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SPECIAL ISSUE: Personality Assessment in Medical Settings

Introduction to the Special Issue on Personality Assessment in Medical Settings

Piero Porcelli
IRCCS De Bellis Hospital
Castellana Grotte, Italy

Robert E. McGrath
Department of Psychology
Fairleigh Dickinson University

This special issue of the *Journal of Personality Assessment* brings together 3 review articles and 5 research studies on personality assessment in medical settings that should help clinicians become more familiar with the current status of this field. In 1 review article, Sirri, Fabbri, Fava, and Sonino (2007/this issue) summarize evidence of a new approach to the assessment of psychological syndromes in somatizing patients based on the Diagnostic Criteria for Psychosomatic Research (Fava et al., 1995). The other reviews focus on 2 personality constructs widely used in investigations with medical patients. Kupper and Denollet (2007/this issue) review the Type D personality, whereas Lumley, Neely, and Burger (2007/this issue) provide an overview of alexithymia. Of the research articles, 2 also focus on alexithymia, specifically on the factor structure of the 20-item Toronto Alexithymia Scale (Bagby, Parker, & Taylor, 1994), which is the best-validated and most commonly used measure of alexithymia (Bagby, Taylor, Quilty, & Parker, 2007/this issue; Gignac, Palmer, & Stough, 2007/this issue). The other 3 research studies examine the relationship between specific personality dimensions (behavioral problems relevant to medicine, resiliency, and interpersonal sensitivity) and medical outcomes (adherence to treatment, coping with injury, and postsurgical sexual functioning) from medical samples of patients with HIV, spinal cord injury, and prostate carcinoma (Berry, Elliott, & Rivera, 2007/this issue; Cruess, Meagher, Antoni, & Millon, 2007/this issue; Siegel et al., 2007/this issue). Each article touches on the role person variables can play in the expression of medical problems.

When the idea was first raised to organize a special section on "Personality Assessment in Medical Settings," we thought the topic was worth pursuing for at least two reasons. First, after years of low quotations on the stock exchange of science, the prospects for psychosomatic medicine has been spiraling upward recently as evidenced by the recognition of its role in scientific debates (Freedland, Gregory, Miller, & Sheps, 2006) and clinical practice with medical patients (Henningsen, Zipfel, & Herzog, 2007). The last 30 to 40 years have not been kind to psychosomatic medicine. The refutation of early theoretical models in psychosomatic medicine that suggested personality factors specific to certain disorders, the failure of insight-oriented psychotherapies with medical patients, as well as the discovery of biological causes or effective biological treatments for several diseases that were thought to be of functional etiology (e.g., the use of corticosteroids for inflammatory processes or antisecretory drugs for peptic ulcer) led to a progressive abandonment even of the word *psychosomatic* in clinical and academic settings in favor of other similar terms as *behavioral medicine, health psychology,* or *consultation-liaison psychiatry.* Ultimately, though, changes in medicine provided a basis for an alternate approach to psychosomatic medicine. Contributing to this parallel process was the recognition of limitations to narrow biomedical models. Specifically, the focus in Western medicine has shifted away from disorders such as infection that reflect a simple biological etiology to disorders demonstrating a progressive rather than acute onset and a chronic course; that are sensitive to multiple determinants including genetic makeup, nutritional status, immunological

experience, and psychological status; that involve multiple rather than single organ systems; with clinical manifestations that are only indirectly related to the putative main cause; and that require multidisciplinary interventions that address the different facets of illness manifestation such as symptom relief, manipulation of the environment, disease modification, effective coping, and patient support (Bradfield, 2006). Out of the changing focus within medicine has emerged the biopsychosocial model of illness (Engel, 1977) in which diseases are viewed as the result of interacting mechanisms at the cellular, tissue, organismic, psychological, interpersonal, and environmental levels. Each of these factors (personality, biological mechanisms, physical environment, and social relationships) should be evaluated in their interactions and the role played by each of them in both the clinical expression (onset, relapses, improvement, severity, etc.) and the subjective experience (symptom perception, narratives, referrals, health-related quality of life, etc.) of illness. As claimed by Kissen (1963), "it would appear possible for an illness generally thought of as being 'psychosomatic' to be non-psychosomatic in certain individuals. Likewise an illness generally thought as being 'not psychosomatic' may be psychosomatic in some individuals" (p. 40).

