PRE-MORBID PERSONALITY IN THE FUNCTIONAL PSYCHOSES OF THE SENIUM. A COMPARISON OF EX-PATIENTS WITH HEALTHY CONTROLS

By

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Introduction

In the last few years many studies have appeared relating directly or indirectly to the role of adjustment in the ageing process. What factors influence the adaptability of the elderly person to his or her own disability, isolation or approaching death? In general the studies done by sociologists stress the importance of the social situation in which these persons find themselves. P. Townsend's book "The Family Life of Old People" (1957), the articles of Havighurst (1958) and his group in Chicago, and of Post (1958) are examples of this view. In what may be regarded in some way as a reaction to this tendency, we have the theory of disengagement of Cumming *et al.* (1960), in which "ageing is seen as an inevitable mental withdrawal or disengagement resulting in decreased interaction between the ageing person and others in the social system to which they belong". But it is Irving Rosow (1960) who emphasizes this point more clearly. After critically reviewing diverse approaches, he states (and I quote from different paragraphs throughout his paper), "The root of the problem lies in regarding adjustment as a state or a condition at a point in time". "What gerontologists have called adjustment is actually the result of the product of the ageing process". "Thus it follows that the only way to evaluate conditions in later life is to compare them with some earlier patterns". From there on he presents his own sociological theory of adjustment. Strengthening this view still further, a psychologist, Robert Peck (1960), reporting on one phase of the "Kansas Study of Adult Life" by the University of Chicago Committee on Human Development writes, "Adjustment to middle age and old age, in so far as it has been measured in this research, seems largely determined by personality characteristics which have been laid down earlier in life". It is psychiatrists, however, who have insisted on the importance of the previous personality in the problems related to ageing, as may be noted in the publications of Cameron (1956) and Roth (1959).

Roth writes (1959), "Our knowledge of the long-term changes in the organization of traits, in motivation and feeling, in emotional control and expression during the life-span is of a rudimentary kind. Still less do we have any precise data about the bearing of temperamental attributes in maturity upon the fate of the individual in senescence". Further on, he remarks, "Clinical observation does suggest that those whose adult life has been marked by unhappiness, unfulfilled yearnings and aspirations without compensatory satisfactions, and by mental ill-health in general, are more likely to be the subjects of mental illness in old age than those in whom personality has permitted a rich and harmonious life previous to senescence".

Purpose of the Present Study

A comparative study was made of a group of persons over the age of sixty-five years who had a primary mental breakdown (excluding organic

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states) after their sixtieth year, with another group who showed no such antecedent and who had led what might be termed an acceptably normal existence. We attempted to investigate, as far as possible, their previous personalities, social histories and their present adjustment.

Our aim was to try to elicit some common patterns in the previous personality of one group which would distinguish it from the opposing group.

Methodology and Material

Two groups of twenty-five persons were studied. The "patient" group was made up of ex-patients from the psychiatric divisions of the two principal hospitals of Newcastle upon Tyne. The "normal' group consisted of mentally normal subjects chosen from files compiled during a field survey of elderly people living at home, carried out by Professor Roth and Dr. Kay (Kay and Roth, 1961). The subjects were sent a letter requesting their co-operation in the study and enclosing a simple form, bearing return postage, on which they could show whether or not they were agreeable to participate in the project.

As far as possible, an effort was made in compiling these two groups to maintain an equal distribution in respect of age, sex, civil and economic status and home setting, since we wished to eliminate any possible effect of these variables. Table I demonstrates to what extent we succeeded in achieving this.

Table I

Distribution of Sex, Age, Civil State and Home Setting among Patients and Normals

Sex	Patients	Normals	*Civil State*	Patients	Normals
Males ...	5	6	Single	2	2
Females ...	20	19	Married	7	9
			Widowed	16	14

Age	Patients	Normals	*Home Setting*	Patients	Normals
65–69 ...	11	3	Living alone	6	9
70–74 ...	7	15	Living with spouse (with or without children) ...	7	9
75–79 ...	6	3			
80–84 ...	1	3	Living with another relative or friend	12	7
85–89 ...	0	0			
90–94 ...	0	1			

It was necessary to write to fifty-six "normals" in order to obtain twenty-five subjects. The selection of the "patients" was much simplified by the fact that it was possible to approach them on a "follow-up after discharge from hospital" basis and for this reason they were more easily available and agreed more readily to be interviewed. Our purpose in making this further assessment was explained to them at the time of interview.

