

Chapter 6

Personologic Diathesis and Human Stress

Where malignant disease is concerned it may be more important to understand what kind of patient has the disease rather than what kind of disease the patient has.

Sir William Osler, M.D.

Recall from Chap. 2 that the manner in which an individual chooses to perceive and interpret his or her environment (cognitive interpretation) serves as the single most important determinant of whether the stress response will be elicited in response to a psychosocial stressor. We may then argue that the *consistent* manner in which an individual perceives and interprets the environment, in addition to the aggregation of consistent attitudes, values, and behavior patterns, serves as an operational definition of the construct of “personality.” If we accept such a proposition, it becomes reasonable to assume that there may well exist individuals whose consistent personality traits, including cognitive interpretations regarding their environment, may predispose them to excessive elicitation of the stress response and, therefore, increased risk of stress-related disease. Such personality-based predispositions for stress may exist in the form of personologic diatheses, such as cognitive distortions, persistent irrational expectations, “ego” vulnerabilities, and/or consistent stress-producing overt behavior patterns.

If indeed one’s personologic idiosyncrasies can predispose to excessive stress arousal, it behooves the clinician to familiarize him or herself with the common manifestations of such personologic predispositions. Investigations into such relationships between personality factors and stress arousal have typically taken one of two perspectives.

1. Historically, investigations into the relation between personality and stress have focused upon highly *specific* personality traits that appear to predispose individuals to highly *specific* diseases, without consideration of the global personality structure within which those traits reside (Alexander, 1950; Dunbar, 1935).

2. Investigations have pursued the proposition that there exist consistent, personality-based predispositions, that is, “vulnerabilities” unique to and inherent within each and every basic personality pattern (Millon, 1996; Millon, Crossman, Meagher, Millon, & Everly, 1999). Collectively, these characterological susceptibilities serve as a form of Achilles’ heel, referred to here as *a personologic diathesis*, serving, under the right set of circumstances, to predispose one to the elicitation of the stress response and a host of subsequent stress-related disorders (Everly, 1987; Frances, 1982; Millon & Everly, 1985). These characterological susceptibilities may exist in the form of “ego” vulnerabilities, consistent cognitive distortions, expectations, and repeated stress-producing behaviors. Such an approach tends not to focus on specific traits and their association with specific diseases, but rather sees each different personality style or pattern as possessing a personologic diathesis consisting of an aggregation of personality-based susceptibilities to stress. Let us pursue these notions further.

Historical Foundations

When one first thinks of the relation between personality and stress, the Type A coronary-prone behavior pattern invariably comes to mind (Friedman & Rosenman, 1974). Yet the search for the stress-prone personality far predates the discovery of the Type A pattern.

The work of Dunbar (1935) represents one of the earliest and most noteworthy efforts at formulating psychosomatic theory based upon personality profiles. Dunbar described various personality profiles that seemed to be predisposed to specific stress-related diseases. For example, from her perspective, the hypertensive patient could be seen as characterologically shy, reserved, rigid, yet possessing the propensity for “Volcanic eruptions of feelings.” The migraine patient, on the other hand, could be seen as perfectionistic and overachievement oriented.

As noted earlier in this volume, the conflict theory of French and Alexander (Alexander, 1950) argued that persons prone to repeated characterological conflicts are prone to specific stress-related disorders.

In addition to the work of Dunbar and Alexander, there were other early contributions from the analytically oriented theorists, yet early interest waned, with rather low reliability among the findings of the various theorists. Similarly, even reliable findings contributed only minimal variation to the overall disease process. Thus, research into the relationship between personality and disease significantly diminished for over a decade until interest was rekindled by cardiologists Friedman and Rosenman (1974) in their investigations into the Type A coronary-prone behavior pattern.

