

Maternal personality profile of children affected by migraine

Maria Esposito¹
 Michele Roccella²
 Beatrice Gallai³
 Lucia Parisi²
 Serena Marianna Lavano⁴
 Rosa Marotta⁴
 Marco Carotenuto¹

¹Center for Childhood Headache, Second University of Naples, Naples, Italy; ²Department of Psychology, University of Palermo, Palermo, Italy; ³Unit of Child and Adolescent Neuropsychiatry, University of Perugia, Perugia, Italy; ⁴Department of Psychiatry, Magna Graecia University of Catanzaro, Catanzaro, Italy

Background: Empirical evidence of the important role of the family in primary pediatric headache has grown significantly in the last few years, although the interconnections between the dysfunctional process and the family interaction are still unclear. Even though the role of parenting in childhood migraine is well known, no studies about the personality of parents of migraine children have been conducted. The aim of the present study was to assess, using an objective measure, the personality profile of mothers of children affected by migraine without aura (MoA).

Materials and methods: A total of 269 mothers of MoA children (153 male, 116 female, aged between 6 and 12 years; mean 8.93 ± 3.57 years) were compared with the findings obtained from a sample of mothers of 587 healthy children (316 male, 271 female, mean age 8.74 ± 3.57 years) randomly selected from schools in the Campania, Umbria, Calabria, and Sicily regions. Each mother filled out the Minnesota Multiphasic Personality Inventory – second edition (MMPI-2), widely used to diagnose personality and psychological disorders. The *t*-test was used to compare age and MMPI-2 clinical basic and content scales between mothers of MoA and typical developing children, and Pearson's correlation test was used to evaluate the relation between MMPI-2 scores of mothers of MoA children and frequency, intensity, and duration of migraine attacks of their children.

Results: Mothers of MoA children showed significantly higher scores in the paranoia and social introversion clinical basic subscales, and in the anxiety, obsessiveness, depression, health concerns, bizarre mentation, cynicism, type A, low self-esteem, work interference, and negative treatment indicator clinical content subscales ($P < 0.001$ for all variables). Moreover, Pearson's correlation analysis showed a significant relationship between MoA frequency of children and anxiety ($r = 0.4903$, $P = 0.024$) and low self-esteem ($r = 0.5130$, $P = 0.017$), while the MoA duration of children was related with hypochondriasis ($r = 0.6155$, $P = 0.003$), hysteria ($r = 0.6235$, $P = 0.003$), paranoia ($r = 0.5102$, $P = 0.018$), psychasthenia ($r = 0.4806$, $P = 0.027$), schizophrenia ($r = 0.4350$, $P = 0.049$), anxiety ($r = 0.4332$, $P = 0.050$), and health concerns ($r = 0.7039$, $P < 0.001$) MMPI-2 scores of their mothers.

Conclusion: This could be considered a preliminary study that indicates the potential value of maternal personality assessment for better comprehension and clinical management of children affected by migraine, though further studies on the other primary headaches are necessary.

Keywords: MMPI-2, childhood migraine, maternal personality

Correspondence: Lucia Parisi
 Child Neuropsychiatry, Department of Psychology, University of Palermo, 15 Viale delle Scienze, Palermo 90128, Italy
 Tel +39 091 2389 7756
 Fax +39 091 651 3825
 Email lucia.pari@unipa.it

Introduction

Migraine without aura (MoA) may be considered the most frequent primary headache in childhood.¹ Children affected by migraine have been consistently shown to have more recurrent illnesses² and school absences, decreased academic performance, social stigma, and impaired ability to establish and maintain peer relationships.^{3,4} In

fact, the quality of life in children with migraine has been shown to be impaired to a degree similar to that in children with arthritis or cancer.⁵

In order to improve the quality of life of children affected by MoA, alternative drugs and methods have been applied to limit adverse effects,^{6–9} and many nondrug treatments have been useful in MoA children.^{10–13}

