

TYPE A BEHAVIOR

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1. Core Definition and Overview

The **Type A Behavior Pattern** (TABP) is a distinctive behavioral and emotional complex initially identified by cardiologists Meyer Friedman and Ray Rosenman. It is defined by a chronic, excessive sense of time urgency, intense ambition, elevated competitiveness, and, critically, an underlying level of free-floating hostility and aggression. This pattern reflects an individual's persistent, vigorous, and often aggressive struggle to accomplish more and more in less and less time, sometimes even in opposition to the perceived constraints of time or the efforts of other people.

It is paramount to understand that TABP is not synonymous with high achievement or simple hard work. Many high achievers demonstrate discipline and motivation without exhibiting the pathological impatience or hostility central to the Type A construct. Instead, the Type A individual experiences a constant internal pressure and stress, viewing the environment as perpetually challenging or frustrating. This leads to characteristic behaviors such as hurried speech, rushing activities, impatience with delays, and an inability to relax or delegate effectively. Friedman and Rosenman theorized that this pattern results from an interaction between a specific set of personality traits and an environment that provides appropriate challenges and demands.

The significance of TABP lies primarily in its long-suspected relationship with cardiovascular health. The constant emotional and cognitive vigilance required by this pattern leads to chronic physiological arousal, including elevated heart rate, blood pressure, and cortisol levels. This sustained sympathetic nervous system activation is the proposed pathway through which **Type A behavior** translates into an escalated threat of coronary heart illness, making the concept fundamental to the study of psychosomatic medicine and the relationship between personality and disease.

2. Historical Origin and Development

The discovery of the **Type A Behavior Pattern** is a landmark moment in behavioral medicine, credited primarily to American cardiologists Meyer Friedman and Ray Rosenman in the 1950s. Their initial interest was sparked by anecdotal observations regarding their patients; they noted that the furniture in their waiting rooms, particularly the armrests of chairs, were frequently worn down, suggesting a high degree of motor restlessness and agitation among those suffering from heart disease, a pattern not observed in waiting rooms for other specialties.

This led to the design and execution of the Western Collaborative Group Study (WCGS), a

comprehensive longitudinal study initiated in 1960. The WCGS tracked over 3,000 healthy men aged 39-59 over an eight-and-a-half-year period. Participants were rigorously screened for behavioral patterns, primarily through a structured interview (SI) designed to provoke characteristic Type A responses under mild stress. The study's findings, published throughout the 1970s, provided compelling statistical evidence linking the Type A pattern, measured prospectively, to a significantly increased risk of developing coronary heart disease (CHD) independent of traditional biological risk factors such as smoking, cholesterol, and blood pressure.

The structured interview method became the gold standard for assessing TABP, as it focused not only on the content of the interviewee's answers but, crucially, on the style and demeanor of their delivery--the speed of speech, vocal volume, underlying hostility, and signs of motor tension. The development of this measurable, behaviorally defined risk factor revolutionized the approach to CHD etiology, forcing medical science to acknowledge the powerful role of psychosocial factors in chronic physical illness. The resulting classification distinguished **Type A individuals** from those exhibiting Type B behavior, characterized by a more relaxed, patient, and non-competitive approach to life.

3. Defining Components of Type A Behavior

The **Type A Behavior Pattern** is a composite construct comprising several interconnected behavioral and emotional elements. While the overall pattern is what was initially linked to cardiovascular risk, the three core components are Time Urgency and Impatience, Competitiveness and Achievement Motivation, and Hostility and Aggression.

The component of **Time Urgency and Impatience** is perhaps the most visibly manifest aspect of Type A behavior. This is characterized by an altered feeling of time impulsency, where the individual feels constantly pressured by time constraints, even when deadlines are distant or non-existent. They frequently attempt polyphasic activity, meaning they try to perform two or more tasks simultaneously, such as reading while eating or dictating while driving. This impatience manifests as discomfort when waiting in line, interrupting others during conversation, rapid speech, and accelerated motor movements.

The second major component is **Competitiveness and Achievement Motivation**. Type A individuals possess a high drive for achievement and success, which often translates into an excessive need to win or outperform others in professional, social, and even recreational settings. They measure their self-worth heavily based on external accomplishments and often display exaggerated vigilance toward performance standards, leading to self-imposed stress and relentless pressure. This drive fuels the constant activity and effort required to sustain the Type A lifestyle.

4. The Hostility Component: A Critical Element

While competitiveness and time urgency characterize the active struggle of the Type A individual, it is the element of **Hostility and Aggression** that subsequent research identified as the most toxic component relating directly to cardiovascular morbidity. Hostility in this context is not limited to overt acts of violence, but includes a broader range of negative cognitive and emotional states, such as cynicism, resentment, mistrust, anger, and proneness to verbal aggression.

This hostility often takes the form of "cynical hostility," which is a pervasive sense of mistrust and negativity concerning the motives and actions of others. The Type A individual with high hostility tends to view the world as unjust, frustrating, and potentially threatening. When faced with minor inconveniences--such as traffic congestion, slow service, or perceived incompetence from colleagues--they react with intense anger and irritation, often suppressing or poorly managing these negative emotional responses.

