

A Brief Review to Support the Neurobiology of the Safety-Oriented Personality Style or Phobicentric Psychopathology (SOPS/PCP)

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Abstract

Background: Since SOPS/PCP entered the psychological literature, it has lacked empirical confirmation of its neurobiology. With greater clarity of the unit of interest being investigated (e.g. Generalized Anxiety Disorder), the findings are more easily interpretable. Applying neuroscience to psychopathology is not exempt, which SOPS/PCP is a case in point. This personality type claims to be “purer” than the DSM can produce thus making the study of SOPS/PCP more appealing. As such the search for its neurobiological underpinnings would produce informative and understandable results. The areas of the brain addressed in this Review are common to many models and functional imaging of these areas has helped considerably in promoting objective methods of accessing how anxiety disorder is maintained and its pathogenesis differentiated from other conditions. The Default Mode Network and amygdala play central roles in this process and their dysfunction may be at the root of anxiety disorder. Indeed, the study of the neurobiology of human fear-anxiety is complex, in a way that animal studies, its precursor, could not fully account. **Purpose:** The present study is aimed at providing evidence of the neural status of SOPS/PCP. **Method:** Selective information from neurobiological sources mainly shows that SOPS/PCP originates from and usually adopts the same behavioral characteristics as all other fear-anxiety states. **Results and Discussion:** The results of this study mainly confirm the previously hypothesized biological underpinnings of SOPS/PCP as presented by Bickersteth et al., (2018). **Conclusions:** This study depicts the DMN and amygdala as essential “players” in the fear anxiety sphere, where the PFC also functions to modulate anxiety disorder. This much less than exhaustive presentation of the topic has served to also indicate a need for a more adequate model than currently.

Keywords

Default Mode Network, Homogeneous Set of Symptoms, Amygdala, Attention Bias, Brain Imaging, Reverse Trajectory

1. Introduction

The Safety-Oriented Personality Style or Phobicentric Psychopathology (SOPS/PCP) is a relatively, newly, formulated and empirically verified psychological disorder (Bickersteth et al., 2018). It claims to be a unique anxiety disorder, which offers an important opportunity to study the pathogenesis of fear-anxiety in its “purer” manifestation (See **Appendix 1** & **Appendix 2**). In other words, SOPS/PCP is unencumbered by the confounding comorbidities, encountered in the categorical system found in the Diagnostic and Statistical Manual (DSM) that previously “cluttered” the diagnostic and clinical presentation. SOPS/PCP now makes it practical to arrive at an unblended diagnosis of anxiety disorder. In the context of SOPS/PCP, fear, anxiety, anxiety disorder and anxiety personality disorder are distinct only in ascending degrees of seriousness or worsening of fear states. This construct however, needs additional validation of its authenticity in view of its newness. The point of this article is to make a case for SOPS/PCP’s legitimacy in view of a confirmed neurobiology rather than a hypothesized condition.

In the theoretical background laid out (see Bickersteth et al., 2018), the emotional centers were said to include, in general, the amygdala, hippocampus, PFC and/or ACC and presented as the brain mechanisms expected to mediate SOPS/PCP in the occurrence of or predisposition to this personality disorder.

Evidence from functional neuroimaging studies by previous writers, for example, Etkin et al. (2007) have shown that the same brain mechanisms are responsible for normal fear as well as for anxiety disorders—thereby supporting the claim of SOPS/PCP theory that all anxiety disorders are related by virtue of hailing from the same neurobiological source and differentiated only by severity. For example, a study by Terburg et al. (2012), which demonstrated that damage to the basolateral amygdala (BLA) impaired the inhibitory function of the brain’s threat vigilance system, provides support for this aspect of SOPS/PCP’s theoretical position.

According to Kirk et al., (2022) threat-vigilance is constantly evoked by characteristics of the environment in a top-down manner in the dmPFC-amygdala circuitry and bottom-up, amygdala-PFC, in response to anxiolytic agents.

