



## **Personality and Heart Disease**

Much has been said and written about stresses and the development of heart disease. Some claim that heart disease arises because of so called "coronary prone" behaviours or aspects of personality. This article looks at some of the claims.

### **Type A Behaviour**

The most widely accepted concept in the past was the "Type A behaviour pattern" (TABP). Those considered to have TABP were people who were usually rushing, fast talking, fast responding and competitive (e.g. James Cagney, Ernest Borgnine). By contrast, individuals in the Type B category were relaxed, measured, agreeable, even slow (e.g. Gary Cooper, James Stewart, Gregory Peck). Those who were supposedly Type B were less prone to coronary heart disease. However, studies carried out over the last 20 years have shown this is not so. This is particularly true when allowances are made for the usual risk factors for heart disease – smoking, blood pressure, cholesterol, obesity, physical inactivity, diabetes and socioeconomic status. Thus TABP has been abandoned.

### **Hostility**

Some have latched on to one aspect of TABP as possibly being a risk factors for heart disease – hostility. Hostility is similar to aggression. It is linked to willfulness and non adherence to medication or medical advice. A recent paper has explained that hostility leads to adverse behaviours (as set out above) and reluctance to change. Hence risk factors for heart disease are high amongst those with high hostility scores. The risk factors account for the higher incidence of heart disease and death amongst them.

### **Denial**

Those who choose to deny threat, disability or illness are likely to reject care or support. Denial can be so effective a method of handling stressors that suffering may not even be felt, let alone accepted.

### **Pessimism**

Some people respond cautiously, sadly or pessimistically to most aspects of living. With illness they may become depressed. Such depression may lead to a sense of despair in the face of illness or of the need to change. "Why bother? It's no use. We

have to die some time". Such attitudes may prevent improved habits.

### **Optimism**

Optimism is often valuable, both in itself and in its outcomes. "I can change and all will be well. Let's get on with it". The optimistic tend to look for and accept advice and support for behaviour change and do well.

### **Dependency**

Some people seem to depend on others. They are likely to accept advice, embrace support and appreciate care. They generally do well in the face of adversity, provided they receive the support they require. If that support is not available, they may start to magnify their display of ill health, manipulating others in order to obtain support. However, this can lead to a withdrawal of support instead, which may prove harmful.

### **Fatalism**

It is not uncommon to consider that fate determines the future. Fate may be seen as positive or negative, depending on individual attitudes. Favourable outcomes are likely amongst those who consider "All will be well. God will decide. I must do what I can to merit God's help". Adverse fatalism may lead to thoughts of "It is in the hands of fate. There is nothing I can do. It is too late to change my ways".

### **Summary**

We are all far more complex than may be described in a few captions about attitudes and personality characteristics. Risks are largely determined by behaviours (and also by genetic inheritance). Behaviours are largely determined by personality (and also by education and resources).

As we can't change our personalities much, perhaps we should leave them alone. We may be better advised to raise our levels of education and community resources. That is a surer way to improve our health behaviours and, hence, the prevention of heart disease.

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