

An Investigation of Temperamental Traits in Patients With Somatoform Disorder: Do They Belong in the Affective Spectrum?

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Background: *About 10% of the general population report multiple and persisting physical symptoms resulting in extensive screening but with no organic explanation found.* **Objective:** *The authors sought to determine whether these somatoform-disorder patients show characteristics of the affective disorder spectrum, with the cyclothymic temperament likely showing the highest specificity for somatoform disorder.* **Method:** *This study examined temperamental traits and current mood states of 44 general-hospital inpatients diagnosed with somatoform disorder.* **Results:** *There was a higher prevalence of abnormal temperamental traits in patients with somatoform disorder.* **Conclusion:** *Based on the idea of a continuum between temperament and affective disorders, the results should trigger further research on this issue possibly leading to novel treatment options in the future.* (Psychosomatics 2009; 50:605–612)

Physical complaints not fully explained by somatic disorders are a common phenomenon in primary care. About 10% of the general population report multiple and persisting physical symptoms, often resulting in extensive, but frustrating diagnostic screening when no organic explanation is found.¹ Patients with somatoform disorder (SD) utilize medical care services approximately twice as often and cause twice the volume of expense for medical care as medically ill patients without SD.² Medical staff are often frustrated as SD patients do not readily accept “normal” findings and repeatedly ask for further physical diagnostics.³ Psychopathologically, patients with SD suffer from persistent affective dysregulation and emotional instability,^{4–6} and often lack any insight into the psychological components of their disease (similar to (hypo)manic/mixed patients), which hampers adequate psychosomatic or pharmacological treatment.⁷

The pathogenetic and biological factors underlying the process of somatization are not fully understood to date. Neurocognitive disturbances, for example, difficulties in cognitive-emotional processing, called alexithymia, and personality traits, for example, high Harm-Avoidance scores as measured by the Temperament and Character Inventory (TCI),⁸ have been reported in SD.⁹ Moreover,

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Temperament Traits in Somatoform Disorder

increased cortisol levels,¹⁰ changes in brain structure,¹¹ and alterations of regional cerebral function,^{12,13} have been found in SD. Hakala et al.¹³ recently reported an association of low Novelty-Seeking and high Harm-Avoidance scores with low glucose metabolism in the caudate and putamen as demonstrated by 18-fluorodesoxyglucose positron emission tomography (18FDG-PET) in severe SD. In contrast, another study, also using the TCI, did not find specific temperamental traits in SD patients.¹⁴

Originally, Emil Kraepelin¹⁵ described four temperamental traits (depressive, manic, irritable, and cyclothymic) and believed that these are not only basic affective dispositions, but also subclinical types of affective psychosis. Later, Akiskal et al. changed the “manic” temperament to “hyperthymic” and added a “generalized anxious temperament.”^{16–18} The conceptualization of these five temperaments led to the development of an operational instrument, the Temperament Evaluation of Memphis, Pisa, Paris, and San Diego, CA (TEMPS), as well as a self-rating questionnaire (TEMPS–A), with 109 (for men) and 110 (for women) items.¹⁹ The English,^{19,20} French,^{21,22} Spanish,²³ and German versions²⁴ show robust psychometric characteristics and good validity. A brief and clinically more practical version, consisting of 35 items (briefTEMPS–M), has been validated in German.^{25,26}

Temperament, as an enduring aspect of personality, best captures stable behavior, predicts mood changes, and is influenced in part by genetic constitution.^{27–29} The modern concept of affective disorders focuses increasingly on the study of subthreshold conditions that border on manic or depressive conditions. Mendlowicz et al.³⁰ demonstrated that relatives of patients with bipolar disorder scored higher in the cyclothymic and anxious temperament domains than did normal-controls, but lower than euthymic bipolar patients. Thus, Akiskal et al.³¹ suggested classifying the cyclothymic temperament within the bipolar spectrum, termed bipolar disorder II 1/2.

Other investigators have also proposed including temperamental traits into the bipolar spectrum, ranging from abnormal temperament (bipolar disorder I and II) to schizoaffective disorder.³² Furthermore, affective disorders and abnormal temperament are also diagnosed in patients suffering from migraine³³ and bulimia.³⁴ Therefore, affective temperament might be considered to be an intermediate step between pheno- and genotypes in affective disorders, sharing a common genetic or pathophysiological disposition with various other psychiatric or somatic diagnoses/symptoms.

In our study, we investigated temperamental traits of patients with SD as compared with an age- and gender-matched control group of 44 patients admitted for psychiatric evaluation before a transplantation procedure. The primary hypothesis of the study was that SD patients show a persistent affective dysregulation and emotional instability, also explained by abnormal temperament traits and therefore belonging in the affective spectrum.

METHOD

Between 2004 and 2005, of 323 patients who were routinely assessed by our psychiatric consultation–liaison (C–L) service at the University Hospital Munich, Germany-Grosshadern and who were able to fill out the questionnaires, 51 patients were considered as suffering from SD. The process of diagnosis was established on the basis of an extensive diagnostic interview using ICD–10,³⁵ DSM–IV³⁶ criteria, and the Screening for Somatoform Symptoms (SOMS). The SOMS is an established self-rating questionnaire that includes all items relevant for SD, showing high internal consistency and validity.³⁷

Also, demographic data were documented, and a complete somatic and psychiatric history was recorded by an experienced psychiatrist (BA, TB, or GL). It should be emphasized that all patients with SD had been investigated thoroughly in several peripheral general hospitals over some years, but no somatic diagnoses accounting for all their symptoms had been found. However, 7 out of 51 patients in the SD group ultimately did not fulfill diagnostic criteria for SD and therefore were excluded of our analysis. The remaining 44 patients were diagnosed following ICD–10 criteria with somatization disorder (N=17), autonomous somatoform disorder (N=8), chronic somatoform pain disorder (N=4), and dissociative disorder (N=15). After being given the ICD–10 SOMS questionnaire, 10 patients were diagnosed with SD and 15 with autonomous somatoform disorder.

The control group consisted of 44 patients who were admitted to our psychiatric C–L service for routine psychiatric assessment before heart, liver, or kidney transplantation. The control group was selected so as to match SD patients in age and gender.

Besides the clinical interview and the SOMS used for diagnosis, all patients were asked to complete the following self-rating battery: The Beck Depression Inventory (BDI),^{38,39} the Self-Report Manic Inventory (SRMI),^{40,41} and the briefTEMPS–M25, which consists of 35 ques-

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