In general, a homogenous set of symptoms is expected to produce “unadulterated” samples (as in the case of SOPS/PCP), comprising people who, individual differences considered, are all fear-controlled, whose condition evinces the same etiology and who present with a similar emotional, perceptual and behavioural profile, regardless of their DSM-styled categories. When such is the case, neurobiological and treatment investigations will be directed at a single known needle

in a haystack, so to speak, instead of starting with a sample consisting of a hodgepodge of symptoms (mislabelled in the DSM model), named as an identifiable psychological condition, despite their heterogeneous causal origins—equivalent to searching the haystack for an unknown number of needles, with a variety of needle descriptions.

This issue is important, for example, in the light of investigating GAD as a clear case in point. It may be questionable how “pure” is the construct that this illness is said to represent, considering its hefty co-morbidity (Simon, 2009; Nutt et al., 2002; Noyes, 2001). That is, about which psychological or psychiatric problem or category of illness (expressed or “hidden”) would the neural pattern of GAD inform, if the pathogenesis or causal factors are unknown or misguided? Skodol’s (2010) statement appears still true: “... No laboratory marker has been found to be specific for any DSM-defined syndrome. Epidemiological and clinical studies have shown high rates of co-morbidity within and across axes, as well as short-term diagnostic instability. And a lack of treatment specificity for individual disorders has been the rule rather than the exception.” (Bickersteth et al., 2018: p. 362).

All other things being equal, the clarity of the neural pattern of an anxiety disorder, evidently, will lend itself more readily to developing more reliable anxiety-targeted treatments. Indeed, when the origin of a disease or disorder, within a dimensional continuum is known, as in the case of SOPS/PCP and supported neurophysiologically, its management would be expected to be relatively precise and defensible. That is, the reverse trajectory from treatment to etiological cause would be easily demonstrable.

2. Purpose

The purpose of this paper is to review selected, empirical data pertaining to the probable neural pathways and networks, which would further elucidate the hypothesized neurobiology of PCP and, eventually, promote logical treatment options.

Notably, the description of people with SOPS/PCP indicates that they carry a heavy thinking load, perceive threat in many situations whether there is threat or not and that overall, this would create a drain on mental resources, which also impairs memory. In this case, Eysenck’s theory seems to be in close parallel with SOPS/PCP’s. For example, he states (Eysenck, 1967): “Biological causes act in such a way as to predispose an individual in certain ways to stimulation; this stimulation may or may not occur, depending on circumstances which are entirely under environmental control” (p. 222).

Stronger neural activation (greater processing effort) for goal-directed control of attention has been shown to result from trait-anxiety, in individuals with high levels of anxiety during the mental manipulation of information while performing a memory task that did not include threatening stimuli (Basten et al. 2012). In that study brain centers associated with executive functions were implicated

in the mental processing exertion. That study provides support for emotional and thinking load postulated for individuals with SOPS.

3. The Role of Main Structures

Many studies, which address human fear, have shown the DMN (comprised by, among others, mPFC, posterior cingulate cortex, inferior parietal lobule, lateral temporal cortex, hippocampal formation, precuneus) and amygdala to be the main structures implicated in anxiety disorder. The DMN forms a network of functional connections of the brain regions, which show activity when individuals are engaged in internally focused tasks, such as of a self-referential or introspective nature, including retrieval of declarative memory, visualizing the future, and conceiving the perspectives of others. The network seems to also maintain a high level of metabolic activity at rest, in the absence of any task demands.

On the other hand, Engel et al., (2009) referred to "... growing evidence of the existence of a complex anxiety network, including limbic, brainstem, temporal, and prefrontal cortical regions" (p. 703). Holzschneider et al. (2011) noted: "Apart from the amygdala, the insula and anterior cingulate cortex (ACC) seem to be critical, and all three have been referred to as the 'fear network.'" (p. 458). This means the network should be considered in all aspects of fear-anxiety.

Schiller & Delgado (2010), connected these structures with treatment strategies and concluded: "Irrespective of the particular strategy involved in modulating fear responses, the amygdala ... and the vmPFC were found to identify stimuli in the environment that are predictive of danger, while also adjusting their responses when predictions change..." (p. 7).

Consistently, neuroimaging studies show abnormalities in the PFC in anxiety disorder individuals.