Friedman (1969) described the Type A pattern as a characteristic “action—emotion complex” exhibited by individuals engaged in a chronic struggle to “obtain an unlimited number of poorly defined things from their environment in the shortest period of time.” Originally, the Type A pattern was believed to constitute chronic

time urgency, competitiveness, polyphasic behavior, and poorly planned, often impulsive behavior (Friedman & Rosenman, 1974). The Type A pattern has also been described as consisting of primary traits of time urgency, hostility, ambition, and immoderation. Friedman and Rosenman also described secondary traits of impatience, aggression, competitiveness, and denial.

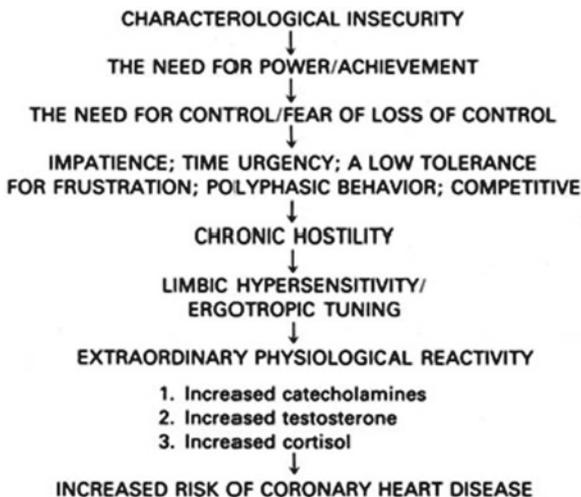
The original search for the Type A pattern was, indeed, a search for a consistent behavior pattern that predisposed to premature coronary artery disease. When diagnosed via the standardized structured interview technique, the Type A pattern has consistently shown a relation with coronary artery disease (see Powell, 1984; Shepherd & Weiss, 1987; Williams, 1984; Williams et al., 1980). Major investigations that have failed to uncover a relationship between coronary heart disease and the Type A pattern have generally used techniques other than the structured interview to assess the pattern (Everly & Sobelman, 1987; Shepherd & Weiss). The use of diverse measurement technologies may have inadvertently added to the confusion surrounding the nature of the Type A pattern (Everly & Sobelman). Indeed, the pursuit of the Type A pattern has taken on a life of its own, so much so that individuals invariably ask if there is such a thing as a “good” Type A pattern. By definition, the answer to such a question must be “no,” if one only remembers that the original quest for the Type A pattern was actually a search for a behavior pattern that predisposes to premature coronary heart disease. Considering this point, how could there be a “good” Type A?

The relation between Type A behavior and coronary heart disease has prompted researchers to conduct various components analyses in search of the pathogenic core of the Type A pattern (Powell, 1984; Williams, 1984; Williams et al., 1980). Such endeavors have uncovered myriad Type A constituents that serve to clarify further the nature of the pattern.

Figure 6.1 represents an integration of findings reported as part of the “second generation” of Type A research designed to better understand the constituents of coronary-prone behavior (Powell, 1984; Williams, 1984, 1986; Williams et al., 1980). It portrays a deeply rooted personologic insecurity as the foundation of the Type A pattern. That characterological insecurity is thought to give rise to an extraordinary need for power and achievement, perhaps as a means of compensating for or contradicting the feelings of insecurity. Power and achievement are related to control, and it has been found that Type A individuals possess not only high achievement motives but also an extraordinary need for control. The need for control and the fear of the loss of control may then account for the observed impatience, time urgency, polyphasic behavior, competitiveness, and related traits that Type A persons exhibit. Studies by Williams and his colleagues have suggested that chronic hostility and cynicism may be an important psychological factor in the increased coronary risk that Type A individuals exhibit. Dembroski and Costa (1988) reviewed the assessment of the Type A pattern and noted that the “global” Type A pattern is not a good predictor of heart disease, but the hostility component may play a critical pathogenic role.

Research has also shown that Type A individuals exhibit extraordinary physiological reactivity when confronted with a psychosocial challenge.

