

**Original Article**

# Associations Between Personality and End-of-Life Care Preferences Among Men With Prostate Cancer: A Clustering Approach

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**Abstract**

**Context.** Increased focus on patient-centered care models has contributed to greater emphasis on improving quality of life at the end of life through personalized medicine. However, little is known about individual-level factors impacting end-of-life care preferences.

**Objectives.** To examine whether the five-factor model of personality explains variation in preferences for end-of-life care in men with prostate cancer.

**Methods.** Two hundred twelve men with a prostate cancer diagnosis (mean age = 62 years) completed a measure of the five-factor model of personality—spanning the personality dimensions of neuroticism, agreeableness, extraversion, openness, and conscientiousness—and reported on end-of-life care preferences. Cluster analyses were used to partition the sample into groups with similar care preferences. Analyses of variance and Chi-square tests were used to evaluate differences in care preferences among the groups.

**Results.** Cluster analyses revealed three groups of participants: “comfort-oriented patients,” “service-accepting patients,” and “service-reluctant patients.” Most (67%) were comfort oriented, preferring palliative care and opposing life support services. A subset of patients were service accepting (17%), preferring both palliative care and life support, or were service reluctant (16%), preferring neither. Service-reluctant patients endorsed significantly higher levels of neuroticism (emotional instability and negativity) than comfort-oriented patients. Comfort-oriented patients endorsed significantly higher levels of agreeableness than service-accepting patients and service-reluctant patients.

**Conclusion.** Findings suggest that personality traits are associated with specific health care preferences. Individuals high on neuroticism are likely to report reluctance toward all forms of end-of-life care and may benefit from in-depth information about the process and likely outcomes of receiving life support and palliative care services. *J Pain Symptom Manage* 2016;51:52–59. © 2016 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

**Key Words**

*End-of-life care, prostate cancer, personality, health care preferences, palliative care*

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**Introduction**

Decisions about care at the end of life are arguably some of the most difficult that patients and their families are faced with over the course of terminal illness. In addition to the emotional toll, decisions about

end-of-life care are further complicated by the availability of diverse medical interventions for prolonging life and by the variability in physicians' comfort and competency with initiating end-of-life care discussions.<sup>1</sup> An increased focus on patient-centered

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care models aimed at personalizing medicine has contributed to increased attention on shared decision-making about end-of-life care preferences and greater emphasis on improving quality of life at the end of life. These trends are evident in the recent Institute of Medicine (IOM) report<sup>2</sup> on “Dying in America,” which highlights the challenges of providing care at the end of life tailored toward the individual patient.

As outlined in the IOM report,<sup>2</sup> a key component of quality end-of-life care centers around first understanding patients’ physical, emotional, social, and spiritual context, and then personalizing medical care. Consequently, it is imperative to understand individual-level factors that contribute to patient preferences for end-of-life care. Arguably, personality characteristics may play an important role in the development of an individual’s health care preferences, including end-of-life care preferences. Although several models of personality have been developed, the five-factor model of personality has been extensively studied and validated and is presently the most widely adopted personality framework.<sup>3,4</sup> The “Big Five” personality dimensions include extraversion (implying sociability, sense of agency), neuroticism (characterized by moodiness, anxiety, and sensitivity to threat), agreeableness (the concern for maintaining relationships, characterized by being friendly, helpful, and empathic), conscientiousness (self-disciplined, persistent, achievement oriented), and openness to experience (characterized by curiosity, flexibility, and a willingness to engage in atypical experiences). Few studies have explored the relationship between personality factors and health care preferences<sup>5</sup>, particularly those surrounding end-of-life issues.<sup>6</sup> Given the stability of personality traits in adulthood<sup>7</sup> and the relationship between personality and coping among samples facing a high degree of stress (relative to those with little stress<sup>8</sup>), identifying associations between personality and health care preferences may offer health care providers insight into preference patterns among their patients. These findings could inform clinical practice without requiring physicians to administer a formal personality measure. People routinely draw reasonably accurate inferences about others’ personality traits,<sup>9–11</sup> and many traits could be identified by physician observation.