4. Discussion

Brain imaging research in anxiety disorders has become increasingly important, particularly, because of its role in validating the neurobiology of anxiety disorders (Damsa et al., 2009). For example, anxiety disorders have been reputed to have common features with other disorders but show marked difference in their pathophysiology, from conditions, such as MDD (Sylvester et al., 2012).

Of particular interest in this article is the DMN, whose role is considered to include functions such as self-inspection, emotion regulation and future planning. It is believed to show activity when no environmental, mental or physical task is the focus. Impairment in DMN connectivity in early life through stress, according to Zeev-Wolf et al., (2019) leads to long-term negative consequences, which according to Bickersteth et al. (2018) may result in SOPS/PCP that last throughout life. Decreased functioning of the DMN may manifest as difficulty adaptively regulating emotions based on current goals and influencing brain activity at rest potentially including ongoing cognitive processes.

In the amygdala, another important region of interest in this discussion, the

central nucleus (Ce) and BLA seem to contribute the most prominent activity, with Ce appearing to be the main output structure of the amygdala. Kim et al. (2011) described stronger structural and functional connectivity between the amygdala and the PFC as indicative of efficient crosstalk, which improves emotion regulation and modulates anxiety. Interestingly, preclinical and clinical studies have shown that the PFC inhibits the amygdalae via the central nuclei, but that it is possible for this top-down process to be disrupted by an even stronger bottom-up competitive power. Notably, increased or over-active functioning of the cingulo-opercular and ventral attention networks in tandem with decreased or under-active functioning of the fronto-parietal and over-active default mode networks has been shown to characterize the amygdala and PFC (Kim et al., 2011).

Considering that the cingulo-opercular network is believed to detect errors in behavior, thereby signaling the possible need for strategy adjustment, on the other hand, the fronto-parietal (executive) network may incorporate this feedback to make adjustments in future processing (Kim et al., 2011).

Attentional components, mediating mechanisms, and stages of information-processing may be presented as the sources of data supporting the hypothesis that prefrontal regulatory structures may be responsible for difficulty disengaging from threat.

Difficulty in disengagement seems to occur when amygdala hyperactivity tends to coincide with PFC hypoactivity in both healthy individuals, as well as in anxiety groups as predicted in several models. The amygdala facilitates attention to threat, with the DMN exerting overall attentional control. The only consistent prediction across models, however, is that a threat detection mechanism, operates at the automatic stage of processing and underlies facilitated attention to threat. As SOPS/PCP would suggest, apparently, the threat detection mechanism would be effective mainly within the scope of the person's comprehension (e.g. Hearing a knock on the back door would register as a threat if a child was playing in the yard and that it might be a stranger knocking).

According to Patrick & Bernat, (2010), "... coordinated chiefly between the amygdala and the prefrontal cortex (PFC) in association with the anterior cingulate cortex (ACC), the fear response is of a stimulus-specific phobic nature. Dysfunction results in a non-adaptive internally cued distress-type fear (anxiety)." (p. 441) From the study by Gentili, et al., 2009, it may be conjectured that the findings indicate an alteration of the DMN in the PCun/PCC region may play a role in several anxiety disorders.

5. Conclusion

Collectively, the findings of neuroimaging studies strongly suggest that the subjective nature and the intentional content of anxiety-related processes (e.g., thoughts, feelings, beliefs, volition) would definitely tend to modulate anxiety-network functioning and plasticity.

Far from being an exhaustive review of the psychobiology of fear-anxiety, this

study basically provides snippets of information to support the neurobiology of SOPS/PCP as stated in the purpose.

Through the course of this review, it has become clear that a more clearly defined approach is called for to understand the complexity of human anxiety disorder than the use of, still complex, animal models would permit (Sylvester et al., 2012; Bremner, 2004).

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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Appendix 1

SOPS/PCP: Colloquial Explanation

SOPS stands for Safety-Oriented Personality Style. The technical name is: Phobicentric Psychopathology (PCP).