Fig. 6.1 An integrative model of Type A characteristics



That reactivity has been shown to be manifest in increased release of catecholamines, testosterone, and cortisol—all well-known atherogenic agents. The physiological reactivity, according to the work of Everly (1985b), may well be based upon some form of limbic system hypersensitivity, or what Gellhorn (1967) has called the “ergotropic tuning phenomenon.” Finally, the unusually high levels of circulating catecholamine, cortisol, and testosterone appear to be directly related to the increased risk of coronary artery disease manifested by Type A males. It should be noted that, at rest, the Type A individual manifests no significant differences in catecholamine, testosterone, or cortisol secretion when compared with non-Type A individuals. Only upon psychosocial challenge are the aforementioned differences seen to emerge.

The Type A pattern remains a promising area for continued research into the relationship between personality and disease, especially stress-related disease. It will be recalled that the catecholamines, testosterone, and cortisol are all key stress-responding hormones. The interested reader should refer to Shepherd and Weiss (1987) for an early yet important review.

The next major contribution to the stress and personality phenomenon comes from Suzanne Kobasa, who investigated personality characteristics that seem to act as a buffer between individuals and the pathogenic mechanisms of excessive stress. Her research investigated the domain of “hardiness,” that is, characterological factors that appear to mitigate the stress response. Kobasa (1979) and Kobasa & Puccetti (1983) defined hardiness as the aggregation of three factors:

1. Commitment, that is, the tendency to involve oneself in experiences in meaningful ways.
2. Control, that is, the tendency to believe and act as if one has some influence over one’s life.
3. Challenge, that is, the belief that change is a positive and normal characteristic of life.

The hardiness research has shown that individuals who demonstrate a commitment to self, family, work, and/or other important values; a sense of control over their lives; and the ability to see life change as an opportunity will experience fewer stress-related diseases/illnesses even though they may find themselves in environments laden with stressor stimuli.

The hardiness construct is indeed a tempting concept to entertain. This formulation has received a serious challenge from Lazarus and Folkman (1984), however, who argue that there is a paucity of systematic studies that examine the relation between antecedent variables and health. Conclusions, they suggest, are typically formulated on the basis of inference with regard to coping mechanisms. They argue that Kobasa's conclusions about hardiness are based on tenuous inferences about coping mechanisms generated through the use of questionable measurement technologies.

It seems clear that factors such as those described in the hardiness research may indeed play an important role in mitigating otherwise pathogenic circumstances. Nevertheless, it may be useful to better operationalize these factors before employing such notions in psychotherapeutic formulations.

No review of historical foundations in personality and stress research would be complete without mentioning the oldest longitudinal research investigation, specifically, the relationship between personality and disease. The Johns Hopkins Precursors Study (see Thomas & McCabe, 1980) seeks to answer the question "Do individuals have distinctive personal characteristics in youth that precede premature disease and death?" The Precursors Study cohort consisted of 1,337 graduates of the Johns Hopkins School of Medicine between the years of 1948 and 1964. Thomas and McCabe investigated, via self-report, consistent "habits of nervous tension" (HNT) and subsequent disease.

Compared with those of the healthy group, the overall HNT patterns were significantly different for the cancer, coronary occlusion, mental illness and suicide groups. ... It therefore appears that youthful reactions to stress as self-reported in a checklist of habits of nervous tension reflect individual psychobiological differences that are linked with future health or disease. (p. 137)

Thus, in the most liberal interpretation of personality, the Precursors Study continues to reveal links between what may be argued to be characterological traits and the subsequent formation of disease.

Indeed, in a meta-analytic investigation in search of the "disease-prone personality," Friedman and Booth-Kewley (1987) reviewed a research base including *Psychological Abstracts* and *Index Medicus*. Focusing upon psychosomatic disease processes, the authors found 229 studies, of which 101 were ultimately used in the meta-analysis. They conclude: "The results point to the probable existence of a generic 'disease-prone' personality that involves depression, anger/hostility, anxiety, and possibly other aspects of personality" (p. 539).