Individuals high on openness and agreeableness have been seen to use complementary and alternative medicine services more readily,<sup>12</sup> and a large population-based study found that higher levels of both conscientiousness and agreeableness were associated with a greater likelihood of end-of-life care planning.<sup>13</sup> However, past research indicates that elevated levels of neuroticism may be particularly salient for

health care providers to evaluate and consider when tailoring treatment. A meta-analysis of personality traits and coping responses found that neuroticism was related to a wide variety of disengagement responses and to lower use of problem-solving<sup>8</sup> (for a more complete review of personality and coping, Carver and Connor-Smith<sup>14</sup>). Consistent with past research demonstrating the difficulties associated with neurotic tendencies, Denburg et al.<sup>15</sup> found that poor decision-making, as measured by an experimental task, was related to elevated levels of neuroticism among older adults. Individuals with higher levels of neuroticism are often seen to fare more poorly at end of life. In a study of end-stage cancer patients, neuroticism had a significant, positive relationship with end-of-life distress, including depression, anxiety, loss of sense of dignity, and hopelessness.<sup>16</sup>

Less is known about how personality factors, such as neuroticism, relate to the end-of-life care preferences that may contribute to these poorer psychological outcomes. End-of-life care can consist of both life-sustaining treatment (life support measures, such as use of a ventilator) and comfort-focused treatment (palliative care), which are occasionally at odds with one another.<sup>2</sup> One individual may prefer comfort-focused treatment and reject life-sustaining treatment, whereas another individual may prefer both types of care. Little is known regarding the patterns of these patient preferences. This study examines patterns of end-of-life care preferences (for both life support and palliative care measures) among a sample of men with a history of prostate cancer in active oncologic care, and whether personality factors (specifically Big Five personality factors) are related to these varied preferences for end-of-life care. The trajectory of prostate cancer from diagnosis to end of life lends itself to an examination of end-of-life care preferences, as it is often a treatable illness (life expectancy typically ranges from several months to years), yet ultimately can result in death (second leading cause of cancer death in men<sup>17</sup>). This combination of factors offers patients and health care providers both ample opportunity and motivation for initiating end-of-life care discussions.

## Methods

### *Participants and Procedures*

Men with a history of prostate cancer in active oncologic care were recruited via the National Institutes of Health (NIH) ResearchMatch recruitment tool<sup>18</sup> and cancer health education Web sites. This patient group was selected for this study because of the high prevalence of disease (second highest incidence of cancer in the U.S., and second highest number of cancer

deaths annually for males). Participants were contacted via e-mail to complete an online psychosocial survey as part of grant-funded research on medical decision-making at a large East Coast cancer center. Of 687 participants completing the online screener, 207 were excluded because of no cancer history, 104 had a history of cancer but were excluded as a result of no longer being in oncologic care, and 164 cancer patients were excluded because of not having prostate cancer. The present analyses involve 212 men in active care for prostate cancer.<sup>6</sup>

### Measures

**Demographic/Disease Measures.** Participants completed a short demographic questionnaire designed for this study that assessed age, gender, marital status, ethnic/racial identity, education level, health insurance status, and cancer stage. Participants also completed measures of financial strain<sup>19</sup> and health history.<sup>20</sup>

**Big Five Personality Measure.** The Mini-IPIP<sup>21</sup> is a 20-item short form of the International Personality Item Pool–Five-Factor Model measure.<sup>22</sup> This measure includes four items for each of the Big Five traits (neuroticism, extraversion, openness, agreeableness, and conscientiousness). Internal consistency reliability was comparable in this sample ( $\alpha_s = 0.65$ – $0.77$ ) to the original scale development samples ( $\alpha_s = 0.65$ – $0.82$ ). Participants rated the accuracy of self-describing statements such as “have a vivid imagination” and “get chores done right away” using the following scale: 1 (very inaccurate), 2 (moderately inaccurate), 3 (neutral), 4 (moderately accurate), 5 (very accurate).