SOPS is a fear-anxiety emotion-based condition. We know that emotions are expressed in such behaviors as laughing, crying, anger, sadness and fear. They are however expressed in many other behaviors that we may not usually associate with emotions, such as wanting something, deciding on anything (e.g. to read a story, go shopping etc) or being interested in anything (e.g. math, sports, art or science etc.); in fact an emotion is what prompts and sustains every action, whether mental or physical that we perform, although we may not necessarily be aware of the distinct “emotional state” as soon as it arises or even at all; and often not how to label it.

Nonetheless, immediately after the emotional prompt, the areas of the brain, which among other things are responsible for rational and critical thinking, as well as for organizing intellectual skills, are activated to guide the mental experience, whether to make a decision or attend to something interesting etc., towards a “reasonable” behavior. This behavior or reaction is reasonable in the perception or judgment of the person who has to act and not necessarily from an observer’s point of view. In people with SOPS, mood plays a disproportionately influential role in determining the behavior of choice. As such, a person with SOPS seems to process information differently.

How It Makes People Behave

Normally in other individuals in ordinary (not intense) situations, the triggered emotion is supposed to turn off, guided by rational thinking, within a few seconds or less as other interests attract our attention. The kind of reaction that we become aware of mentally and/or in one’s body is what defines our anger, fear, joy, despair etc. In the case of SOPS, fear-anxiety is the dominant reaction; and when that emotion triggers a reaction, more often than not the emotion does not appear to switch off to allow non-emotional, rational thinking to occur. In fact the fear reaction stays on and directs the entire course of the response. Often however fear is mostly underlying rather than being openly or clearly displayed.

Neuroscientists are fond of describing fear as what causes us to jump from stepping on a snake; or our first ancestors to run or freeze when confronted by a saber-toothed tiger in our evolutionary history.

Fear and safety are two sides of the same coin and this is where SOPS gets its name. The always-dominant need for safety (from fear) as seen in SOPS would have undergone changes as it develops into a personality style in a person. As a result, the thoughts, behaviors and other emotions that a person with SOPS exhibits are mostly reactions prompted by fear-anxiety.

This happens when, for a variety of reasons, some people’s pattern of behaving and thinking become fear-controlled causing them (after being this way for

many years) to display a fear-based or safety-oriented personality. This is what it means to say a person has SOPS. Like all other human qualities SOPS may be expressed to a mild, moderate or excessive degree. Be aware that the current description is a simplified version of SOPS. A full account of it is to be found in the book: “*TO YOUR HAPPINESS: A Self-Healing Guide to Peace of Mind*” (See under Publications on the homepage, <https://www.findinnerpeace.co>).

People who have SOPS often tend to display self-centered behaviors, however, mostly unconsciously. They also usually want to control situations, including how others behave around them and can change very quickly from a normal and calm demeanor to being angry, depressed or anxious (though usually angry); they can be stubborn, abusive and vindictive. Self-contradiction and impulsive reactions are not uncommon among people with SOPS; but they can also show great insight (but not necessarily self-awareness) and are usually very skillful in defending their point of view. To them the most persuasive source of information tends to be their own thinking regardless of the validity of objective sources.

You might know people like this in the country you live in, where you work, in your family or among your acquaintances; but you would not have described them as having SOPS. Or you may have found yourself behaving in this way and, before now, not understand why.

Leaders with SOPS Become Dictators

A great deal has been written about how to identify our emotions but all experts do not agree even on the definition or nature of an emotion. Nonetheless, they and the public do agree on some issues; one of which is fear. No one disputes that fear is an emotion. It is considered to be one of the most ancient and crucial of our survival characteristics. Such an essential and somewhat powerful emotion has made it a target for an enormous amount of scientific research. A number of behavioral conditions have been discovered that arise from it. SOPS has been empirically confirmed and its role in accounting for why some people would behave in those ways has been uncovered in a 2018 study (<https://doi.org/10.4236/psych.2018.97098>).

The vast amount of information on how fear affects people however supports the concern that it is important to fully understand SOPS.