Let us now turn to a discussion of more recent trends in personality research as it pertains to excessive stress arousal.

The Principle of Personologic Primacy

Should the patient with passive-dependent traits presenting with a stress-induced chronic migraine headache syndrome be treated in the same manner as the patient with histrionic traits and a migraine syndrome of equal severity? Should the patient with avoidant traits and a panic disorder be treated in the same manner as a patient with compulsive traits and a diagnosed panic disorder of equal intensity? A growing body of evidence argues that the answer to both questions is “no” (Millon, Krueger, & Simonsen, 2010; Millon, 2011).

Theoretical (Everly, 1987; Widiger & Frances, 1985; Millon & Davis, 2011), as well as empirical evidence (Kayser, Robinson, Nies, & Howard, 1985; Millon et al., 1999; Strupp, 1980; Taylor & Abrams, 1975) suggests that clinical and subclinical personality patterns may be a uniquely important factor in the diagnosis and treatment of many psychiatric and stress-related disorders. More specifically, the “principle of personologic primacy” as proposed by Everly (1987) denotes that personologic style plays a uniquely important role in the following:

1. The consistent propensity to create psychosocial stressors (via some diathesis).
2. The phenomenological course of psychiatric and stress-related disorders.
3. Diagnostic refinement of major psychiatric syndromes.
4. Psychotherapeutic, as well as psychopharmacological, treatment responsiveness.
5. The long-term prognosis for many psychiatric and stress-related disorders.

The “principle of personologic primacy” further argues that basic personality patterns and their respective hosts of idiosyncratic interpretational predispositions (i.e., personologic diatheses) for stress and other clinical syndromes serve as phenomenological foundations from which major stress-related illnesses and psychiatric syndromes may emerge. Thus, such syndromes are best understood as pathological extensions of potentially malignant personologic undergirdings, for example, consistent cognitive distortions, irrational expectations, “ego” vulnerabilities, unfounded assumptions, and the like (Everly, 1987; Millon & Everly, 1985; Millon et al., 1999; Millon & Davis, 2011). Adverse environmental events, psychoactive drug reactions, and physical and/or psychological trauma may serve as sufficient impetus to cause the personologic substructure to express itself in pathological clinical manifestations such as headaches, panic attacks, and hypertensive and acute tachycardic episodes mediated through the physiological stress response (Chap. 2).

In summary, with regard to stress-related disorders, the “principle of personologic primacy” may be understood as suggesting that (1) a patient’s *chronic* propensity to interpret the environment cognitively in such a manner as to engender the stress response with extraordinary frequency is more likely than not to be a function of a personality-based predisposition (diathesis); similarly, (2) a chronic and consistent pattern of elicitation of the stress response is perhaps best viewed more as a manifestation of a dysfunctional characterological predisposition, rather than merely one’s exposure to a series of consistently hostile environments. This brings us to the natural corollary of the “principle of personologic primacy”: personality-based psychotherapy.

Personologic Psychotherapy and Stress-Related Disorders

If, indeed, we accept personality as playing an important role in the etiology of stress-related disease, then we might logically assume that it must play some role in the treatment of such disease as well. Everly (1987) has introduced the concept of “personologic psychotherapy” as one way of recognizing the role that personality may play in treatment formulation. According to Everly, personologic psychotherapy represents a metatherapeutic approach to the treatment of psychiatric as well as stress-related disorders. More specifically, it is the embodiment of the belief that in most chronic psychiatric and stress-related syndromes, a dysfunctional personologic style supports these syndromes and, therefore, must also become a target for therapeutic intervention, if the chronic nature of the problem is to be addressed. Similarly, the concept of “personologic psychotherapy” embodies the belief that treating only the symptoms of *chronic, recurrent* clinical syndromes may in many cases be analogous to palliatively attending to a clinical veneer while ignoring an important aspect of the etiological malignancy (see also Millon et al., 1999).