**Preferences for Palliative Care and Life Support.** Participants were provided with the prompt “Patients are often asked to think about difficult decisions, such as whether they want life support in the event of an emergency, or what to do if treatments stop working. If your doctor advised you that further anti-cancer treatment was unlikely to be helpful, would you want any of the following interventions?”<sup>23</sup> They were asked to rate their interest in “life support (e.g., breathing machine, tube for feeding, electric shock to the heart)” and “palliative care (e.g., comfort care, focused on quality of life but not a cure)” using the following scale: 1 (definitely no), 2 (possibly no), 3 (unsure), 4 (possibly yes), or 5 (definitely yes).

### Statistical Analysis

Analyses were conducted using SPSS, version 19 (IBM Corp., Armonk, NY). Parametric Pearson correlations and nonparametric Spearman rank-order correlations were used to examine relationships

between study variables. As a first step to partitioning the sample into groups of participants with similar preferences for life support and palliative care services, a hierarchical cluster analysis using Ward’s method<sup>24</sup> (a hierarchical agglomerative method) was conducted. Based on squared Euclidean distance (a measure of similarity of cases), the most statistically appropriate number of clusters was determined. Then, a k-means cluster analysis (an iterative partitioning method), in which participants are assigned to the nearest cluster center, was run with the maximum number of iterations limited to 10. To confirm stability of the cluster solution, assignment of participants to cluster groups was examined between Ward’s method and the k-means method.

Analyses of variance and Chi-square tests were used to evaluate differences in care preferences as a function of demographic characteristics, cancer stage, and personality factor. Means, SDs, and T scores (scores standardized to have a mean of 50 and SD of 10) were used to describe the relative standing of each cluster on the end-of-life preference variables. Results with a *P*-value of less than 0.05 were deemed statistically significant.

### Results

A sample of 212 men, with an average age of 62 years (SD = 8, range = 42–84) participated in the study. The majority were white/Caucasian (96.2%), married (85.1%), and well educated (69.3% held a bachelor’s degree or higher). Metastatic disease was reported by 27.4% of participants, and the median time since diagnosis was 1.5 years. Participants’ report of personal cancer therapy history included radiation (29.7%), surgery (22.2%), chemotherapy (9.4%), biologic/targeted therapies (9.0%), other therapies (24.1%), and no treatment (22.2%).

Examination of the preference for palliative care and preference for life support data revealed significant skew. Specifically, 83.5% of participants indicated “possibly yes” or “definitely yes” to palliative care. Similarly, 80.1% of participants indicated “definitely no” or “possibly no” to life support. Nonparametric Spearman rank-order correlations between preferences for palliative care and life support and personality variables revealed that individuals who were more neurotic had lower preferences for palliative care ( $r_s = -0.146$ ,  $P = 0.033$ ) and individuals who were more agreeable had lower preferences for life support ( $r_s = -0.137$ ,  $P = 0.047$ ).

A negative relationship also was observed between age and preference for life support ( $r_s = -0.156$ ,  $P = 0.024$ ), such that older participants in this sample endorsed a lower preference for life support. As seen

Table 1  
Correlation Matrix of Key Study Variables

Study Variables	1	2	3	4	5	6	7	8
1. Neuroticism	—							
2. Agreeableness	-0.186 <sup>a</sup>	—						
3. Extraversion	-0.137 <sup>a</sup>	0.262 <sup>b</sup>	—					
4. Openness	0.314 <sup>b</sup>	0.229 <sup>b</sup>	0.107	—				
5. Conscientiousness	-0.130	0.249 <sup>b</sup>	0.250 <sup>b</sup>	0.016	—			
6. Interest in palliative care	-0.146 <sup>a</sup>	0.102	-0.075	0.114	-0.006	—		
7. Interest in life support	0.087	-0.137 <sup>a</sup>	-0.086	0.015	-0.090	-0.117	—	
8. Cancer stage (nonmetastatic vs. metastatic)	-0.169 <sup>a</sup>	0.159 <sup>a</sup>	0.062	0.146	0.084	0.098	0.178 <sup>b</sup>	—
9. Age	0.201 <sup>b</sup>	0.051	0.001	-0.090	0.056	0.036	-0.156 <sup>a</sup>	0.200 <sup>b</sup>

<sup>a</sup>*P* < 0.05

<sup>b</sup>*P* < 0.01.

in Table 1, no significant relationship was observed between participant age and preference for palliative care. Preferences for both palliative care and life support did not significantly vary by marital status, ethnic/racial identity, education level, or cancer stage (all *P*s > 0.05).