Each person was interviewed by the doctor and, in many instances, also by a social worker. The emphasis in the interview was distributed over three main points, i.e. social history, personality in middle age and present adjustment. The questionnaire used in the field survey mentioned above for the collection of social data was used, as it was already available in the files of the "normal" group, and in the "patient" group it was filled in by the doctor at the time of the interview. We relied on the clinical histories from the hospitals and the medical questionnaires from the survey in establishing the physical status of the subjects.

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In the interview we did not use direct questioning but tried rather to obtain a general history, while introducing into the conversation the points in which we were particularly interested. The disadvantage of this method was that we did not always obtain the clear-cut answers we should have liked. We felt, however, that it was an advantage to have the interview conducted in a more natural manner which gave the information obtained more validity. An attempt was always made to interview a relative who had had close contact with the subject over an extended period of time. We stressed in these interviews the same points that were stressed in the interviews with the subjects. When relatives were not immediately available for interview, questionnaires were forwarded to them, with the permission of the subjects, in which they could give assessments of the previous personality and present adjustment.

The plan to use psychological testing was abandoned when the psychologists consulted decided that there were no tests available which would give an accurate picture of the previous personality. This was not entirely to our satisfaction, but we decided to proceed with our project and regard it more as a pilot study, believing that the resultant difficulties encountered in evaluating the previous personality might prove of assistance to future research in this field.

In Table II we have listed the thirty-six features termed '*personality traits*' which we attempted to assess. When we were unable to obtain a clear answer

TABLE II

Personality Traits about which Information was Obtained

1	Sociability (enjoyment of social activity)
2	Ease in making friends
3	Ability to retain friends
4	Isolation
5	Field of interest (narrow—broad)
6	Attitude towards relatives (interested—disinterested)
7	Warm-heartedness (kind, affectionate, sympathetic)
8	Demonstrativeness
9	Introversion
10	Seriousness
11	Shyness, timidity
12	Depressed, gloomy disposition
13	Mood swings
14	Emotional tendencies (easy crying), sensitiveness
15	Anxiety-proneness
16	Chronic tendency to worry
17	Tendency to phobic reactions
18	Meticulousness, perfectionism
19	Tendency to doubts, irresolution
20	Hasty temper, irritability
21	Resentfulness
22	Hostile or aggressive disposition
23	Quarrelsomeness
24	Stubbornness
25	Tolerance of others
26	Rigid code of ethics
27	Suspicious, distrustful attitude
28	Reserve, reticence
29	Jealousy
30	Selfishness, selfcentredness
31	Snobbishness, aloofness, superiority
32	Good sexual adjustment
33	Activeness
34	Climacterium: neurotic manifestations
35	Childhood: neurotic traits
36	Adolescence: neurotic traits

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concerning a particular trait or when the statement of the subject and that of the relative were contradictory or when the subject did not consider the feature in question characteristic of his personality, we did not tabulate the response.

We evaluated the personality traits about which we obtained satisfactory information as + (present) or — (absent). Although in some cases ++ or —— denoted more accurately the intensity of the trait elicited, we have omitted showing this on our tables to make them simpler. These findings were then divided into "favourable" and "unfavourable". The "favourable" findings were those we considered to be closest to normal. For example, the — response to "tendency to phobic reactions" and the + response to "attitude towards relatives" were taken as favourable.

With the aid of Dr. D. Kay, we divided the thirty-six personality traits into five classes (table III), attempting to group together those traits felt to be closely related. As a result of this, we have in Class I traits related to social and personal relationships. Class II is made up of manic-depressive tendencies.

