

Type D personality A potential risk factor refined

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Abstract

Objective: Acute and chronic psychological distress have been associated with coronary heart disease (CHD) but little is known about the determinants of distress as a coronary risk factor. Broad and stable personality traits may have much explanatory power; this article selectively focuses on negative affectivity (NA; tendency to experience negative emotions) and social inhibition (SI; tendency to inhibit self-expression in social interaction) in the context of CHD. **Methods:** The first part of this article reviews research on NA and SI in patients with CHD. The second part presents new findings on NA and SI in 734 patients with hypertension. **Results:** Accumulating evidence suggests that the combination of high NA and high SI designates a personality subtype (“distressed” type or type D) of coronary patients who are

at risk for clustering of psychosocial risk factors and incidence of long-term cardiac events. Type D and its contributing low-order traits (dysphoria/tension and reticence/withdrawal) could also be reliably assessed in a community-based sample of patients with hypertension. This finding was replicated in men and women, and in Dutch- and French-speaking subjects. Type D hypertensives reported more depressive affect than their non type D counterparts. **Conclusions:** There is an urgent need to adopt a personality approach in the identification of patients at risk for cardiac events. NA and SI are broad and stable personality traits that may be of special interest not only in CHD, but in other chronic medical conditions as well. © 2000 Elsevier Science Inc. All rights reserved.

Keywords: Coronary heart disease; Hypertension; Personality; Depression; Prognosis

Introduction

In recent years, a wide variety of psychosocial factors has been associated with the incidence and progression of coronary heart disease (CHD). Most of this research focused on affective disorder [1–4], negative emotions [5–19], and social isolation [20–23] as risk factors. Hence, depression and low perceived social support are often considered to be the psychosocial features that are most prominently linked to CHD morbidity and mortality [24].

One generally assumes that depression is *the* psychosocial factor that should be accounted for in the prognosis of patients with CHD, at the risk of ignoring other psychosocial variables that may be of equal importance. Many negative affective states other than depressed affect (e.g., anxiety,

anger, hostility, vital exhaustion) have been associated with CHD as well [25–28]. In addition, the specificity of the relationship between clinical depression and CHD may be limited, e.g., only 7 out of 19 patients who died from cardiac causes at 18 months follow-up in the Frasure-Smith et al. study (a frequently cited study in favor of the depression — CHD hypothesis) were classified as clinically depressed [29], implying that 63% of the cardiac deaths were not diagnosed with a depression at baseline. The findings of this study also indicated that clinical depression, as opposed to self-reported depressive symptoms, did *not* improve the predictive ability of the standard risk factors. Others have shown that depressive symptoms as a risk factor for CHD may reflect a chronic psychological characteristic rather than a discrete, transient psychiatric condition [6,30,31].

These observations do not refute the notion that clinical depression [32–34] and depressive symptoms [5–9,29] are important risk factors in the context of CHD. Rather they point out the importance of examining multiple psychosocial factors — both acute and chronic — in the evaluation of

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individuals at risk of coronary events [35–37]. In addition, there is an urgent need to document the determinants of depression [38] and psychological distress [39,40] in CHD patients. In nonclinical populations, evidence suggests that broad and stable personality traits represent major determinants of depression [41], psychological distress [42], life stress [43], and subjective mood [44] and well-being [45]. Individual differences in personality and coping have also been associated with psychological distress in CHD [39,40].

Hence, in addition to focusing on specific psychological risk factors, there is a need to adopt a personality approach in the early identification of those coronary patients who are at risk for emotional stress-related cardiac events. Evidence suggests that psychological risk factors tend to cluster together and that clustering of these factors, in turn, substantially elevates the risk for cardiac events [37]. Broad and stable personality traits may have much predictive value regarding this clustering of risk factors in patients with CHD [39,46].