Hierarchical cluster analysis suggested a three-cluster solution. Using three clusters, the k-means cluster analysis produced distinct groups of individual preferences toward life support and palliative care. Cluster I consisted of men (*n* = 141) who were in favor of receiving palliative care services (mean = 4.62, SD = .49, *T* = 53.65) and opposed to life support services (mean = 1.28, SD = .45, *T* = 45.30) and were therefore labeled “comfort-oriented patients.” Cluster II consisted of men (*n* = 37) who were amenable to receiving life support services (mean = 3.54, SD = .73, *T* = 67.79) but also favorably disposed toward palliative care (mean = 4.57, SD = .56,

*T* = 53.03) and were categorized as “service-accepting patients.” Cluster III consisted of men (*n* = 34) who were not strongly interested in either life support services (mean = 1.76, SD = .70, *T* = 50.14) or palliative care services (mean = 2.62, SD = .70, *T* = 31.55) and were labeled as “service-reluctant patients.” As seen in Table 2, there were no group differences by age, marital status, ethnic/racial identity, education level, or cancer stage.

Controlling for age, cancer stage, and education, significant between-group differences were observed for both neuroticism [*F*(2, 206) = 4.393, *P* = 0.014] and agreeableness [*F*(2, 206) = 3.499, *P* = 0.032], but not for extraversion, openness, or conscientiousness (*P*s > 0.05; Table 3). “Service-reluctant patients” endorsed a higher degree of neuroticism than “comfort-oriented patients” (*P* = 0.004). As a covariate, age had a significant relationship with neuroticism, *F*(1, 206) = 5.946, *P* = 0.016, such that older adults

Table 2  
Sociodemographic and Disease Characteristics

	Total Sample	Comfort Oriented	Service Accepting	Service Reluctant	Comparison
Age in yrs, M (SD)	62.43 (8.22)	62.41 (7.84)	62.57 (8.44)	62.35 (9.67)	<i>F</i> (2, 209) = 0.007, <i>P</i> = 0.993
Marital status, <i>n</i> (%)					$\chi^2(2, N = 212) = 0.883, P = 0.64$
Married	179 (84.4)	117 (83.0)	33 (89.2)	29 (85.3)	
Not married	33 (15.6)	24 (17.0)	4 (10.8)	5 (14.7)	
Ethnic/racial identity, <i>n</i> (%)					$\chi^2(2, N = 212) = 1.173, P = 0.56$
Non-Hispanic white	193 (91.0)	130 (92.2)	32 (86.5)	31 (91.2)	
Racially/ethnically diverse	19 (9.0)	11 (7.8)	5 (13.5)	3 (8.8)	
Education level, <i>n</i> (%)					$\chi^2(10, N = 212) = 15.483, P = 0.12$
Eighth grade or less	1 (0.5)	0 (0)	1 (2.7)	0 (0)	
Some high school	2 (1)	2 (1.4)	0 (0)	0 (0)	
High school graduate	15 (7.1)	7 (5.0)	3 (8.1)	5 (14.7)	
Some college/associate’s degree	47 (22.2)	30 (21.3)	7 (18.9)	10 (29.4)	
Bachelor’s degree	75 (35.4)	54 (38.3)	9 (24.3)	12 (35.3)	
Master’s or doctoral degree	72 (34.0)	48 (34.0)	17 (46.0)	7 (20.6)	
Cancer stage, <i>n</i> (%)					$\chi^2(6, N = 212) = 4.744, P = 0.58$
No evidence of disease	39 (18.4)	24 (17.0)	9 (24.3)	6 (17.6)	
Early stage: localized to one part of body	82 (38.7)	53 (37.6)	17 (46.0)	12 (35.3)	
Advanced: cancer has metastasized to other regions	58 (27.4)	42 (29.8)	5 (13.5)	11 (32.4)	
Unknown stage	33 (15.6)	22 (15.6)	6 (16.2)	5 (14.7)	

