



Original article

Big Five personality traits and medically unexplained symptoms in later life

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ABSTRACT

Background: Personality dysfunction has been postulated as the most clinically salient problem of persons suffering from medically unexplained symptoms (MUS) but empirical studies are scarce. This study aims to compare the personality profile of older patients suffering from MUS with two comparison groups and a control group.

Methods: Ninety-six older patients with MUS were compared with 153 frequent attenders in primary care suffering from medically explained symptoms (MES), 255 patients with a past-month depressive disorder (DSM-IV-TR), and a control group of 125 older persons. The Big Five personality domains (NEO-Five-Factor Inventory) were compared between groups by multiple ANCOVAs adjusted for age, sex, education, partner status and cognitive functioning. Linear regression analyses were applied to examine the association between health anxiety (Whitley Index) and somatization (Brief Symptom Inventory). **Results:** The four groups differed with respect to neuroticism ($P < 0.001$), extraversion ($P < 0.001$), and agreeableness ($P = 0.045$). Post hoc analyses, showed that MUS patients compared to controls scored higher on neuroticism and agreeableness, and compared to depressed patients lower on neuroticism and higher on extraversion as well agreeableness. Interestingly, MUS and MES patients had a similar personality profile. Health anxiety and somatization were associated with a higher level of neuroticism and a lower level of extraversion and conscientiousness, irrespective whether the physical symptom was explained or not.

Conclusions: Older patients with MUS have a specific personality profile, comparable to MES patients. Health anxiety and somatization may be better indicators of psychopathology than whether a physical symptom is medically explained or not.

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1. Introduction

Medically unexplained symptoms (MUS) are physical symptoms that cannot be entirely explained by somatic disease [1]. Patients with persistent MUS report significant decreases in quality of life, impairment in daily functioning, increased high health care utilization and often undergo medical examinations and treatments unnecessarily [2–4]. This is especially relevant for frail older persons being most vulnerable for iatrogenic damage. Persistent MUS are classified within the section of somatoform

disorders in the DSM-IV-TR if a psychological origin can be assumed. This section has been replaced by somatic symptom disorders in the DSM-5 [5]. A somatic symptom disorder can be classified when physical symptoms are accompanied by maladaptive cognitions, emotions or behavior irrespective of whether the physical symptom is medically explained or not [5]. Personality dysfunction has been hypothesized to be the most clinically salient problem of patients with a somatoform disorder. The largest study on comorbidity rates hitherto showed that 50.6% of patients suffering from MUS or somatoform disorders has a comorbid personality disorder when assessed systematically with the SCID-II [6]. Smaller studies that have assessed systematically comorbidity rates with personality disorders have reported even higher rates,

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i.e. 48.0% [7], 60.6% [8], 62.9% [9], and 72.0% [10]. This contrasts sharply with clinical data of 283 patients (mean age 41 years) suffering from a somatoform disorder in which only 4.2% were considered to have axis II disorders [11]. This huge difference can most likely be explained by both referral bias in the first studies as well as under-detection of personality disorders in routine clinical care in the last study. A bit more data is available on the relationship between personality dimensions and somatization. Somatization, the tendency to experience and communicate psychological distress in the form of physical symptoms, is considered an important psychological mechanism underlying MUS. Somatization has been examined in relation to the Big Five personality profile and is, among adults, associated with a higher level of neuroticism and a lower level of agreeableness [12,13]. The only study conducted in an older sample found that a higher level of somatization was associated with a lower level of emotional stability, dominance and vigilance in 126 community-dwelling healthy older persons [14].

In later life, MUS frequently co-occurs with medically explained symptoms (MES) [15] and with affective disorders, primarily depression [16–18]. Therefore, from a clinical point of view, discrimination between patients with MUS and patients with either MES or depression seems to be more relevant than a scientifically considered healthy control group of community-dwelling elderly. Therefore, we have included two comparison groups in addition to a formal control group.