The theoretical basis for “personologic psychotherapy” is Millon’s biosocial learning theory (Millon, 1988, 1996). It is referred to as a metatherapy because the specific manner in which the personologic dysfunction is treated is left to the discretion of the treating therapist.

With specific attention to stress-related disorders, personologic psychotherapy is broadly interpreted to suggest that in addition to treating the florid symptoms of *chronic* stress-related disorders, it is necessary to direct some aspect of therapeutic effort toward the personologic predispositions (diatheses) that may be serving to sustain the chronic stress-related disorder.

Let us examine one example of how these concepts may be used in treatment planning with a patient who can be said to possess a dependent characterological style while manifesting a chronic and more florid stress-related gastrointestinal (GI) dysfunction. According to the theoretical basis (Millon & Everly, 1985; Millon, 2011), a major sustaining mechanism in a chronically dependent character structure is an extraordinary need for interpersonal affection, affiliation, and support. Such an individual is most vulnerable to chronic stress when this critical need is denied or perhaps only jeopardized. In such a scenario, alleviation of the stress-related GI symptomatology may serve to address only the immediate medical concern. If, indeed, symptom removal has been the only outcome achieved in treatment, then nothing has been done to preclude recurrent GI dysfunction. On the other hand, therapy directed with personologic considerations in mind would certainly consider the potentially self-sustaining mechanisms of extraordinary dependency needs and target the dependent pattern as an additional focus for therapy. Once again, the specific therapeutic technology employed remains at the discretion of the therapist.

The principle of personologic primacy and its therapeutic corollary by no means dictate that formal psychotherapy needs to be conducted in all stress-related disorders. Certainly, there are acute stress-related manifestations that may have little or no etiological basis in personality-related dysfunction. Similarly, “psychotherapeutic” change may well be realized on the basis of therapies not traditionally seen as being

“psychotherapeutic” in nature, such as relaxation training and biofeedback therapy (Adler & Morrissey-Adler, 1983; Green & Green, 1983; Murphy & Donovan, 1984). Such therapies commonly yield outcomes such as an improved sense of self-efficacy, a more internal locus of control, improved self-esteem, and what has been called by some a state of “cultivated low arousal” (Adler & Morrissey-Adler; Green & Green; Sarnoff, 1982; Stoyva & Budzynski, 1974).

Millon’s Personality Theory and Stress

Preceding sections in this chapter have argued basically two points: (1) that personality type is related to disease, including stress-related disease, and (2) that treatment planning for stress-related diseases should take into consideration the undergirding personality structure if treatment is to be considered complete. It has also been argued that different personalities possess relatively unique characterological “vulnerabilities,” or personologic diatheses, which serve as characterological “weak points” for the initiation of pathogenic stress mechanisms should environmental conditions support such development. Yet one factor that has served to limit the progression of the field of research related to personality and stress is the lack of a coherent superordinate theory of personality from which to extend relational investigations. This is in contrast to the traditional search for unique and specific independent personality factors, such as the Type A pattern.

The biosocial learning theory of personality is a theoretically sound but, more important, clinically useful perspective from which to examine the role that personality plays in the initiation and prolongation of the human stress response (Millon, 2011). A comprehensive review of Millon’s theory is beyond the scope of this chapter. Interested readers should refer to Millon (2011). A brief description of his basic personality styles will be presented below.

Considering the realm of “normal” personologic styles, Millon (Millon & Everly, 1985) suggests that there exist eight basic and theoretically pure styles. These normal styles are fundamentally adaptive under most circumstances. Yet each one of these styles will be considered to possess, as part of its intrinsic constituency, idiosyncratic “vulnerabilities” or uniqueness that can serve to predispose to excessive stress arousal under the proper set of environmental circumstances.