Table 3  
Big Five Personality Scores by Patient Group

Personality Factor	Comfort Oriented, M (SD)	Service Accepting, M (SD)	Service Reluctant, M (SD)	ANCOVA
Neuroticism	10.35 (3.26)	11.11 (3.66)	12.32 (3.69)	$F(2, 206) = 4.393, P = 0.014$
Extraversion	12.09 (3.67)	10.65 (3.12)	11.59 (3.30)	$F(2, 206) = 2.504, P = 0.112$
Openness	15.82 (2.82)	15.86 (2.56)	15.65 (2.24)	$F(2, 206) = 0.149, P = 0.066$
Agreeableness	15.95 (2.32)	14.92 (3.13)	14.91 (2.56)	$F(2, 206) = 4.441, P = 0.032$
Conscientiousness	15.04 (2.72)	14.05 (3.19)	14.35 (3.37)	$F(2, 206) = 1.789, P = 0.170$

ANCOVA = analysis of covariance.

endorsed lower degrees of neuroticism. Education and cancer stage were not significant contributors to the model ( $P$ s > 0.05).

“Comfort-oriented patients” endorsed significantly higher levels of agreeableness than “service-accepting patients” ( $P = 0.028$ ) and “service-reluctant patients” ( $P = 0.031$ ). As a covariate, cancer stage had a significant relationship with agreeableness, such that individuals reporting metastatic disease reported a higher degree of agreeableness. Education and age were not significant contributors to the model ( $P$ s > 0.05).

## Discussion

To our knowledge, this is the first study evaluating the “Big Five” personality factors associated with end-of-life care preferences among men with a history of prostate cancer in active oncologic care. Consistent with prior research,<sup>5</sup> Big Five personality traits were significantly associated with medical decision-making. Neuroticism was associated with a lower preference for palliative care, whereas agreeableness was linked to a lower preference for life support.

This study extends the literature on personality and end-of-life medical decision-making by examining the intersection of preference for palliative care and life support. In this sample of men with a history of prostate cancer in active oncologic care, results support the presence of three main types of preferences toward palliative and end-of-life care. The most common end-of-life care preference (66.5% of the sample) consisted of being in favor of palliative care services, but generally opposed to life support services. These “comfort-oriented patients” value comfort and a focus on quality of life rather than quantity of life. The care preferences of this group are the most coherent, as they both emphasize quality of life. A second, less prevalent, style of end-of-life care preference (17.5% of the sample) includes being in favor of receiving both life support services and palliative care services. These “service-accepting patients” can be viewed as opting for all health care services available, even when these services may appear to have contradictory and, at times, incompatible goals. A third and least common style of

end-of-life care preference (16% of the sample) involves minimal interest in either life support services or palliative care services. These “service-reluctant patients” are more difficult to characterize, but they appear to prefer minimal engagement with health care systems. Notably, despite social norms that patients should maintain a “fighting spirit”,<sup>25</sup> no patients clustered into a group preferring life support in the absence of palliative care services.

Results of this study demonstrate that “service-reluctant patients” scored significantly higher on a scale of neuroticism. A tendency to be tense, moody, and anxious may result in individuals being less interested in receiving both medical care aimed at comfort (palliative care) and aimed at life extension (life support). These findings may appear counter to the idea of a hypochondriacal anxious person seeking medical testing<sup>26</sup> and also seem inconsistent with a recent study documenting associations between neuroticism and health care utilization.<sup>27</sup> Why might neuroticism be associated with both increased service utilization<sup>26,27</sup> and lower preferences for both palliation and life support when prompted to “think about difficult decisions, such as whether they want life support in the event of an emergency, or what to do if treatments stop working”? One possibility is an individual higher in neuroticism may be more avoidant<sup>28–30</sup> of thinking deeply about impending frailty and death when faced with a threatening hypothetical scenario. In “real-world” settings, their avoidance can lead them to refrain from preparing for the future (e.g., not complete advanced directives; not engage in meaningful end-of-life conversation<sup>31,32</sup>), which could subsequently lead to more intensive service utilization.<sup>33</sup> Alternatively, this avoidance could manifest in more neurotic individuals having lower preferences for both types of end-of-life care simply out of a general desire to be “left alone” when facing significant stressors.<sup>8</sup>

Given the high correlations between neuroticism and depression broadly observed in the literature, depression may be a strong contributor to the development of end-of-life care preferences. It is possible that depression longitudinally mediates the relationship between the personality trait neuroticism and the development of a “service-reluctant” preference,

such that high levels of neuroticism predict depressive symptoms, and depressive symptoms predict service reluctance at end of life. For instance, these patients may engage in more helpless and pessimistic thinking that contributes to poorer expectations of symptomatic relief. This potential relationship should be explored in future, longitudinal research.

