



Psychiatric symptoms and response quality to self-rated personality tests: Evidence from the PsyCoLaus study



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ABSTRACT

Despite the fact that research has demonstrated consistent associations between self-rated measures of personality dimensions and mental disorders, little has been undertaken to investigate the relation between psychiatric symptoms and response patterns to self-rated tests. The aim of this study was to investigate the association between psychiatric symptoms and response quality using indices from our functional method. A sample of 1,784 participants from a Swiss population-based cohort completed a personality inventory (NEO-FFI) and a symptom checklist of 90 items (SCL-90-R). Different indices of response quality were calculated based on the responses given to the NEO-FFI. Associations among the responses to indices of response quality, sociodemographic characteristics and the SCL-90-R dimensions were then established. Psychiatric symptoms were associated with several important differences in response quality, questioning subjects' ability to provide valid information using self-rated instruments. As suggested by authors, psychiatric symptoms seem associated with differences in personality scores. Nonetheless, our study shows that symptoms are also related to differences in terms of response patterns as sources of differences in personality scores. This could constitute a bias for clinical assessment. Future studies could still determine whether certain subpopulations of subjects are more unable to provide valid information to self-rated questionnaires than others.

1. Introduction

Over the last several decades, a formidable corpus of research has been provided highlighting associations between personality using self-rated tests and mental disorders. The evidence that some personality traits are either risk factors or protective factors for mental health is now consistent, and covers different disorders so far. Regarding psychiatric disorders, personality has been particularly studied among patients with major depressive disorders (Bagby et al., 1996, 1997; Huprich, 2000; Huprich et al., 2012; Quilty et al., 2013), bipolar disorders (Akiskal, 1983; Young et al., 1995; Engstrom et al., 2003; Almeida and Lafer, 2009; Quilty et al., 2009; Almeida et al., 2011; Kim et al., 2011; Jabben et al., 2012; Dupuis et al., 2016), and schizophrenia and other psychotic syndromes (Bagby et al., 1997; Lonqvist et al., 2009; Boyette et al., 2013; Gurrera et al., 2014; Schirmbeck et al., 2015).

Nevertheless, little has been undertaken in order to check whether subjects affected by mental disorders are able to provide the same response patterns compared to individuals not affected by a mental

disorder; likewise, nothing has been done to question this among individuals who suffer from subthreshold syndromes or even isolated symptoms. Despite the evidence of the relation between personality measures and mental disorders, mental disorders might be associated with something other than personality itself, namely, response patterns related to psychological status that interfere with personality measurement. Associations between personality and psychological issues also depend on factors such as age (Graham and Lachman, 2014; Lechner and Rammstedt, 2015); such associations are thus less generalizable than usually stated, and might still be attributable to confounders.

Two studies, Gurrera et al. (2005) and Gurrera et al. (2014) concluded that consistent abnormalities in personality measured in patients suffering from schizophrenia appeared to be caused by the cognitive deficits and symptoms related to the disorder. In addition, Lysaker et al. (1999) stated that these consistent differences were related to positive symptoms of schizophrenia and emotional discomfort, while Bell et al. (2007) concluded that impaired insight makes self-rated measures of some personality factors less valid. These conclusions therefore contradict the rarely questioned assumption that

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Table 1
Summary of conceptual levels and differences in observed scores.

Level	Definition	Meaning of individual differences
Trait	The latent dimension that an instrument aims to measure, its true score.	Differences in a trait are actual differences that a perfect measurement instrument is supposed to ensure once measurement error and biases are partialled out.
Responding	The voluntary and involuntary strategy adopted to respond to a questionnaire. Responding includes very different patterns; some of them correspond to response biases: situational social desirability bias (i.e. faking either good or bad), agreeing with every proposition of a questionnaire (i.e. acquiescence), completing a questionnaire with little care (i.e. insufficient effort responding), etc. Some patterns result from social (e.g. culture, gender, etc.), and some from individual characteristics (i.e. cognitive abilities, age, etc.).	Responding refers to a qualitative process, differences in responding are thus difficult to measure. Nevertheless, they imply that two true scores of a same trait are expressed in a different way which might not be comparable.
Response	The observed score on the latent construct, what the instrument actually measures: the response is an observed score or an answer which is provided to a given item.	Differences in responses are observed differences. They consist of both potential differences in traits and errors in measurement. Response-level differences correspond to differences that neither result from differences in traits nor from differences in responding, that-is-to-say to differences attributable to error in measurement.