TABLE III

Method of Grouping of Personality Traits

Class I Social and personal intercommunication tendencies
1 Sociability
2 Ease in making friends
3 Ability to retain friends
4 Isolation
5 Field of interests
6 Attitude towards relatives (interested—disinterested)
7 Warm-heartedness
8 Demonstrativeness
28 Reserve, reticence
33 Activeness

Class II Manic-depressive tendencies
12 Depressed, gloomy disposition
13 Mood swings

Class III Hypersensitivity and phobic-anxiety tendencies
14 Emotional tendencies
15 Anxiety proneness
16 Chronic tendency to worry
17 Tendency to phobic reactions
9 Introversion
10 Seriousness
11 Shyness, timidity

Class IV Obsessive-compulsive tendencies
18 Meticulousness
19 Tendency to doubts
24 Stubbornness
25 Tolerance of others
26 Rigid code of ethics

Class V Paranoid tendencies
20 Hasty temper
21 Resentfulness
22 Hostile or aggressive disposition
23 Quarrelsomeness
27 Suspicious, distrustful attitude
29 Jealousy
30 Selfishness
31 Snobbishness, aloofness

Under Class III we have grouped features demonstrating hypersensitivity and phobic anxiety tendencies. Class IV lists the obsessive-compulsive tendencies

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and Class V the paranoid and hostile ones. We have not included in these five groupings the personality traits numbers 32, 34, 35 and 36. We recognize that the grouping of the traits into these five classes may appear to be somewhat artificial but it was felt that it might give us a clearer demarcation between the two groups under study.

Table IV lists the *social and family data* which we recorded. The information collected in this connection was evaluated on the scale 1-2 or 1-2-3 owing to the presence of a greater range of difference in certain of the items in this division. Here again the responses have been assessed as being favourable or unfavourable in instances where the type of response permitted this classification. The eleven of the fifteen responses so qualified are denoted by * in Table IV. The similarity among certain of these eleven items facilitated an easy division into three classes. Under Class I we have concentrated items relevant to family background. Class II lists what may be considered as recent physical and psychic traumas and Class III includes items related to present social adjustment.

TABLE IV

Social and Family Data

Unclassified Family Data
- 1 Position among siblings
- 2 Number of children
- 3 Age of patient when parents died
- 4 Age on marriage

Class I Family background
- 5* Subjects' opinion about their childhood
- 6* Subjects' opinion about school life
- 7* Subjects' opinion about their parents
- 8* Subjects' opinion about their marriage

Class II Recent physical and psychic traumas
- 9* Physical condition
- 10* Bereavements
- 11* Apparent reason for breakdown

Class III Present social adjustment
- 12* Contact with relatives
- 13* Contact with friends
- 14* Social life, membership of a Church or club
- 15* Use of time, hobbies

RESULTS

We shall first show the results of the enquiry into *personality traits*. Table V illustrates the number of responses tabulated in relation to these traits, their division into + and −, and their grouping into favourable and unfavourable.

On application of χ^2 to the answers in Table V we find that there are significant or highly significant differences between the "patients" and the "normals" in six traits. These are shown in Table VI. Seven additional χ^2 results which come very close to being significant also appear in this table.

When the personality traits are arranged in the five groups and the number of favourable and unfavourable responses are added together we have the picture shown in Table VII. On applying χ^2 to these figures we find that there are highly significant differences between the responses of the patients and the normals in all five groups.

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TABLE V

Personality Traits: Numbers of Responses Grouped into Favourable and Unfavourable