“Comfort-oriented patients” had higher scores on our measure of agreeableness than the other two groups. Individuals who are high on agreeableness may prefer palliation over life support because they tend to be concerned with maintaining relationships and tend to be friendly, helpful, and empathic.<sup>34,35</sup> As well, they may be able to process the negative emotions that may come with choosing to opt against life support, for the broader goal of striving for a harmonious, comfortable end of life. Furthermore, as palliative care usually involves continuous intimate care of a patient during the final stages of life, as well as the opportunity for the individual to spend potentially more meaningful time surrounded by those who he/she loves (e.g., family, friends, spiritual advisors), agreeable individuals who are relationship oriented may be more comfortable with this type of end-of-life experience.

No differences were observed among care preference groups based on age, marital status, ethnic/racial identity, education level, or cancer stage. Furthermore, there were no group differences in the personality factors of openness, conscientiousness, or extraversion. However, there was a small correlation between age and preference for life support. These findings were partially consistent with Chen et al.,<sup>36</sup> who found that older individuals, and those who were white, demonstrated a stronger preference for hospice, a very specific type of end-of-life care.

Although participants in the present study did have a prostate cancer diagnosis, they provided their preferences for care in the hypothetical situation that further anticancer treatment would likely be unhelpful. Although the question prompts offered specific examples of what constitutes palliative care and life support treatments, the degree to which participants have thorough understandings of these treatment options is unknown. Past longitudinal research on a general older adult sample found that declines in physical or psychological functioning over time resulted in decreased interest in life-sustaining treatments.<sup>37</sup> To determine the robustness of the relations observed in this study of hypothetical preference, future research should examine the health care decisions made among men with prostate cancer who have been told that additional anticancer treatment is unlikely to be effective or beneficial.

Furthermore, this sample was exclusively male and primarily white, well educated, and middle class; thus, findings may not generalize to more diverse populations. A systematic review of individual factors influencing decision-making during critical illness suggests that white patients, and those from North America and Northern Europe, may prefer less intensive end-of-life care than patients from other racial and geographic backgrounds.<sup>38</sup> Research examining the stability of these end-of-life care preference clusters and relations between preferences and personality factors should be conducted on a more racially/ethnically and geographically diverse sample.

Results of this study shed light on the end-of-life care preferences among men with prostate cancer. Given the high prevalence of this disease and the increased focus on improving quality of end-of-life care, it is essential that health care providers understand the preferences of this patient population. The most common end-of-life care preferences consisted of being in favor of palliative care services, but generally opposed to life support services. Patients who received palliative care services and do not receive life support services may be the most comfortable at end of life, and the decision to embark on this care plan may indicate a sense of acceptance of one’s medical status.

Two smaller groups of men endorsed preferences for end-of-life options that if chosen could lead to a less comfortable end of life. The first group, “service-accepting patients,” reported interest in receiving both life support services and palliative care services, which may be at odds with one another. The second group, “service-reluctant patients,” reported no interest in either life support services or palliative care services. This group of men tended to be higher on a measure of neuroticism than the other two groups and may reject care as a method of disengaging and avoiding the difficult or unpleasant task of carefully considering their own end of life or simply prefer to withdraw from intensive service near the end of life. Although individual preferences in end-of-life care should be honored, patients from both of these groups may benefit from receiving more in-depth information about the process of and likely outcomes of receiving life support care and palliative care. It may be particularly important to provide sensitive assessment and intervention to those men who report minimal or no interest in both life support and palliative care. This may be one way to further advance the IOM recommendation of understanding patients’ contexts, and then personalizing medical care in accordance with these contexts to best support quality end-of-life care.

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