatives live out of the town, and who do not have any relatives who may describe their premorbid personality traits (do not have any relatives knowing them since at least 25 years) are also excluded from the study. All of the subjects were patients living in the community, 41 of them living at their own home, and 4 living at homes of their children.

3. Measurements

3.1. Socio-demographical data form

A questionnaire prepared by the first author of the study. It was filled in by relatives of patients as most of the patients could not answer the questions in the form. It is a form containing such questions as age, gender, education and marital status of patient, and starting age of disease, duration of disease, and place where the patient lives.

3.2. Standardized Mini Mental Test (SMMT)

Standardized Mini Mental Test has for the first time been published by Folstein, Folstein, and McHugh (1975). It is a short, practical and standardized test, which can globally be used to determine the cognitive level. It is comprised of eleven articles collected under five main headings, namely orientation, recording memory, attention and calculation, remembrance and language, and is assessed over a total score of 30 (Folstein et al., 1975).

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