Most studies concerning the impact of migraine have focused on its effects on many aspects of life.^{14–21} In 1998, Mannix and Solomon reported that people affected by migraine and chronic headaches have a significantly reduced quality of life, even between attacks,²² raising the question of the effects of migraine on quality of life in the broader context of the family. A study on families found that 60% of the participants with migraine believed that their families were significantly affected by their migraines.²³ Indeed, it has been argued that the impact of any illness is not only experienced by the individual but also by those around them who are exposed to the various forms of psychological, economic, and social stressors that accompany an illness,²⁴ such as the comparatively high levels of parental stress among the parents of children affected by MoA.²⁵

On the other hand, the empirical evidence of the important role of the family in primary pediatric headache has grown significantly in the last few years, although the interconnections between the dysfunctional process and the family interaction are still unclear.²⁶ However, some authors suggest that migraine could be considered a sort of familial disorder.²⁷ Even though the role of parenting in childhood migraine is well known, no studies about the personality of parents of migraine children have been conducted.

Therefore, the aim of present study was to assess, using an objective measure, the personality profile of mothers of children affected by MoA.

Materials and methods

Study population

A total of 452 children consecutively referred for MoA were enrolled at the Center for Childhood Headache of the Clinic of Child and Adolescent Neuropsychiatry at the Second University of Naples, to the Unit of Child and Adolescent Neuropsychiatry at Perugia University, to the Azienda Sanitaria Locale of Terni, to the Department of Psychiatry at the University of Catanzaro, and to Child Neuropsychiatry at the University of Palermo.

The diagnosis of MoA was made according to the pediatric criteria of the 2013 International Headache Society classification criteria.²⁸ Exclusion criteria were allergies,

endocrinological problems (ie, diabetes), preterm birth,^{29,30} neurological (ie, epilepsy, all types of headache other than MoA) or psychiatric symptoms (attention deficit/hyperactivity disorder, depression, behavioral problems), mental retardation ($IQ \leq 70$), borderline intellectual functioning (IQ ranging from 71 to 84),^{31,32} overweight (body mass index [BMI] ≥ 85 th percentile) or obesity (BMI ≥ 95 th percentile),^{33,34} sleep disorders,^{14,35–39} primary nocturnal enuresis,^{40–42} and anticonvulsant^{43,44} or psychoactive drug administration.

No children in prophylactic treatment for migraine were recruited for this study. Mothers affected by psychiatric (ie, depression, anxiety, panic attacks, psychosis) or neurological illness or affected by headaches were excluded. Finally, 269 (59.52% from starting population) mothers of MoA children (153 male, 116 female; aged between 6 and 12 years; mean 8.93 ± 3.57 years) were considered eligible for the present study.

Following recruitment, there was a 4-month run-in period to verify headache characteristics. At the end of run-in, monthly headache frequency and mean headache duration were assessed from daily headache diaries kept by all the children. Headache intensity was assessed on a 0–10 visual analog scale (VAS), with 0 being “no pain” and 10 being “the worst possible pain,” as previously reported.^{10,12,13} The minimum length of headache required for admission in this study was 7 months, with a minimum of four attacks monthly, each lasting for a duration of 1 hour, according to International Classification of Headache Disorders III criteria.²⁸

The results were compared with the findings obtained in a sample of 587 healthy controls (316 male, 271 female; mean age 8.74 ± 3.57 years) randomly selected from schools in the Campania, Umbria, Calabria, and Sicily regions. The subjects in both groups were recruited from the same urban area; participants were all Caucasian, and held a middle-class socioeconomic status (between class 2 or class 3, corresponding to €28,000–€55,000/year to €55,000–€75,000/year, respectively, according to the current Italian economic legislation parameters), as previously reported.^{17,45}

All parents gave their written informed consent. The departmental ethics committee at the Second University of Naples approved the study design. The study was conducted according to the criteria of the Declaration of Helsinki.⁴⁶

Measures and procedures

Minnesota Multiphasic Personality Inventory – second edition

For assessment of personality habits, each mother filled out the Minnesota Multiphasic Personality Inventory – second

edition (MMPI-2),⁴⁷ widely used to diagnose personality and psychological disorders. The MMPI-2 consists of 567 items, all true-or-false format, and usually takes between 1 and 2 hours to be completed. In order to verify the mean differences between the two groups of mothers, we took into account only the two main scales: the clinical basic scale and content scale.