The prevalence of MES increases with ageing. This contrasts with prevalence rates for MUS and somatoform disorders, which decreases after the age of 65 [19]. These lower prevalence rates of MUS and somatoform disorders in later life as compared to younger cohorts may be an artifact: physicians might be reluctant to classify symptoms as unexplained out of fear of missing a somatic explanation [19]. Interpretation of the personality profile of older persons with MUS against a sample of older patients with MES who frequently visit their general practitioner is thus relevant (being an important differential diagnosis in clinical care). A comparison group suffering from depression can be relevant as a depressive disorder amplifies the subjective severity of somatic symptoms and is associated with functional impairment [9,20,21]. Moreover, depression in later life often has a more somatic presentation [22] and a depressed state may contaminate the personality profile [23] due to an increase in neuroticism scores and decrease of scores on extraversion, openness, and conscientiousness [24]. In other words, actual depressive symptoms seem to amplify the personality profile somewhat.

The primary aim of this study is to explore the Big Five personality traits in older patients suffering from MUS with a control group and two comparison groups, the first being frequent attenders in primary care who suffered from MES and the second being depressed older persons. The secondary aim was to explore the association between the Big Five personality traits and indices of somatization in older patients with MUS and MES and whether this differed in the two patients groups.

2. Methods

2.1. Study design and participants

Using a case-control design, we compared 118 older patients with MUS (cases) with 132 controls and with two comparison groups. The first comparison group consisted of older patients suffering from MES who frequently attend their general practitioner ($n = 154$). The second group consisted of patients suffering from a past-month major depressive disorder ($n = 275$).

Data for the present study were extracted from the Older Persons with medically Unexplained Symptoms (OPUS) study (patients with MUS and MES) and the Netherlands Study of

Depression in Older Persons (NESDO) (depressed older patients and controls). Both studies will be summarized below.

2.2. OPUS study

OPUS is a case-control study aimed to explore determinants of MUS in later life. The recruitment process was designed to compose a sample of older patients with MUS in various developmental and severity stages in order to overcome setting-specific findings. Therefore, possible participants with MUS and MES were recruited in the community by advertisements in local newspapers, in primary care, and in secondary health care. Inclusion criteria were:

- age of 60 years or above;
- MUS for at least three months according to their general practitioner (GP);
- met the definition for MUS of the Dutch College of General Practitioners, i.e. physical symptoms that have existed for more than several weeks and for which adequate medical examination has not revealed any condition that sufficiently explains the symptoms [1].

We operationalized 'several weeks' as at least three months. Also, patients were included if a so-called functional syndrome was present, i.e. fibromyalgia, chronic fatigue syndrome, irritable bowel syndrome or a whiplash syndrome [25]. Furthermore, as part of the study protocol, the unexplained nature of the patient's symptoms was checked by either a comprehensive geriatric assessment conducted by geriatrician ($n = 70$) or an additional chart review of the GP for patients refused a geriatric assessment ($n = 48$).

Exclusion criteria were:

- presence of primary psychotic disorder;
- established or suspected diagnosis of dementia;
- suffering from terminal illness;
- not sufficiently speaking the Dutch language;
- severe auditory and/or visual limitations hindering reliable data collection.

For the MES patient group (comparison group 1), we selected patients frequently consulting their primary care physician (top 20% of frequent attenders aged 60 years or above based on the medical records) for medically explained symptoms. We chose for frequent attenders for two reasons. First, we strive for a comparison group with actual severity of the primary physical complaint. This is more likely among MES who frequently visit their GP, as patients with stable chronic diseases or multimorbidity do not necessarily have actual physical symptoms. Secondly, the discrimination between MUS and MES in frequent attenders is most difficult in primary care, resulting in direct clinical relevance of differences identified in the OPUS study.

This resulted in 118 patients with MUS (12 recruited in the community, 77 in primary care, 29 in specialized health care) and 154 with MES (11 recruited in the community, 134 in primary care, 9 in specialized health care). After obtaining informed consent, data on socio-demographic, medical, psychological and social characteristics were collected in two study interviews. The Mini-International Neuropsychiatric Interview version 5.1 (MINI) [26], a semi-structured interview, was used to assess psychopathology conform DSM-IV criteria. The local Medical Ethics Committee approved the OPUS study.

2.3. NESDO study

NESDO is a multi-site naturalistic cohort study that includes 378 depressed and 132 non-depressed subjects aged 60 through

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