Following the initial WCGS findings, significant refinement occurred in the TABP research. Researchers found that when isolating the components, measures of hostility were far better predictors of heart disease than measures of impatience or competitive drive alone. This led to a theoretical shift, focusing research efforts away from the broad TABP construct and onto specific, measurable indicators of chronic anger and hostility as the primary behavioral pathway linking stress to detrimental physiological outcomes.

5. Physiological Correlates and Stress Response

The correlation between **Type A behavior** and heart disease is underpinned by specific physiological mechanisms driven by chronic stress exposure. The Type A individual's constant state of struggle and perceived threat leads to frequent activation of the body's fight-or-flight response, taxing the cardiovascular and endocrine systems over time. This chronic activation is why Type A behavior is thought to be tied to higher occurrences of heart disease due to the increased stress placed on the individual by their self throughout their life.

Physiologically, Type A individuals often exhibit exaggerated sympathetic reactivity when exposed to stressors. When challenged, they show greater increases in heart rate, blood pressure, and vascular resistance compared to Type B individuals. Over decades, this exaggerated cardiovascular response contributes directly to physical damage, specifically endothelial dysfunction (damage to the lining of the blood vessels) and the acceleration of atherosclerosis (hardening of the arteries).

Furthermore, chronic stress associated with TABP influences the endocrine system, leading to sustained elevated levels of stress hormones such as cortisol and norepinephrine. High cortisol levels can contribute to abdominal fat deposition, insulin resistance, and inflammation, all known

risk factors for metabolic syndrome and CHD. Norepinephrine, a catecholamine, contributes to increased platelet aggregation, making the blood more prone to clotting and increasing the risk of acute coronary events.

6. Correlation with Coronary Heart Disease

The primary significance of the **Type A Behavior Pattern** rests on its robust correlation with an escalated threat of coronary heart disease (CHD). The initial WCGS provided the foundational evidence, demonstrating that Type A men were approximately twice as likely as Type B men to develop CHD over the study period. This finding propelled TABP into recognition as a significant independent psychosocial risk factor.

While the initial findings were highly influential, subsequent large-scale prospective studies, particularly those using self-report questionnaires instead of the structured interview, produced mixed results throughout the 1980s. This discrepancy led researchers to refine the measurement of TABP, ultimately confirming that the Structured Interview (SI), which captures the stylistic and affective components of behavior, was superior to paper-and-pencil tests, which tend to miss the critical hostile interaction style.

The consensus that emerged from meta-analyses emphasized that the generalized Type A pattern is not uniformly detrimental; instead, the toxic element is the underlying hostility. Hostility, particularly cynicism and suppressed anger, is consistently linked to hypertension, myocardial infarction (heart attack), and overall cardiovascular mortality. Thus, while the global construct of Type A behavior remains relevant, contemporary health psychology often focuses interventions specifically on mitigating cynical hostility.

7. Measurement and Assessment Tools

Accurate assessment of the **Type A Behavior Pattern** is crucial for both research and clinical application, yet it has been complicated by the multimodal nature of the construct. The two most utilized methods are the Structured Interview and various self-report questionnaires.

The **Structured Interview (SI)** remains the gold standard, as it is designed not only to assess what the subject says (content) but how they say it (style). The interviewer deliberately challenges the subject with certain questions (e.g., asking them to recall events under time pressure, or questioning their professional dedication) to elicit characteristic Type A responses such as explosive speech, verbal aggression, and motor tension (fist clenching, rapid movements). The SI is highly effective because it directly measures the behavioral manifestation of the pattern, particularly the critical hostility component.

Conversely, self-report measures, such as the Jenkins Activity Survey (JAS) or the Framingham

Type A Scale, are easier and cheaper to administer but have demonstrated lower predictive validity for CHD compared to the SI. These questionnaires typically assess time urgency and achievement striving effectively but often fail to capture the affective components of hostility and chronic irritation, which individuals may be reluctant or unable to self-report accurately. This difference in measurement methodology largely accounts for the variance in research findings regarding TABP's risk association.

8. Criticisms and Evolution of the Model

Despite its initial revolutionary impact, the **Type A Behavior Pattern** model faced significant methodological and conceptual criticisms, leading to its evolution in modern psychology and cardiology. The primary criticism centered on the lack of consistency in findings when different measurement tools were used, particularly the failure of self-report measures to replicate the strong correlation found by the SI.

The most important evolution of the model involved the "fractionation" of the Type A construct. Researchers recognized that Type A was a heterogeneous category and that linking the entire pattern to CHD diluted the true risk factor. This led to the identification of the **Hostility component** (often assessed by the Cook-Medley Hostility Scale) as the truly "toxic core." Contemporary research often bypasses the broader Type A category entirely to focus specifically on chronic anger, cynicism, and hostility as independent risk factors for inflammation, hypertension, and cardiovascular events.

Furthermore, the dichotomous nature of the Type A/Type B classification has been critiqued as overly simplistic. Behavioral science now favors dimensional models that recognize personality traits exist on a spectrum. While the terminology of Type A and Type B remains prominent in popular culture, academic psychology and cardiology have largely moved toward examining more granular constructs such as cynical mistrust, trait anger, and negative affectivity in relation to chronic disease risk.

Further Reading

[Meyer Friedman \(Wikipedia\)](#)

[Polyphasic Activity \(Wikipedia\)](#)

[Jenkins Activity Survey \(JAS\)](#)