The clinical basic scale is used to evidence different psychotic conditions, and is composed of ten items: hypochondriasis (Hs; to assess a neurotic concern over bodily functioning), depression (D; originally designed to identify depression, characterized by poor morale, lack of hope in the future, and a general dissatisfaction with one's own life situation), hysteria (Hy; designed to identify the "hysterical" response in stressful situations), psychopathic deviate (Pd; originally developed to identify psychopathic patients, this scale measures social deviation, lack of acceptance of authority, and amorality, and can be considered also as a measure of disobedience), masculinity/femininity (Mf-f; this scale was designed by the original authors to identify homosexual tendencies, but was found to be largely ineffective; high scores on this scale are related to factors such as intelligence, socioeconomic status, and education; women tend to score low on this scale), paranoia (Pa; originally developed to identify patients with paranoid symptoms, such as suspiciousness, feelings of persecution, grandiose self-concepts, excessive sensitivity, and rigid attitudes), psychasthenia (Pt; this scale could be considered more reflective of obsessive-compulsive disorder), schizophrenia (Sc; this scale was originally developed to identify schizophrenic patients and reflects a wide variety of areas, including bizarre thought processes and peculiar perceptions, social alienation, poor familial relationships, difficulties in concentration and impulse control, lack of deep interests, disturbing questions of self-worth and self-identity, and sexual difficulties), hypomania (Ma; this scale was developed to identify such characteristics of hypomania as elevated mood, accelerated speech and motor activity, irritability, flight of ideas, and brief periods of depression), social introversion (Si; this scale is designed to assess the tendency to withdraw from social contacts and responsibilities).

The content scale is composed of 15 items: anxiety (ANX), fears (FRS), obsessiveness (OBS), depression (DEP), health concerns (HEA), bizarre mentation (BIZ), anger (ANG), cynicism (CYN), antisocial practices (ASP), type A (TPA), low self-esteem (LSE), social discomfort (SOD), family problems (FAM), work interference (WRK), and negative treatment indicators (TRT).

In our study, MMPI-2 profiles met all of the following validity criteria: fewer than 30 item omissions, *L*-scale ≤ 65 ,

F-scale ≤ 100 , *K*-scale ≤ 65 , *F(b)*-scale ≤ 100 , variable response inconsistency *T*-score ≤ 80 , true response inconsistency *T*-score ≤ 80 , and raw *F-K*-score ≤ 11 . The MMPI-2 was evaluated by a trained physician (ME) to assess the personality habits of both mothers of MoA and typical developing children.

Statistical analysis

The *t*-test was used to compare age and MMPI-2 clinical basic and content scales between mothers of MoA children and typical developing children. Pearson's correlation test was used to evaluate the relation between MMPI-2 scores of mothers of MoA children and frequency, intensity, and duration of migraine attacks of their children. $P < 0.05$ was considered statistically significant.

Results

The two study groups were not significantly different for age (8.93 ± 3.57 years in MoA group vs 8.74 ± 3.57 in control group, $P = 0.519$) or sex (ratio male:female 153:116 in MoA group vs 316:271 in control group, $P = 0.449$).

Among the MoA clinical characteristics, in the MoA group the attacks occurred with a mean frequency of 10.21 ± 2.69 a month, a mean duration of 5.92 ± 4.09 hours, and a mean intensity of 6.95 ± 3.41 , according to VAS parameters. In the MMPI-2 clinical basic scale, the mothers of MoA children showed significantly higher scores in the Pa and Si ($P < 0.001$) subscales than mothers of typical developing children (Table 1 and Figure 1).