The growing awareness of the importance of a biopsychosocial approach to medical conditions has provided a new context in which to place psychosomatic medicine, one in which psychosocial factors are treated not as the sole determinant of physical conditions but as an essential consideration in understanding specific aspects of certain physical conditions (Fava & Sonino, 2007). Several events testify to this renewed interest in psychosomatic medicine. In 2003, psychosomatic medicine was recognized as the seventh subspecialty of the American Board of Psychiatry and Neurology (Gitlin, Levenson, & Lyketsos, 2004). In 2005, the American Psychiatric Association's *Textbook of Consultation-Liaison Psychiatry* was revamped as the *Textbook of Psychosomatic Medicine* (Levenson, 2005), and the annual congress of the American Psychiatric Association was entitled *Psychosomatic Medicine: Integrating Psychiatry and Medicine*. The time would seem ripe for psychologists interested in assessment to reconsider the potential for contributing to the treatment of traditional medical disorders in innovative ways.

The second factor contributing to our interest in a special issue was our belief that the synthesis of personality assessment on one hand and medical disorders on the other potentially can inform both domains. The use of reliable data about personal functioning can provide unique information about individuals with medical conditions that traditional medical methods cannot reveal. At the same time, the use of personality assessment instruments with physically ill patients broadens the scope of settings in which such instruments can play a role (Porcelli, 2004).

The articles included in this Special Issue provide insight into a core problem for psychosomatic medicine: to what extent does the evaluation of psychopathology and personality dimensions contribute to the understanding of medical patients and their global health, effective communication among clinicians, and optimal decision-making and treatment planning. Sirri et al. (2007/this issue) point out the criticism raised against the evaluation of psychological factors in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [*DSM–IV*]; American Psychiatric Association, 1994). The limitation of the *DSM–IV* approach to the somatization process is currently a topic of much discussion in psychosomatic journals, and several alternatives have been proposed for the next edition. Proposals range from simply reducing the number of somatoform disorders (Hiller, 2006) to the abolition of the rubric of somatoform disorders (Mayou, Kirmayer, Simon, Kroenke, & Sharpe, 2005). Sirri et al.'s (2007/this issue) article focuses on the Diagnostic Criteria for Psychosomatic Research (DCPR; Fava et al., 1995), which has been offered as an alternative framework for conceptualizing the role of psychological factors in medical disorders. In particular, Sirri et al. review the eight DCPR constructs that were found to be most prevalent across studies (disease phobia, persistent somatization, conversion symptoms, illness denial, demoralization, irritable mood, and Type A behavior) and suggest their addition to the current *DSM–IV* definition of Psychological Factors Affecting Medical Conditions (PFAMC) together with the currently defined hypochondriasis. Recognizing that the PFAMC diagnosis is vague, lacking in clinical specificity, and is rarely used in clinical practice, the DCPR syndromes are suggested as a framework for translating psychosocial variables that were derived from psychosomatic research into operational tools.

Some personality patterns thought to be strictly involved with somatic illness have been extensively studied in the past decades, and some new personality constellations are attracting the attention of many researchers worldwide. One of the most influential personality constructs in psychosomatic medicine is undoubtedly the construct of alexithymia, whereas one of the most promising constructs is Type D personality. The popularity of alexithymia as a construct in psychosomatic medicine is highlighted by its centrality to three articles included in this Special Issue. Alexithymia, conceived as a deficiency in the cognitive processing of emotions, is not specific to psychosomatic disorders but it is currently recognized as a risk factor for medical, psychiatric, or behavioral problems that are influenced by difficulties modulating arousal, appropriately expressing or suppressing emotions, employing fantasy, and obtaining and using social support (Taylor, Bagby, & Parker, 1997). In the first article, Lumley, Neely, and Burger (2007/this issue) examine the current status of the alexithymia construct. They review the most important assessment methods used to evaluate the construct (interviews, by proxy, performance-based testing, verbal response analysis, and self-reports) as well as its role in the etiology and the pathophysiology of somatic illnesses, the presentation of symptoms and the utilization of health care resources, the maintenance of maladaptive behaviors (sedentary lifestyle, eating-disordered behaviors, abuse and

dependence, body mass index, suicide), and the prediction of therapeutic process and outcomes. In their article, Lumley et al. also discuss many questions that are yet unanswered such as whether alexithymia can be reduced by target-specific psychological treatments, whether it is a stable personality dimension or occurs secondary to traumatic events and severe health-related problems, whether it is a coherent psychological construct or is an accumulation of distinct facets, whether there are differentiable subtypes of alexithymia, and which is the best approach to measuring this construct.