		Patients		Normals	
		F.	Unf.	F.	Unf.
1	Sociability	+15	−10	18	7
2	Ease in making friends	+13	−12	20	5
3	Ability to retain friends	+14	−11	22	3
4	Isolation	−17	+ 7	23	1
5	Field of interest (narrow—broad)	+ 9	−16	17	8
6	Attitude towards relatives	+20	− 5	25	0
7	Warm-heartedness	+16	− 6	21	4
8	Demonstrativeness	+ 7	−15	11	12
9	Introversion	− 7	+10	11	9
10	Seriousness	−10	+14	12	10
11	Shyness, timidity	− 9	+13	11	10
12	Depressed, gloomy disposition	−12	+13	22	3
13	Mood swings	−12	+12	21	4
14	Emotional tendencies, sensitiveness... ...	− 3	+19	9	16
15	Anxiety proneness	− 9	+14	18	7
16	Chronic tendency to worry	−11	+12	20	5
17	Tendency to phobic reactions	− 9	+11	17	5
18	Meticulousness	− 8	+17	9	16
19	Tendency to doubts, irresoluteness	− 5	+ 9	9	3
20	Hasty temper, irritability	− 8	+17	14	11
21	Resentfulness	− 8	+ 4	12	5
22	Hostile or aggressive disposition	−14	+ 1	20	2
23	Quarrelsomeness	−17	+ 4	22	2
24	Stubbornness	− 2	+ 9	4	9
25	Tolerance of others	+ 3	− 9	16	1
26	Rigid code of ethics	− 2	+ 5	10	7
27	Suspicious, distrustful attitude	− 7	+12	14	6
28	Reserve, reticence	− 9	+12	7	12
29	Jealousy	−20	+ 4	24	1
30	Selfishness, selfcentredness	−12	+10	21	4
31	Snobbishness, aloofness, superiority ...	−13	+ 6	21	3
32	Good sexual adjustment	+12	− 3	11	5
33	Activeness	+19	− 4	24	1
34	Climacterium: neurotic manifestations ...	− 2	+ 9	11	2
35	Childhood: neurotic traits	−20	+ 4	24	1
36	Adolescence: neurotic traits	−19	+ 5	25	0
	Totals ...	393	344	596	200
		737		796	

Possible number of answers ... 900

% of answers from patients ... 737·100 = 81·88%

% of answers from normals ... 796·100 = 88·44%

χ^2 of difference between patients and normals = 77·27 d.f. 1 (P < ·0001)

Moving on to the social and family data, when we apply χ^2 to the results which are shown in Table IV we discover that the only trait significantly different between the patients and the normals is "Apparent reason for breakdown" (χ^2=4·631, P=<·05). By the term "Apparent reason for breakdown" we mean factors which could be considered to have precipitated the patients' breakdown (e.g. physical disability, bereavement, departure of relatives) and which could be supposed to have carried a risk of breakdown in the normals.

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Two additional traits showed up here as being very close to being significant when χ^2 was applied. These are "Frequency of contact with friends" and "Subjects' opinion of their parents". When the responses relating to the eleven social and family data classifiable into favourable and unfavourable are compared, we see that the differences between the sums of the favourable and unfavourable responses from patients and normals are highly significant ($P < \cdot 01$) (Table VIII).

TABLE VI

Traits showing Significant or Highly Significant Differences between Patients and Normals

	Trait	χ^2	P
3	Ability to retain friends (poor) ...	$\chi^2 = 4 \cdot 861$	$P = < \cdot 05$
5	Field of interests (narrow)	$\chi^2 = 3 \cdot 962$	$P = < \cdot 05$
12	Depressed, gloomy disposition ...	$\chi^2 = 7 \cdot 44$	$P = < \cdot 01$
15	Anxiety proneness	$\chi^2 = 4 \cdot 01$	$P = < \cdot 05$
16	Chronic tendency to worry	$\chi^2 = 4 \cdot 105$	$P = < \cdot 05$
25	Tolerance of others	$\chi^2 = 11 \cdot 972$	$P = < \cdot 001$

Traits Close to Showing Significant differences

	Trait	χ^2	P
2	Ease in making friends	$\chi^2 = 3 \cdot 208$	$P = < \cdot 10 > \cdot 05$ (all)
4	Isolation	$\chi^2 = 3 \cdot 75$	
13	Mood swings	$\chi^2 = 3 \cdot 185$	
17	Tendency to phobic reactions ...	$\chi^2 = 3 \cdot 359$	
27	Suspiciousness	$\chi^2 = 3 \cdot 079$	
30	Selfishness	$\chi^2 = 3 \cdot 548$	
36	Adolescence: neurotic traits ...	$\chi^2 = 3 \cdot 75$	