Table 1 and Figure 2 summarize the differences between the MMPI-2 results in mothers of MoA children in respect of mothers' comparisons for the content scale. Pearson's correlation analysis showed a significantly positive relationship between MoA clinical characteristics of studied children and MMPI-2 scores of their mothers. In particular, the MoA frequency of children was significantly positively related with ANX ($r = 0.4903$, $P = 0.024$) and LSE ($r = 0.5130$; $P = 0.017$) MMPI-2 scores of their mothers.

On the other hand, the MoA duration of children was significantly positively related with Hs ($r = 0.6155$, $P = 0.003$), Hy ($r = 0.6235$, $P = 0.003$), Pa ($r = 0.5102$, $P = 0.018$), Pt ($r = 0.4806$, $P = 0.027$), Sc ($r = 0.4350$, $P = 0.049$), ANX ($r = 0.4332$, $P = 0.050$), and HEA ($r = 0.7039$, $P < 0.001$) MMPI-2 scores of their mothers.

Discussion

The main findings of the present study suggested that the personality of mothers of children affected by MoA tends

Table 1 Differences in clinical basic scale and in content scale of MMPI-2 test among mothers of MoA and typical developing children (controls)

	MoA (n = 269)	Controls (n = 587)	P
Hs	56.905 ± 13.171	54.979 ± 15.556	0.075
D	54.143 ± 9.743	53.292 ± 10.999	0.276
Hy	49.762 ± 10.163	48.500 ± 9.147	0.067
Pd	52.476 ± 8.813	53.396 ± 9.346	0.170
Mf-f	53.809 ± 7.639	52.354 ± 12.828	0.081
Pa	56.809 ± 11.931	50.917 ± 9.380	<0.001
Pt	52.667 ± 13.904	51.479 ± 12.331	0.207
Sc	55.524 ± 10.299	54.125 ± 11.139	0.077
Ma	54.619 ± 14.589	52.937 ± 13.759	0.099
Si	54.762 ± 8.927	50.042 ± 8.490	<0.001
ANX	59.814 ± 9.929	50.958 ± 8.158	<0.001
FRS	58.667 ± 11.114	56.792 ± 15.067	0.065
OBS	57.809 ± 11.931	50.333 ± 8.740	<0.001
DEP	54.524 ± 9.948	49.042 ± 7.217	<0.001
HEA	61.571 ± 11.902	52.375 ± 7.731	<0.001
BIZ	59.381 ± 11.491	52.333 ± 7.054	<0.001
ANG	50.809 ± 9.943	49.250 ± 12.078	0.061
CYN	59.714 ± 11.136	53.875 ± 10.878	<0.001
ASP	53.095 ± 8.431	51.729 ± 10.860	0.065
TPA	57.571 ± 11.952	51.542 ± 9.563	<0.001
LSE	56.381 ± 8.640	48.792 ± 6.461	<0.001
SOD	53.381 ± 11.084	52.583 ± 12.683	0.379
FAM	51.095 ± 8.312	50.896 ± 8.745	0.749
WRK	57.190 ± 9.647	49.854 ± 5.975	<0.001
TRT	57.667 ± 10.432	52.396 ± 7.718	<0.001

Note: $P < 0.05$ was considered statistically significant (t-test).