A brief review of these eight normal styles seems appropriate at this point. We label each of the styles (with one exception) with the traditional diagnostic terms. The reader must keep in mind, however, that although the terms used will be those most commonly associated with personality “disorders,” the present discussion refers NOT to personality disorders but to the “normal” personologic variants.

The individual with an *aggressive* personality has difficulty trusting others. He or she tends to usurp the rights of others and to be defensively self-centered. Action-oriented and highly independent, the behavioral style of the personality is forceful. The individual often displays intimidating interpersonal conduct and angry affective expressions, yet the self-perception is one of assertiveness. There is a significant need to control and dominate the environment. The basic, sustaining reinforcement pattern

is that of negative reinforcement, in which the individual strives to avoid a loss of control, humiliation, and any position or status that is perceived as being inferior.

The individual with a *narcissistic* personality, even in its normal variation, has difficulty postponing gratification. The person is passively independent, and a poised behavioral appearance is usually manifest. Interpersonal conduct is usually seen as being unempathic, and the affective expression may be seen as serene. The self-perception of the narcissist is one of confidence. Narcissistic individuals seem preoccupied with being seen as unique or special. Such persons often resort to creating illusions of extraordinary competence or influence. They usually are so self-absorbed as to be incapable of seeing any point of view other than their own. This lack of empathy often leads to poor interpersonal communications and shallow relationships. The basic reinforcement pattern is that of positive reinforcement, wherein these individuals act to secure for themselves a position of "entitlement."

The *histrionic* personality is driven by a need for approval, affection, affiliation, and support. Histrionic individuals project an animated, sociable, sometimes dramatic, appearance. An exaggerated affective expression is often present. These individuals are often seen as superficial. However, boredom, especially interpersonal boredom, often plagues the person with histrionic traits. With a flair for the drama in life, the histrionic personality moves about searching for approval, yet it seems that this search is never-ending. Thus, these individuals tend to pursue activities that make them the center of attention. The basic sustaining reinforcement pattern is positive, in which support, approval, and affiliation are inherently reinforcing.

The *schizoid* personality style is described as a characterological pattern typified by a passive behavioral appearance and detached, unobtrusive interpersonal conduct, manifesting a rather bland affective expression. The self-perception of the character style is one of placidity. The individual with a schizoid personality style, juxtaposed to the histrionic style, expresses virtually no desire for interpersonal affiliation or support. The classic prototype of the "lone wolf," this individual appears to view interpersonal exchange as a burdensome process. The schizoid seeks isolation as a defense against excess stimulus bombardment and a sense of being overwhelmed. Thus, the reinforcement pattern of the schizoid can be said to be negative.

The *compulsive* personality is a highly respectful personologic style. Driven by the need to behave in a socially acceptable manner, and to avoid making mistakes, individuals with a compulsive personality walk the "straight and narrow." They consistently adhere to foredrawn rules and regulations, ethics and mores. They often appear as rigid and inflexible, tending to suppress emotions and any signs of distress. These people are most comfortable with the concrete things in life. The abstract and ambiguous are to be avoided as sources of distress. Their sustaining pattern of reinforcement is negative; that is, their behavior is driven by the need to avoid making mistakes and being perceived as socially inappropriate.

The *avoidant* personality desires social affiliation and support yet is so afraid of social rejection that social avoidance becomes a way of life. Shy and withdrawing, individuals with an avoidant personality remain extraordinarily sensitive and vigilant to anything that resembles interpersonal rejection. The sustaining pattern of reinforcement appears to be negative, that is, the avoidance of interpersonal rejection and/or humiliation.

The *dependent* personality is driven by the search for support. Unlike the histrionic style, which actively attracts approval and support, the dependent personality acquiesces to gain affection and support. The chronic pattern of submissiveness and passivity often prohibits the natural development of independent skills and autonomous behaviors. The sustaining pattern of reinforcement is dual, that is, both positive and negative reinforcement. The negative reinforcement is revealed as a pattern in which submissiveness “earns” the affection and support of others, thereby, through a negative reinforcement pattern, avoiding the penultimate stressor—rejection, abandonment, and interpersonal isolation.