D.F. of all above $\chi^2 = 1$

TABLE VII

Distribution of Responses among Five Main Groups of Personality Traits

	Patients		Normals	
	F.	Unf.	F.	Unf.
Class I				
Social and personal intercommunication tendencies	139	98	188	53
$\chi^2 = 19 \cdot 84$ d.f. 1 $P = < \cdot 0001$				
Class II				
Manic-depressive tendencies	24	25	43	7
$\chi^2 = 13 \cdot 86$ d.f. 1 $P = < \cdot 001$				
Class II				
Hypersensitivity and phobic-anxiety tendencies	58	93	98	62
$\chi^2 = 15 \cdot 85$ d.f. 1 $P = < \cdot 0001$				
Class IV				
Obsessive-compulsive tendencies	20	49	48	36
$\chi^2 = 11 \cdot 05$ d.f. 1 $P = < \cdot 001$				
Class V				
Paranoid tendencies	99	58	148	34
$\chi^2 = 13 \cdot 31$ d.f. 1 $P = < \cdot 001$				

However, if we apply χ^2 to the numbers after dividing them into the three classes previously mentioned we see that the only class of social and family data remaining significantly different between the patients and the normals is "Recent physical and psychic traumas" ($P < \cdot 05$) (Table VIII).

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TABLE VIII

Social and Family Data: Differences between Patients and Normal Group

	Patients		Normals	
	F.	Unf.	F.	Unf.
Class I Family Background				
Subjects' opinion about their childhood ...	17	7	13	6
Subjects' opinion about their school life ...	13	9	16	4
Subjects' opinion about their parents	9	8	14	8
Subjects' opinion about their marriage ...	18	4	20	3
Sum of scores ...	57	28	63	21
$\chi^2 = 0{\cdot}93$ d.f. 1 $P = < {\cdot}5 > {\cdot}25$				
Class II Recent Physical and Psychic Traumas				
Physical condition	8	17	13	12
Bereavements	10	15	13	12
Apparent reason for breakdown	0	25	7	18
Sum of scores ...	18	57	33	42
$\chi^2 = 5{\cdot}82$ d.f. 1 $P = < {\cdot}05$				
Class III Present social adjustment				
Contact with relatives	22	3	22	3
Contact with friends	14	11	19	6
Social life, membership of a Church or Club...	13	12	14	11
Use of time, hobbies	22	3	25	0
Sum of scores ...	71	29	80	20
$\chi^2 = 1{\cdot}73$ d.f. 1 $P = < {\cdot}25 > {\cdot}1$				
Sum of all classes ...	146	114	176	83
$\chi^2 = 7{\cdot}67$ d.f. 1 $P = < {\cdot}01$				

DISCUSSION AND CONCLUSIONS

I. Have we sufficient basis to conclude that there is a difference in previous personality between persons whom we have considered to have a normal ageing process and those who have demonstrated a mental breakdown in senescence?

If we can accept the results obtained in our survey as being relatively correct, our answer is yes.

We fully realize that to obtain a more statistically acceptable result, this survey might profit by being extended over a greater number of subjects and perhaps more precision might be used in defining the traits explored, but we feel, in principle, that the findings obtained would be very similar.

We begin to see a slight difference between the two groups when we compare the + and − responses in respect of individual traits as shown in table VI. Two traits show a very marked difference between the two groups ($P < {\cdot}01$), four a marked difference ($P < {\cdot}05$) and in seven the scores, although not reaching the necessary statistical level, are near enough to warrant our attention. These thirteen traits which prove to be outstanding comprise a broad spectrum of the characteristics of a personality. But the difference between the two groups becomes very highly significant ($P < {\cdot}0001$) when the sums of the

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favourable and unfavourable responses are compared (Table V). There could be disagreement about labelling two or three of the traits in this manner as, for example, trait 28. Should "being reserved" be considered favourable or unfavourable? However, the debatable scoring of a few traits is not important enough to affect the overall difference found to exist between the two groups.