One important reason the display of this condition is concerning has to do with its consequences in social-political situations, particularly with respect to leadership roles. Due to the nature of party politics in many countries, someone with this personality can become a leader with a parliamentary majority. Unless there are effective checks and balances, such an individual can easily acquire almost total power, which they will use disproportionately to ensure their own safety while appearing to protect the country. Autocratic rule in such hands can lead to unpredictable, unwelcome, even destructive consequences for a whole country. We have heard descriptions in the news media or through other reports about leaders who are characterized as overly control-oriented, too security-conscious, secretive, having a tendency to be unexplainably angry; easily offended; who are constantly self-promoting or require to be lauded and the like.

These are warning signs in a leader or potential leader at any level in any organization or family.

Partial Profile of SOPS

Here are some other typical characteristics of individuals with SOPS:

- Maintaining fault-free appearance and image are very important (as such they also tend to be very defensive and are selective as to where or when they show certain behaviors).
- Usually keen to get full information but keep their complete agenda undisclosed (although secretive generally, they may also spontaneously offer unrequested information).
- Frequently use sarcastic humor.
- May display “emotional drama”.
- Tend to be controlling; seem to strongly desire others to act or think in agreement with them.
- Use retaliation and punishment for perceived wrongs done to them, though usually in a passive-aggressive or indirect manner.
- Low tolerance of discomfort.
- Tend to be moody, irritable and impatient.
- Very cautious in spending money; or may often spend seemingly freely.
- Close relationships tend to be difficult.

Another social issue of grave importance, which SOPS raises is that it may well be this same behavior pattern that leads to domestic violence, sexual assault, abduction, bullying and even terrorism. The evidence seems to indicate that only when confronted with much greater fear or by receiving total agreement, conformity or support will a person with SOPS back down from or change their disagreeable behavior in a given situation. Whether from damage or acquiring a different structure in the brain due to the process known as brain plasticity, after many years of using and being positively reinforced by a SOPS way of behaving, change in such individuals becomes very complex to achieve.

Our nervous system provides a connection to the world within and outside of us through our senses. This is how we can tell what’s “there”, that is, have knowledge of reality. On the other hand, our emotions inform us about the reaction required for what we perceive, sense or feel. They allow us to interpret our perceptions to ourselves so we can navigate our environment appropriately. The different emotions have special roles to play in this regard and together with our senses they account for our survival. To depend on our emotion alone gives a distorted or unrealistic view of the world around us. And indeed, people who are mainly safety-directed (that is they have SOPS) tend to make unrealistic evaluations of events.

For example, they may express joy or pleasure at something that most observers would not see as joyful; or convey disgust, shame or fear that a majority of other people do not share; or assert that something did or did not happen when the opposite is true. These faulty reactions are most likely the result of fear-anxiety, the dominant emotion, “hijacking” their attention and perception and dis-

torting them. Such misperceptions make SOPS individuals appear to be living in a parallel universe. Indeed, to depend on one channel (emotion) when most others operate on two (emotion and rational thinking) puts one in an alternate reality, often making that person come across sometimes as unintelligent, unrealistic or even irrational.

SOPS Can Show Up Anywhere

From this brief description of SOPS it is clear that people from all areas of life can show from some to many of its characteristics: mayors, presidents, prime ministers, teachers, prison guards, caregivers, the unemployed, CEOs, their deputies, substitutes or potential successors etc. whether male, female or other gender. This means its presence in one or more individuals in any situation is bound to affect the quality of interaction (mostly negatively, though sometimes positively) between people with SOPS and their independent-thinking spouses, work colleagues, members of a non-doting constituency and employees etc. It is however not true that just about anyone is susceptible to SOPS. A person's life comes under the command of fear-anxiety in definite ways as verified in the research. All the characteristics of SOPS are explained in detail in: "*TO YOUR HAPPINESS: A Self-Healing Guide to Peace of Mind*", which is found under the Publication tab on the homepage of this site: <https://www.findinnerpeace.co/>.