The *passive-aggressive* personality, in its pure form, is ambivalent. In many ways it represents an adolescent, from a maturational perspective, in an adult’s body. The individual with a passive-aggressive personality desires interpersonal independence but lacks the skills required to function in such a manner. This causes the individual to resort to a dependent reinforcement pattern, yet not without considerable dissonance. Such individuals tend to behave aggressively, but lacking the “adult” skills of assertiveness, cannot risk rejection, so they are aggressive in a hidden, cloaked, or “passive” manner. The sustaining reinforcement pattern for these individuals is negative. Their chronic pessimism, negativism, and interpersonal “game playing” seem to provide rewards of some kind, especially when they can see others fail, compromise, or become as negative or cynical about the world as they are. Indeed, perhaps misery does love company. More important, the passive-aggressive manipulation allows the person to avoid a sense of interpersonal impotence and dependence.

These, then, are the theoretically “pure” personologic styles as described by Millon (Millon & Everly, 1985). In reality, it should be noted that most people are combinations of two or three of these styles. Furthermore, to reiterate, each of the aforementioned personality styles can be said to be fundamentally “normal” and *not* to be considered a personality disorder, despite the descriptive labels usually used in conjunction with a personality disorder.

Returning to the issue of the human stress response, the notion of personologic psychotherapy as it pertains to the treatment of stress arousal argues that some degree of therapeutic effort needs to be directed toward the unique qualities and/or sustaining reinforcement patterns of the personality being treated, because it is felt that some idiosyncratic qualities or vulnerabilities may play a significant role in the etiology of chronic stress syndromes. Using Millon’s schema, it may be argued that each of the eight basic personality styles possesses its own intrinsic personologic diathesis, that is, factors inherent in the personality that may serve to contribute to extraordinary stress arousal. These factors are listed in Table 6.1. From a clinical perspective, we hope that enumeration of these factors will assist the clinician in (1) understanding how personologic factors may contribute to chronic stress arousal syndromes and (2) targeting psychotherapeutic efforts toward the personologic foundations of excessive stress, that is, the unique vulnerabilities and/or sustaining mechanisms as described in the preceding text or in Table 6.1.

Table 6.1 Personologic diatheses and stress

Personality style	Sustaining reinforcement pattern	Consistent personality factors that contribute to extraordinary arousal
Aggressive	R-	<ol style="list-style-type: none"> 1. Need to exert control of, and to vigilantly monitor, the environment 2. Being placed in a position of having to rely on, or trust, other individuals 3. Fear of being taken advantage of and efforts to avoid that 4. Fear of being humiliated, and efforts to avoid that 5. Assumption that "only the strong survive" and the persistent efforts to be "strong"
Narcissistic	R+	<ol style="list-style-type: none"> 1. Inability to postpone gratification 2. Fear of not being seen as "special" 3. Need to create illusions of extraordinary competence 4. Inability to empathize with others, leading to consistently poor communications 5. Assumption that others will recognize him/her as "special"
Histrionic	R-	<ol style="list-style-type: none"> 1. Interpersonal instability 2. Fear of a loss of affection 3. Fear of a loss of support or actual rejection 4. Frequent changes in life events 5. Need for interpersonal approval 6. Belief that he/she must earn, or "perform" for interpersonal affection, approval, and support
Dependent	R-	<ol style="list-style-type: none"> 1. Fear of the loss of interpersonal support 2. Fear of the loss of affection or of actual rejection 3. Chronic submissiveness and inability to be assertive when desired 4. Fear and avoidance of interpersonal confrontation
Passive-aggressive	R-	<ol style="list-style-type: none"> 1. Desire to behave in a manner contrary to previous learning history 2. Inability to act assertively 3. Chronic tendency to compare self to others 4. Chronic negativism 5. "Successes" of peer group 6. Actual failure or rejection