The authors of two articles focus on a more specific issue in alexithymia. Gignac, Palmer, and Stough (2007/this issue) raise questions about the standard factorial model for the 20-item Toronto Alexithymia Scale (TAS–20; Bagby, Parker & Taylor, 1994). The TAS–20 is the best validated and most commonly used measure of alexithymia, and studies using the TAS–20 have contributed substantially to the knowledge of the construct. The use of a common instrument by multiple research teams around the world has permitted the accumulation of a large body of information uncompromised by the measurement-related concerns that plagued early alexithymia research (Taylor & Bagby, 2004). The TAS–20 is a self-report scale traditionally seen as consisting of three factors mirroring three of the most prominent clinical characteristics of alexithymia: difficulty identifying feelings (DIF), difficulty describing feelings (DDF), and externally oriented thinking (EOT) and has shown excellent factorial stability across different languages and cultures (Taylor, Bagby, & Parker, 2003). By using a nested factor model, Gignac et al. evaluated 335 nonclinical individuals and found that the TAS–20 measures a global alexithymia factor and that the commonly utilized subscales of the TAS–20 suffered from very low levels of internal consistency reliability. Bagby, Taylor, Quilty, and Parker (2007/this issue) comment on the issues raised by Gignac et al. and recognize some important merits of the debate around the TAS–20, particularly surrounding the most controversial factor of the TAS–20, the third EOT factor. Bagby et al. (2007/this issue) disagree however with Gignac et al.'s conclusion that the nested factor modeling represents more reliably the alexithymia construct because the three-factor structure has been widely replicated through various factor analytic techniques and principal component analysis in several studies on various clinical and nonclinical samples, so they believe it is premature to dismiss the wide body of results obtained worldwide on the basis of findings from a single sample.

An increasing number of recently published papers indicate Type D (Distressed) personality is an important risk factor for cardiovascular events, which is among the more frequent causes of morbidity and mortality in Western countries (World Health Organization, 2002). Type D personality is comprised of two dimensions: negative affect, conceived as the tendency to experience negative emotional states across time and situations; and social inhibition, conceived as the tendency to avoid potential dangers involved in social interaction due to anticipation of negative reactions from others such as disapproval. This construct was proposed by Denollet (1993) after studying subtypes of patients with coronary heart disease. In this issue, Kupper and Denollet (2007/this issue) review the wide body of literature on the construct including the different approaches to Type D. The overall results summarized in Kupper and Denollet's review are impressive and suggest that the refinement of this construct is likely to contribute substantially to enhancing the knowledge of cardiovascular disorders. Kupper and Denollet also discuss several unanswered questions such as the role played by Type D in the prediction of the onset of heart diseases and in the prognosis of noncardiac diseases, the identification of physiological mechanisms through which Type D may affect the poor outcome of cardiovascular patients, and interventions specifically tailored to reduce the Type-D risk.