Abbreviations: MMPI-2, Minnesota Multiphasic Personality Inventory – second edition; MoA, migraine without aura; Hs, hypochondriasis; D, depression; Hy, hysteria; Pd, psychopathic deviate; Mf-f, masculinity/femininity; Pa, paranoia; Pt, psychasthenia; Sc, schizophrenia; Ma, hypomania; Si, social introversion; ANX, anxiety; FRS, fears; OBS, obsessiveness; DEP, depression; HEA, health concerns; BIZ, bizarre mentation; ANG, anger; CYN, cynicism; ASP, antisocial practices; TPA, type A; LSE, low self-esteem; SOD, social discomfort; FAM, family problems; WRK, work interference; TRT, negative treatment indicators.

to be different compared to controls, with a significant correlation with some migraine characteristics. We preferred to focus exclusively on MoA, because it is the most frequent type of primary headache in childhood and also because MoA takes a significant toll on the quality of life for people affected and their family members.^{25,48} Consequently, chronic migraine pain may negatively influence daily functioning, emotions, and roles in social and family contexts.⁴⁸ Moreover, we have to take into account that most studies on the personality traits of migraineurs are focused on adult subjects.^{49–54} These studies evidenced that psychiatric disorders, including depression and anxiety, can be concomitant with the presence of migraine, adding significant morbidity.⁵⁵

Overall behavioral disorders have been reported as more common in children who experience headache than in

controls.⁵⁶ Specifically, internalizing symptoms are common in children with headaches, while externalizing symptoms (eg, rule-breaking and aggressivity) are not significantly more common than in controls.^{57,58}

On the other hand, in 2008 Radat et al⁵⁹ showed a higher prevalence of anxiety and depression in children affected by MoA, while other reports showed low levels of self-concept,⁶⁰ higher prevalence of harm-avoidance temperamental style,⁶¹ and other new and suggestive comorbidities.^{14–19}

Alternatively, psychiatric disorders that run in families, specifically anxiety and mood disorders, are particularly frequent in migraineurs and their relatives,⁶² and children affected by migraine seem to be characterized by an higher prevalence of psychiatric disorders in parents than comparisons,⁶³ suggesting that a sort of genetic cotransmission of anxiety and depression traits could exist in migraineurs,⁶² and evidence is pointing in this direction.⁶⁴ Even though many reports have shown the co-occurrence of psychiatric symptoms in subjects affected by migraine,^{25,62,63} there have been no specific reports on the personality aspect of mothers not affected by headache who have children with MoA.

Moreover, social learning theory postulates that children's perception of their physical symptoms can be altered via parental modeling,⁶⁵ which may affect the expression of pain and functionally somatic symptoms. Children with recurrent unexplained pain report more models and positive reinforcement for pain behavior than children with recurrent explained pain.⁶⁶ Parental stress and psychopathology may also play a role in organic diseases, such as MoA.²⁵

Family factors, such as parenting styles and family functioning, may be linked with disability levels across children's physical health problems. However, this body of literature is limited by lack of clarity in distinguishing between individual parenting factors (eg, parenting style), dyadic variables (eg, parent-child communication), and family-level variables (eg, family functioning).⁶⁷ Clinical studies of children with recurrent headaches and abdominal pain show that their parents report greater levels of family problems,^{68,69} marital problems,⁷⁰ divorce and child physical abuse,⁷¹ which we could hypothetically also link to the higher levels in mothers of MoA children of some MMPI-2 scores: ANX, OBS, DEP, HEA, BIZ, CYN, TPA, LSE, WRK, and TRT ($P < 0.001$ for all variables). Specifically, regarding the greater levels of TPA and CYN, we could hypothesize that the personal traits of rigidity and ambition in mothers could impact on the coping-strategy