(continued)

Table 6.1 (continued)

Personality style	Sustaining reinforcement pattern	Consistent personality factors that contribute to extraordinary arousal
Compulsive	R-	<ol style="list-style-type: none"> 1. Efforts to maintain rigid self-control 2. Change 3. Coping with abstract or ambiguous situations 4. Decision making when options are not clear 5. Unclear directions 6. The "gray areas" of rules and policies 7. Fear of making a mistake 8. Need for, and excessive efforts to, earn approval 9. Fear of social disapproval 10. Belief that emotions should be suppressed 11. Assumption that others share compulsive traits and will act accordingly 12. Waste (e.g., to time, money, effort) 13. Risk taking
Avoidant	R-	<ol style="list-style-type: none"> 1. Interpersonal intrusion 2. Fear of interpersonal rejection 3. Need to remain highly vigilant 4. Lack of interpersonal support 5. Actual rejection 6. Interpersonal hypersensitivity
Schizoid	R-	<ol style="list-style-type: none"> 1. Interpersonal intrusion 2. Lack of interpersonal support 3. Hyperstimulation

Summary

In this chapter, the focus has been upon the role that personality plays in the initiation, prolongation, and ultimate treatment of the human stress response. Let us review the main points:

1. There is a commonly held belief that in the case of *chronic* stress arousal and stress-related diseases, one's personality serves to play a significant role from an etiological, as well as therapeutic, perspective.
2. Historically, investigations have focused upon *specific* personality traits and *specific* disease formation (Alexander, 1950; Dunbar, 1935).
3. More contemporary perspectives have chosen to look within the global personality for characterological vulnerabilities, that is, personologic diathesis, for extraordinary stress arousal and a subsequent host of stress-related diseases (Everly, 1987; Frances, 1982; Millon, 1996).

4. The principle of personologic primacy argues that consistent characterological traits serve to undergird and therefore play a unique role in the patient's propensity to create psychosocial stressors. Such factors play a major role in treatment planning and responsiveness (Everly, 1987; Frances & Hale, 1984) as well.
5. The notion of "personologic psychotherapy" is the natural corollary of the principle of personologic primacy and basically argues that even in chronic stress-related disorders, characterological traits require therapeutic attention and therefore should be considered in treatment planning (Everly, 1987; Millon et al., 1999; Millon, 2011).
6. When attempting to better understand and concretize the role of personologic vulnerabilities as factors that predispose to extraordinary stress arousal, Millon's biosocial learning theory of personality serves as a theoretically cogent and clinically practical framework from which to operate. Table 6.1 describes common personologic factors that serve to contribute to extraordinary stress arousal within each of Millon's basic eight "normal" personality formulations. An understanding of these factors serves to foster a better understanding of *chronic* stress arousal and its subsequent disorders, and to facilitate treatment planning and intervention when one looks beyond the florid symptoms of excessive stress arousal.
7. A final point needs to be reiterated before this chapter is brought to a close. We have indeed attempted to sensitize the reader to the belief that personality traits play an important role in the nature and treatment of the human stress response. That is *not* to say, however, that formal psychotherapy needs to be an integral aspect of all stress treatment/stress management paradigms. Processes such as relaxation training, biofeedback, and even health education practices are clearly capable, in some instances, of altering dysfunctional practices. Yet there are instances where chronic, stress-related diseases are a direct function of personologic disturbances such as dysfunctional self-esteem, persistent cognitive distortions, irrational assumptions, inappropriate expectations of self and others, and so on. In such cases, some concerted psychotherapeutic effort would clearly be indicated. The most effective "mix" of therapeutic technologies (e.g., relaxation training, psychotherapy, hypnosis) remains to be determined by the therapist on a case-by-case basis. It is clearly beyond the scope of this volume to dictate such guidelines.

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