Therefore, the present article emphasizes the potential role of personality as determinant of emotional distress in patients with CHD. More specifically, this article will selectively focus on the “distressed” personality type or “type D,” i.e., those individuals who simultaneously tend to (a) experience negative emotions and (b) inhibit self-expression [47]. The present article is organized in two separate parts, each with its own specific perspective on type D. The first part focuses on the conceptual framework that guided research on type D personality and CHD, and briefly reviews some of the empirical findings. The second part presents new findings on the structural validity of the type D construct and its relationship with depressive affect in a hypertensive population. This article concludes with some observations about the role of type D personality in clinical research and practice.

Yet another personality construct?

In the past decade, there was a resurgence of interest in the role of personality in health and disease [48,49]. Personality refers to a complex organization of trait dispositions [41]; these traits reflect consistencies in the general affective level and behavior of individuals. Hence, personality is conceived as a complex system of structures and processes that underlie these consistencies in human affect and behavior [50]. Different models of personality have identified two [51], three [52,53], or five [54,55] global traits that are relevant in a large number of situations. This paper is based on the notion that negative affectivity and social inhibition are two global traits that can be linked to important health outcomes in CHD.

Negative affectivity and social inhibition

Negative affectivity (NA) denotes the stable tendency to experience negative emotions [56,57], i.e., high-NA individuals

are more likely to experience negative affect across time and regardless of the situation. This trait has also been conceptualized as neuroticism [53,54]. NA correlates 0.68 with the neuroticism scale from the NEO-FFI in healthy subjects [58] and 0.64 with the neuroticism scale from the Eysenck Personality Questionnaire in patients with CHD [59]. Hence, these personality constructs share about 40–50% common variance, implying that they are closely related but not identical. Neuroticism may have negative connotations (i.e., “neurotic” disorder) that I prefer to avoid. Because both NA and neuroticism are centrally defined by the tendency to experience negative affect [57], the label NA is used here to designate dysphoric individual differences that are stable over time.

High-NA individuals not only experience more feelings of dysphoria and tension, but have a negative view of self, report more somatic symptoms, and have an attention bias towards adverse stimuli [57]. Overall, they seem to scan the world for signs of impending trouble: neuroticism or NA has been associated with more *exposure* to and *reactivity* to stressful events [60] and with more negative appraisals of interpersonal stressors [61]. In women with breast cancer, for example, NA is associated with heightened sensitivity to treatment-induced symptoms [62] and a self-defeating way of comparing one’s own situation with that of other breast cancer patients [63]. Likewise, evidence suggests that NA is an important determinant of subjective well-being and emotional distress in CHD patients [64].

NA has been associated with chest pain in the absence of CHD [65] but also with actual CHD [66]. Hence, NA may act both as a nuisance variable and as an actual risk factor. In any case, it is premature to write off associations between NA and physical health [67]. NA is assessed well by the Trait Anxiety Inventory [68]; therefore, the Dutch form of this scale [69] was used to assess dysphoric individual differences in previous research on type D.

Social inhibition (SI) denotes the stable tendency to inhibit the expression of emotions and behaviors in social interaction [70], i.e., high-SI individuals are more likely to feel inhibited, tense and insecure when with others. SI correlates -0.52 with the extraversion scale from the NEO-FFI in healthy subjects [58] and -0.65 with the extraversion scale from the Eysenck Personality Questionnaire in patients with CHD [59]. Hence, these personality constructs share about 25–45% common variance, implying that they are closely related but not identical. SI is more closely related to the interpersonal than to the intrapsychic (i.e., positive affect, energy, excitement seeking) dimension of introversion/extraversion [59].

SI has in fact been related to the avoidance of potential “dangers” involved in social interaction such as disapproval or nonreward by others [70]. Although inhibited individuals are quiet on the surface, they may actually avoid interpersonal conflict through excessive control over self-expression [71]. Hence, SI refers to pervasive individual differences in reticence, withdrawal, nonexpression, and discomfort in

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