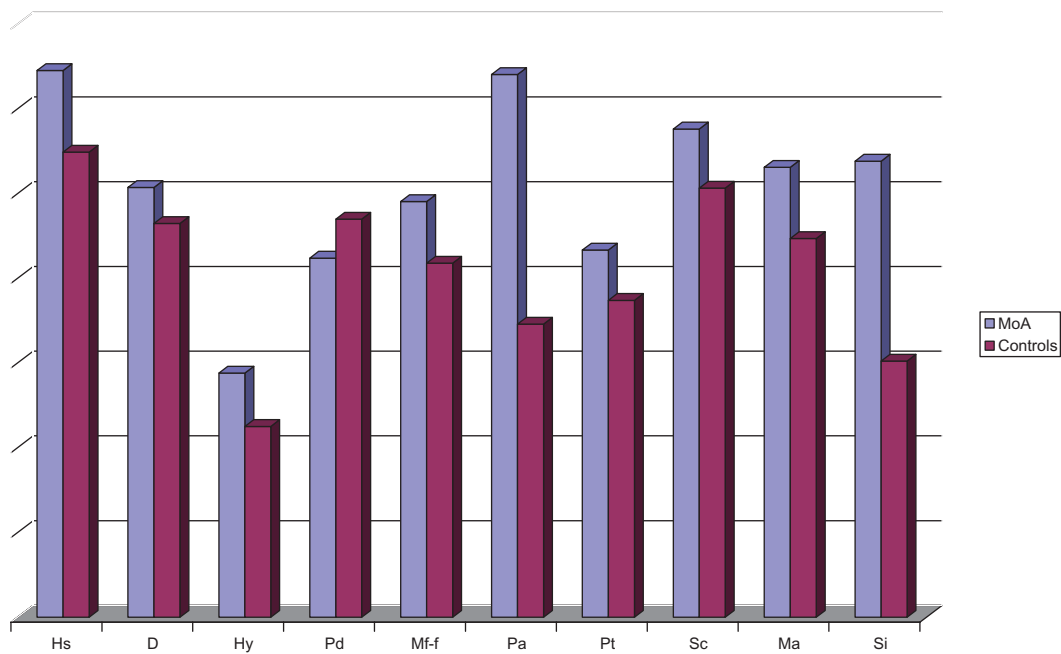


Figure 1 Comparisons in MMPI-2 clinical basic scales results between mothers of MoA children and mothers of control children.

Abbreviations: MMPI-2, Minnesota Multiphasic Personality Inventory – second edition; MoA, migraine without aura; Hs, hypochondriasis; D, depression; Hy, hysteria; Pd, psychopathic deviate; Mf-f, masculinity/femininity; Pa, paranoia; Pt, psychasthenia; Sc, schizophrenia; Ma, hypomania; Si, social introversion.

development of children affected by migraine, as the maternal cynism (CYN) could act too. Conversely, a potential link between children's internalizing disorders, parental psychopathology and headaches has been established.⁷²

Fagan reported that migraine may be associated with dysfunctional parenting patterns, suggesting that in families where the mother has migraine, children may be at risk of inappropriately or prematurely assuming roles for which they are developmentally unready.⁷³ On the other hand, migraine