personality might contribute to the development of schizophrenic syndromes. These findings are of major importance for psychological assessment suggesting that the sources of observed differences in test scores belong to different levels that we have summarized in Table 1. Indeed, the classical *true score theory*, assuming that an observed score is the function of the true score and a random error, could be enriched by hypothesizing that observed trait score differences are a function of trait-level differences, responding-level differences and response-level differences. *Trait-level differences* consist of true differences in a given psychological trait while *responding-level differences* are due to responding conditions, i.e. expectations, cognitive abilities, honesty, faking adequate abilities, so that some differences in test scores between individuals might be attributable to these responding-level differences. Last, *response-level differences* consist of the differences in scores among individuals that are neither attributable to difference in traits nor attributable to differences in responding, corresponding to the errors in measurement, including transient errors (Schmidt et al., 2003). This distinction between response-level differences and responding-level differences is also consistent with recent research that highlighted that differences in self-reported personality tests can be induced by the weather (Rammstedt et al., 2015), or by experimentally induced emotional states (Querengässer and Schindler, 2014) which are linked to responding-level differences. Yet, such an approach is still unique and should be applied to different populations in order to generalize the results, which is the purpose of the current study.

Concerning personality tests, differences in response consistency across individuals have been largely discussed. In particular, authors like Tellegen (1988) or Reise and Waller (1993) have introduced the concept of *traitedness*, referring to the extent to which a respondent's answers to a given test fit the trait construct, and they have provided techniques in order to assess variation in *traitedness* based on item response theory. They concluded that *traitedness* is a phenomenon of high importance for psychological assessment that might lead to major methodological issues and that measuring such a phenomenon is difficult.

From a different theoretical perspective, Gendreau has developed the *functional method* as a new scoring method that consists of modeling individual response patterns in multidimensional questionnaires (Dupuis et al., 2015). Based on response modeling, Gendreau and colleagues proposed various indices (two of them specific to the functional method) to estimate the overall quality of a set of responses to a given self-rated test, and to determine whether the responses are valid enough for interpretation. These indices (*detailed below*) are useful to answer four main questions about response patterns: *how coherent, predictable and informative they are? How stable and reliable they are? How normative or even banal the responses are?*

How many positive and negative aspects are assumed in self-description? Such indices are thus interesting in order to highlight responding-level-differences.

The only application of the functional method to psychiatric patients published so far has highlighted that subjects suffering from schizophrenia provided less coherent and less stable self-descriptions that were thus less reliable (Boulangier et al., 2013). Moreover, an application of the method to subjects from the general population resulted in important differences in responses that were associated with bipolar disorder, although they were not directly attributable to the disorder itself but to its correlates (Dupuis et al., 2016). Yet, the functional method was introduced to the English-speaking scientific community only very recently (Dupuis et al., 2015), and systematic investigation of the role of psychopathological issues in responses to self-rated questionnaires remains largely unstudied.

The aim of this study was thus to use this new method to measure the associations between psychiatric symptoms and the response quality of a self-rated personality test in a community-based sample in Switzerland.

2. Methods

2.1. Study design

Cross-sectional data from the CoLaus|PsyCoLaus cohort study (Firmann et al., 2008; Preisig et al., 2009), a population-based study conducted in the city of Lausanne in the French-speaking region of Switzerland, was used. Briefly, the CoLaus study assessed cardiovascular risk factors and diseases and collected various genetic variants and biomarkers. The baseline recruitment and medical assessment of the CoLaus sample, which was completed between 2003 and 2006, has already been described in detail (Firmann et al., 2008). CoLaus was completed with a psychiatric assessment (PsyCoLaus) conducted after an interval of approximately one year (Preisig et al., 2009). Participants were recontacted five years after the initial somatic and psychiatric assessment s, respectively, in order to complete the follow-up investigation s, and the follow-up of PsyCoLaus also included self-reported measures similarly to the PsyCoLaus baseline assessment. Indeed, during the psychiatric parts, subjects were asked to complete a set of psychological self-questionnaires at home and to send them back to the research unit by post. Some additional self-report measures were introduced at the PsyCoLaus follow-up assessment. This study focuses on data from the follow-up of PsyCoLaus. Participation was voluntary and only transportation costs to the sites where the investigations took place were reimbursed.

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