Three articles are related to the use of specific measures of personality for assessing a variety of clinically relevant topics in medical settings. Cruess, Meagher, Antoni, and Millon (2007/this issue) investigated the problem of adherence to treatment, one of the most critical behavioral problems in medicine particularly with chronic disease (renal dialysis, diabetes) in populations with other relevant behavioral problems such as drug abusers infected by hepatitis C and HIV. As is widely known, HIV is a plague of contemporary society, and it is recognized that the use of highly active antiretroviral therapy (HAART), typically a combination of protease inhibitors and other antiretroviral medications, results in reductions in HIV viral load and increases in immune competency, enhances prevention of viral resistance, and slows down the progression to AIDS development among infected individuals. Many psychological and behavioral factors are thought to influence adherence to HAART including negative affect, low social support, active drug use, use of avoidant coping, food restrictions, stressful events, and complex schedules. However, to date efforts to enhance compliance have been minimal, focusing mainly on simple techniques such as setting an alarm to remind patients to take their medications and ignoring relevant factors such as motivation and personality characteristics. Cruess et al. evaluated a group of HIV patients who participated in medication adherence training with the Millon Behavioral Medicine Diagnostic (MBMD; Millon, Antoni, Millon, Meagher, & Grossman, 2001). Overall adherence to HAART was associated with various MBMD scale scores including Depression, Cognitive Dysfunction, Emotional Lability, Maladaptive Coping, and Medication Abuse. When all of the significant individual MBMD factors were considered together after controlling for relevant demographic, disease, and health behavior variables, the overall model correctly assigned 77% of participants to the groups of adherents or nonadherents, thus showing the potential help to clinicians provided by the MBMD to identify medical patients with adherence problems early in the course of treatment.

Berry, Elliott, and Rivera (2007/this issue) evaluated three personality styles—resiliency, undercontrol, and overcontrol—in patients with spinal cord injury (SCI) admitted to a hospital-based rehabilitation program. Whereas resilient individuals (who are able to use flexible and appropriate self-regulation in response to uncertainty, change, and environmental demands) have been found to be relatively well-adjusted, undercontrolled individuals showed a variety of externalizing problems, and overcontrolled individuals showed internalizing problems. Using results of cluster analysis from the NEO Five-Factor Inventory (Costa & McRae, 1992), Berry et al. show that in their sample, most patients exhibited an undercontrolled style. The results of this study could potentially be generalized to other rehabilitation settings. Patients with overcontrolled personality might be in greatest need of intervention and possibly represent the most cost-effective group for intervention. These individuals possess definite positive problem-solving capacities and show moderate adjustment, but their low conscientiousness and negative problem-solving skills suggest that problems with self-regulation may affect adherence to self-care programs.

Siegel et al. (2007/this issue) investigated interpersonal sensitivity (the predisposition to perceive and elicit criticism and rejection from others) through the Inventory of Interpersonal Problems (Horowitz, Alden, Wiggins, & Pincus, 2000) in men with prostate carcinoma (PC) who underwent radical prostatectomy. Because the prostate gland is enveloped in nerve fibers involved in the erectile response, this kind of surgery often produces unwanted sexual side effects strongly affecting quality of life. Evidence suggests poor interpersonal relationships are associated with less support seeking and more self-blame, more negative reactions to PC-related intrusive thoughts, and greater distress when seeking support in PC patients. Siegel et al.'s study therefore provided some preliminary evidence that certain interpersonal styles may complicate the recovery of sexual functioning after surgical treatment for PC, but this issue is less straightforward than expected and requires further investigations.

The review and research articles included in this Special Issue bear witness to radical changes in psychology's approach to medical illness. Personality factors are no longer treated primarily as causes of medical disease, as they were in older psychogenetic theories and as they are in the common use of the term *psychosomatic illness,* but as moderators or mediators that variously influence preclinical and clinical levels of illness from risk factors and vulnerability to maintenance of symptoms and recovery. As shown in the articles of this Special Issue, psychological dimensions such those addressed in the DCPR, alexithymia, and Type D play a more complex role in the manifestation of disease. In particular, personality dimensions seem to influence medical outcomes because of their impact on such factors as adherence to treatment in HIV patients, effective coping in patients with SCI, and sexual behaviors in men with PC. Future studies on personality assessment in medicine are needed to show the incremental validity of psychological findings in the knowledge and treatment planning of somatic disorders.

With the ascendancy of the biopsychosocial model of medical disorders comes new opportunities for the use of assessment devices. We hope the topics discussed and the findings reported in this Special Issue spark greater interest in the potential value of assessment devices in medical settings and with populations in general that fall outside the traditional psychiatric model. In particular, studies targeted toward the prediction of adherence and prognosis among medically ill patients offer tremendous potential not only in terms of improving patient outcomes but in terms of enhancing the social value of assessment.

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Piero Porcelli
Psychosomatic Unit
IRCCS De Bellis Hospital
Via della Resistenza
70013 Castellana Grotte, Bari
Italy
Email: porcellip@media.it

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