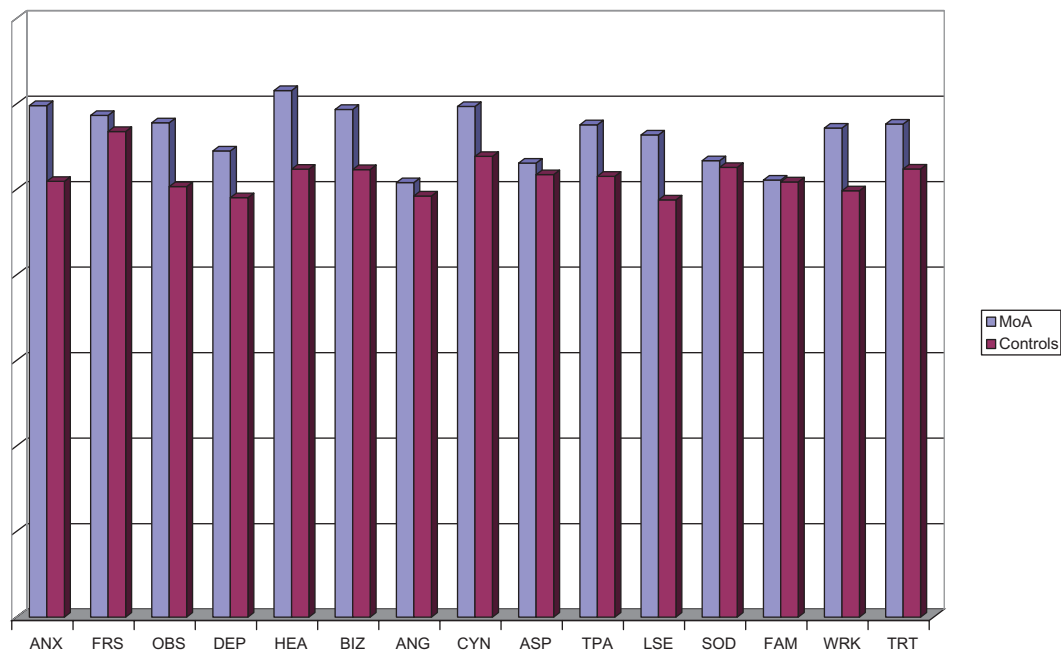


Figure 2 Comparisons in MMPI-2 content scales results between mothers of MoA children and mothers of control children.

Abbreviations: MMPI-2, Minnesota Multiphasic Personality Inventory – second edition; MoA, migraine without aura; ANX, anxiety; FRS, fears; OBS, obsessiveness; DEP, depression; HEA, health concerns; BIZ, bizarre mentation; ANG, anger; CYN, cynicism; ASP, antisocial practices; TPA, type A; LSE, low self-esteem; SOD, social discomfort; FAM, family problems; WRK, work interference; TRT, negative treatment indicators.

has been also interpreted as a sort of altered communication by children in order to consolidate some intrafamilial trajectories.^{74,75}

Alternatively, our findings seem to suggest a potential role of some maternal personality traits (such as Hs, Hy, Pa, Pt, Sc, ANX, and HEA) in children affected by MoA duration perception (Hs, $r = 0.6155$, $P = 0.003$; Hy, $r = 0.6235$, $P = 0.003$; Pa, $r = 0.5102$, $P = 0.018$; Pt, $r = 0.4806$, $P = 0.027$; Sc, $r = 0.4350$, $P = 0.049$; ANX, $r = 0.4332$, $P = 0.050$; and HEA, $r = 0.7039$, $P < 0.001$) and MoA frequency (ANX, $r = 0.4903$, $P = 0.024$; and LSE, $r = 0.5130$, $P = 0.017$). In fact, we could speculate that some maternal personality traits such as ANX or HEA could alter the health-status perception of children and correct coping strategies, also considering that active coping strategies correspond to intrinsically determined behavior, whereas passive coping corresponds to extrinsically determined behavior with reduced aggression.⁷⁶

Moreover, passive coping strategies have been reported to be associated with high degrees of headache intensity.⁷⁷ Several other coping strategies have been described, but in view of the limited number of studies evaluating them, these strategies were considered less determinant for the study of migraine outcomes.⁵⁹ In this perspective, we could consider our results on the relationship between MMPI-2 basic scales results of mothers, and migraine attacks duration of their children, as the effect of abnormal mothers' coping styles linked to their peculiar personality profiles.

Obviously, we cannot affirm that maternal personality traits play a causative role in MoA disease, because migraine is undoubtedly a neurological disease^{78,79} and accompanied by many comorbidities at developmental ages^{14–19} that impact on quality-of-life levels in children affected.

We should take into account a couple of limitations of this study: (1) our data were derived from the administration of a single personality-assessment device and not from a psychiatric clinical evaluation, and (2) we focused only on children affected by MoA, and other types of primary headaches were not considered.

Notwithstanding these limitations, the present study indicates the potential value of maternal personality assessment for better comprehension and clinical management of children affected by migraine, even if further longitudinal studies on the other primary headaches are needed.

In conclusion, our findings could suggest a broader approach to the family of children affected by migraine, with particular attention to the principal caregiver.

Disclosure

The authors report no conflicts of interest in this work.

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