II. Are our findings grouped in a way that will allow us to say that a particular type of previous personality is more prone to suffer a mental breakdown in senescence?

The answer is no. In this survey we were unable to discover the specificity found to exist in the previous personalities of patients with an involutional psychosis in other studies (Titley, 1936; Palmer, 1938; Vispo, 1954 and 1956).

In making the division of the thirty-six personality traits into the five classes (Table III), I requested the assistance of Dr. Kay in order to avoid any unconscious wish on my part to segregate them in a manner which could be considered biassed. The difference illustrated here between the two groups is striking (Table VII), since it is highly significant in all five classes, leading one to believe that a general vulnerability exists in the entire personality structure. Could we then, perhaps, speak of a labile adaptability throughout life which in senescence is incapable of keeping the personality intact when it is confronted with the close proximity of death, which, consciously or unconsciously, inevitably must be accepted? Are not isolation, retirement, increasing physical disabilities and bereavements symbolic representations for our unconscious of the approaching end?

The importance given to the subject of death by older persons is exhibited in the symposium held in San Francisco in August 1960 during the Fifth Congress of the International Association of Gerontology. Here, Rhudick and Dibner (1961) found no relationship between "high death concern" and such demographic variables as age, sex, occupational status, marital status or education; but "high death concern" was associated with high scores on the MMPI dimensions of Hypochondriasis, Hysteria, Dependency and Impulsivity. Nine of our patients are described in their hospital clinical histories as being hypochondriacal; none of the normals can be so described. Rhudick and Dibner interpreted their findings as meaning that concern over death involves neurotic preoccupation, particularly in relation to bodily symptoms. In making his comments at this same symposium, Feifel (1961), a recognized authority in the field of "death attitudes", states: "Death is a multi-faceted symbol whose specific import depends on the nature of the individual's development and his cultural context". And I add, while on the one hand our present society prepares us quite thoroughly for the prospect of atomic annihilation, on the other, it paves the way for longevity and permits us to place the more natural forms of demise almost entirely into the background.

III. Were there differences between the two groups in the sphere of "social and family traits"?

Of the fifteen social and family traits taken to be the variables under study, the only one demonstrating a significant difference between the two groups was "Apparent reasons for breakdown". Yet, eighteen of the twenty-five normals under investigation also presented what could be taken as justifiable reasons for breakdown (as seen in Table VIII). If we are to consider the classified physical disabilities and bereavements as being the sole cause of breakdown in senescence, what explanation can be given for the fact that this did not occur in the eighteen

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normals? We can only account for this if we look upon "Apparent reasons for breakdown" as being simply the precipitating factors in a predisposed personality. It then becomes clear that the ability to manage and resolve these precipitating factors, so often made synonymous with death in the mind of the aged person, is what will determine the difference between a good and bad adaptability to ageing.

I am aware that I may be considered to have gone perhaps a little far in my interpretation of the results but, nevertheless, I present them as hypotheses for further study and confirmation. In essence these are:

1. That adaptability and adjustment in a normal ageing process depend fundamentally on the previous personality.

2. That the premorbid personality of those individuals who suffer a primary mental breakdown in senescence shows a diffusion of neurotic tendencies, as opposed to the more restricted range of neurotic tendencies described in connection with Involutional Psychoses.

3. That the approach of death presents a final challenge, which the neurotic personality may be unable to meet.

Summary

I. A clinical study was made of fifty subjects aged 65 years and over. Twenty-five were ex-psychiatric patients of the two principal hospitals of Newcastle upon Tyne, and all of them had suffered a primary (non-organic) nervous breakdown after the age of 60. The remaining twenty-five were a group exhibiting an apparently normal senescence and were selected from subjects taking part in a field survey being carried out in the same city.

II. All the subjects, and in most cases a relative as well, were interviewed by the author, with the object of comparing the previous personality, present adjustment and social history of the two groups.

III. The results are discussed and some hypotheses presented.

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