Appendix 2

SOPS/PCP QUESTIONNAIRE

1. I feel life is unfair because usually things do not go my way or are not in my favor

0 1 2 3 4 5
Not at all Very true

2. I experience frequent problems in my relationship with others (whether at work, socially, in the family and/or in romantic situations)

0 1 2 3 4 5
Not at all Very true

3. I find it is not too difficult to stop worrying or feeling bad

0 1 2 3 4 5
Not at all Very true

4. Usually, I feel tense and not completely relaxed

0 1 2 3 4 5
Not at all Very true

5. Any amount or kind of hurt (emotional or physical) is unacceptable

0 1 2 3 4 5
Not at all Very true

6. I often feel pressured to act without thinking

0 1 2 3 4 5
Not at all Very true

7. I may react very strongly or "lose it"

0 1 2 3 4 5

8. My motto is: "Do things my way", because that feels the most comfortable
0 1 2 3 4 5
Not at all Very true
9. I think I have mental-emotional problems, which I try to keep private
0 1 2 3 4 5
Not at all Very true
10. Life is full of many problems and dangers; and there's always one waiting for you around the corner.
0 1 2 3 4 5
Not at all Very true
11. I usually find it difficult to wait or be kept waiting
0 1 2 3 4 5
Not at all Very true
12. Most of the time I do not feel panicky or upset
0 1 2 3 4 5
Not at all Very true
13. I find it hard dealing with most problems.
0 1 2 3 4 5
Not at all Very true
14. I tend to fear or worry the worst will happen
0 1 2 3 4 5
Not at all Very true
15. I have a very strong unfavorable reaction when I feel I am being criticized
0 1 2 3 4 5
Not at all Very true
16. Chances are you will be made to feel defensive or offended in many situations
0 1 2 3 4 5
Not at all Very true
17. It upsets me when people I have dealings with are not on time or do not use time effectively
0 1 2 3 4 5
Not at all Very true
18. It is not difficult to stop talking about something I need
0 1 2 3 4 5
Not at all Very true
19. I feel unsafe in many situations
0 1 2 3 4 5
Not at all Very true
20. Usually I feel calm and at ease.
0 1 2 3 4 5
Not at all Very true
21. Most events that make me anxious are outside my control

- 0 1 2 3 4 5
 Not at all Very true
 22. Many of my thoughts are worried or bothersome
- 0 1 2 3 4 5
 Not at all Very true
 23. When I am put under stress, I find it hard to focus on anything other than my anxiety
- 0 1 2 3 4 5
 Not at all Very true
 24. I often regret things soon after I say or do them
- 0 1 2 3 4 5
 Not at all Very true
 25. I look for or go after all the compliments and praise I am due
- 0 1 2 3 4 5
 Not at all Very true
 26. More than a few times a day I feel frustrated or upset
- 0 1 2 3 4 5
 Not at all Very true
 27. I am always worrying about something.
- 0 1 2 3 4 5
 Not at all Very true
 28. In many situations I feel a strong need to protect myself from physical harm or emotional hurt.
- 0 1 2 3 4 5
 Not at all Very true
 29. I am usually concerned that I will not cope well if I become anxious in a difficult situation
- 0 1 2 3 4 5
 Not at all Very true
 30. Most nights I fall asleep easily and get a good night's rest.
- 0 1 2 3 4 5
 Not at all Very true
 31. I can't stop bringing up something that's important to me
- 0 1 2 3 4 5
 Not at all Very true
 32. I have been/am being bullied
- 0 1 2 3 4 5
 Not at all Very true
 33. I have experienced a very difficult or very upsetting emotional life for at least two years
- 0 1 2 3 4 5
 Not at all Very true
 34. I have experienced a dangerous or very threatening personal, political and/

or military event(s) for an extended period

0 1 2 3 4 5
Not at all Very true

35. The person who raised me had emotional problems when I was growing up

0 1 2 3 4 5
Not at all Very true

36. The person who raised me experienced a dangerous or very threatening personal, political and/or military event(s) for an extended period

0 1 2 3 4 5
Not at all Very true^a

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^aBickersteth, P., Rudwan, S., Shojaee, M. and Firoozi, T. (2021) The Safety-Oriented Personality Style or Phobicentric Psychopathology: A Cross-National Replication Study. *Psychology*, **12**, 1361-1362. doi: 10.4236/psych.2021.129084.