Pergamon

0191-8869(95)00053-4

Person. individ. Diff. Vol. 19, No. 4, pp. 569–575, 1995
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0191-8869/95 $9.50 + 0.00

EMOTIONAL SUSCEPTIBILITY, IRRITABILITY AND HOSTILE RUMINATION AS CORRELATES OF CORONARY HEART DISEASE

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(Received 19 November 1994)

Summary—Many studies (see Booth-Kewley & Friedman, *Psychological Bulletin, 101*, 343–362, 1987) show hostility and negative affect as important personality correlates of Coronary Artery and Heart Disease (CAD and CHD). In the present study a set of questionnaires related to various aspects of aggressive inclination (Hostile Rumination, Irritability, Emotional Susceptibility) were given to about 300 patients who recently suffered Myocardial Infarction, and to a control group. Differences between the two groups, as well as temporal stability of the infarcted patients' self evaluations were examined. Infarcted subjects reported to be more emotionally susceptible than non-infarcted subjects. Moreover, they evaluated themselves as even more susceptible one year after the infarction. No other differences emerged among infarcted and non-infarcted subjects.

Psychological and emotional factors have long been associated with Coronary Heart Disease (CHD). Anger and hostility have been identified as responsible for physiological changes (in blood pressure, heart rate, etc.) that impact the coronary heart disease process (for a review of personality correlates of CHD and CAD see Booth-Kewley & Friedman, 1987).

However, contradictory results recently emerged since overt expression and repression of anger and hostility have both been positively associated with CHD (Geen, 1990; Haynes, Feinleib & Kannell, 1980; Jenkins, 1975; Miles, Waldfogel, Barrabee & Cobbs, 1954).

The potential role of hostility in mediating the development of CHD has received a great deal of attention especially in the context of research on the 'Type A Behaviour Pattern' (TABP, Friedman & Rosenman, 1959; Rosenman & Friedman, 1961). Initial analyses of TABP components indicated that hostility was significantly related to the prior occurrence of CHD (Jenkins, Rosenman & Friedman, 1968). Later analyses found that Competitive drive, Impatience and Potential for hostility were particularly able to identify coronary prone *S*s (Matthews, Glass, Rosenman & Bortner, 1977). More recently Type A behavior hostility was found to be a significant predictor of CHD (Dembroski & Costa, 1987; Dembroski & MacDougall, 1985).

However, as noted by Rosenman (1990), too much attention has been given to 'hostility' before this construct was clarified in the context of any relationships with CHD. Interpretations of anger/hostility dimensions are markedly different (Williams, Hanay, Lee, Kong, Blumenthal & Whalen, 1985), and the hostility construct is probably no less multidimensional than the global TABP (Dembroski & Costa, 1987). Siegman, Dembroski and Ringel (1987) differentiated between neurotic and non-neurotic hostility, and found that the former (which is positively correlated to anxiety) is inversely related to Coronary Disease, while the latter (called Reactive or Expressive hostility and unrelated to anxiety) is positively correlated with CHD, being unrelated to anxiety. In the frame of the 'Five Factor Model' of personality traits (John, 1990), Dembroski and Costa (1987) showed that Potential for hostility was positively correlated with Neuroticism, but negatively correlated with Agreeableness: according to these authors Potential for hostility is more related to a pervasive antagonistic attitude than to emotionality and various forms of negative affect.

A rather different pattern resulted from the studies of those authors who suggested that TABP may be associated with CHD only when combined with low coping skills and inappropriate defences such as a depressive response labelled 'vital exhaustion' (Falger, Schouten & Appels, 1988; Glass, 1977; Helman, 1987; Sibilia & Borgo, 1992; Sibilia, Francione & Borgo, 1988; Vickers, Hervig, Rahe &

Rosenman, 1981). This is consistent with the results of a meta-analysis on psychological predictors of CAD and CHD (Booth-Kewley & Friedman, 1987), in which depression was found as the personality correlate most frequently associated with coronary heart and artery disease. Furthermore, this result is consistent with the positive relation between Neuroticism and CHD reported by Eysenck (1990, 1991).

AIM OF THE STUDY

Although the importance of considering hostility as a multidimensional construct has been underlined by several authors, this intuition remained only at a programmatic level (see Dembroski & Costa, 1987; Rosenman, 1990). Yet in most cases measures of hostility do not seem to be rooted in detailed hypotheses concerning the mechanism governing the various expressions of hostility in the realm of total personality functioning, adjustment and health. It is likely that by using more specific constructs than generalized hostility we may clarify which form or aspect of this general trait can be related to CHD and CAD.

In this vein we conceived a number of studies capitalizing on our previous research on individual differences in aggression. We investigated the role personality characteristics play in mediating aggressive behavior (for a review see Caprara, 1987; Caprara, Barbaranelli, Pastorelli & Perugini, 1994a; Caprara & Pastorelli, 1989; Caprara, Perugini & Barbaranelli, 1994b). The use of individual differences seemed to provide a gauge for coming closer to the basic processes and mechanisms which underly and moderate the various forms of aggression. Over the years a number of constructs have been identified, and their scales validated, in different countries and with different populations. Results from these investigations led us to re-examine the traditional distinction between various forms of aggression, paying particular attention to the amount of variability accounted for by either the more affective or the more cognitive components of aggression (Caprara *et al.*, 1994a; Caprara *et al.*, 1994b).

The following two studies have been conceived with the aim to investigate whether Emotional Susceptibility, Irritability and Hostile Rumination play any role in the psychological status of patients who have suffered a cardiac infarction. Both studies were conceived as fundamentally exploratory and descriptive because of the 'difficulties' in gaining access to patients who have experienced such a traumatic event such as an infarct, and given the difficulties in controlling the many variables which may affect the constructs under investigation and the reliability of self and other reports we have been using to examine them.

In the first study, Emotional Susceptibility, Irritability and Hostile Rumination self reports were collected in infarcted and non-infarcted patients shortly after the traumatic event. In the second study the same self reports have been collected in another group of recently infarcted patients and in a group of infarcted *S*s originally examined at one year distant from the traumatic event. The questions we address with this study concern the possible differences between self reports of infarcted patients shortly after the infarct and self reports of infarcted patients one year after the traumatic event with regard to the general population to which these patients can be matched broadly on the basis of sex, age, education and economic level.

STUDY 1. DIFFERENCES BETWEEN INFARCTED SUBJECTS AND NON INFARCTED SUBJECTS IN EMOTIONAL SUSCEPTIBILITY, IRRITABILITY AND HOSTILE RUMINATION

The aim of this study was to examine whether infarcted patients recently experiencing this traumatic event show any differences on Emotional Susceptibility, Irritability and Hostile Rumination compared to a matched group of non-infarcted *S*s.

METHOD

Subjects

*S*s were recruited in two different settings: Como and Naples.

One hundred and five infarcted males recruited in the hospital "S.Anna" of Como, a city in the north

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