PERGAMON

Personality and Individual Differences 34 (2003) 1319–1325

PERSONALITY AND INDIVIDUAL DIFFERENCES

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Emotional distress and the Type A behaviour pattern in a sample of civil servants

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Received 21 September 2001; received in revised form 11 March 2002; accepted 21 April 2002

Abstract

Conflicting data have been reported on the coronary heart disease risks associated with the Type A behaviour. This has promoted the construct of somewhat novel theoretical possibilities of what might be plausible pathways of assessing the risk associated with the Type A behaviour pattern. One such possibility is the potential mediating effect of emotional distress in the risk equation of the Type A behaviour pattern. This possibility offered an opportunity to assess the association between expressions of negative emotions and the Type A behaviour pattern in a sample of 356 males and females in two public sector organisations in Papua New Guinea. These participants completed the Jenkins Activity Survey measuring self-reported expressions of the Type A behaviour pattern, and a measure on some common symptoms of emotional distress. The results showed overall that, the Speed and Impatient scale of the Jenkins Activity Survey was consistently related to expressions of negative emotions. This finding allows for comments on the possibility of exploring the relationship between the Type A behaviour pattern and coronary heart disease through other mediating and equally relevant psychosocial factors such as emotional distress. © 2002 Published by Elsevier Science Ltd.

Keywords: Type A behaviour pattern; Jenkins Activity Survey; Emotional distress; Public sector workers; Papua New Guinea

1. Introduction

There is still no entirely satisfactory explanation on the conflicting data produced on the pathogenic nature of the Type A behaviour pattern (TABP). Several problems have compounded

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0191-8869/02/$ - see front matter © 2002 Published by Elsevier Science Ltd.
PII: S0191-8869(02)00123-X

a clear-cut explanation on the association between the TABP and risk of coronary heart disease (CHD). For example, concerns have been raised on the use of clinical samples or high-risk groups to establish the predictive effect of the TABP on CHD (Miller, Turner, Tindale, Posavac, & Dugoni, 1991). In addition to these problems, a host of other issues have been raised in relation to the contradictory findings (Matthews, 1988). For example, the socio-demographic variables such as level of education, job status, and gender may mediate the strength of the association between the TABP and CHD (Rosenman, 1986), or the TABP may only predict some manifestations of CHD such as angina pectoris and not myocardial infarction (Ragland & Brand, 1988).

In the efforts to clarify these conflicting data, several possibilities were considered. Attempts at isolating individual components of the TABP to identify its most toxic element represents one such possibility in research on TABP and its pathogenic nature. Some researchers questioned if components of the TABP are responsible for CHD instead of the Global Type A (Thoresen & Powell, 1992). Studies have focused on some components of the TABP such as chronic anger and hostility (Kneip, Delamater, Ismond, Milford, Salvia, & Schwartz, 1993), time urgency (Mueser, Yarnold, & Bryant, 1987), and expressive vocal behaviour (Siegman, Feldstein, Tomasso, Ringel, & Lating, 1987) as potential toxic elements of this pattern of behaviour. One component of the TABP, namely hostility, has been extensively investigated compared to these other components combined.

Friedman and Rosenman (1974) first described hostility as a component of the TABP. It was later isolated as a potential pathogenic element of the TABP by Williams and colleagues (Williams, Haney, Lee, Kong, Blumenthal, & Whalen, 1980). Both persuasive and conflicting evidence have emerged on the risk attributed to hostility (Julkunen, Idampaan-Heikkila, & Saarinen, 1993). Booth-Kewley and Friedman (1987) in a meta-analysis concluded that, anger, hostility, and depression emerged as the strongest predictors of CHD compared to other components of the Type A behaviour. A re-analysis of data from the Western Collaborative Group Study further re-affirmed that hostility was linked with the incidence CHD (Hecker, Chesney, Black, & Frautschi, 1988). Part of the results in the Framingham study also showed that "anger-in" (not discussing or expressing anger) was predictive of CHD in both men and women, and this association was independent of the influence of the TABP (Haynes, Feinleib, & Kannel, 1980). Hostility was reported as a significant predictor of the incidence of CHD in 255 physicians studied over a period of 25 years (Barefoot, Dahlstrom, & Williams, 1983). This prospective evidence led to the conclusion that hostility appeared to exert some sort of pathogenic influence on major coronary events.

Some studies have, however, failed to confirm the positive link between hostility and the risk of CHD (Seeman & Syme, 1987). Evidence questioning the pathogenic influence of hostility have been produced in some equally good methodologically designed studies. Barefoot et al. (1989) did not find any evidence confirming the Global Type A and hostility as predictors of non-fatal myocardial infarction. Siegman, Dembroski, and Ringel (1987) reported a negative association between hostility and severity of CHD in patients scheduled for coronary angiography.

Against the background of conflicting evidence produced on the TABP and its components, the potential interactive influence of a host of other environmental, cognitive, psychosocial, and physiological factors have been considered to resolve some of the issues surrounding the risk associated with the TABP and its components. One of those possibilities considered was the mediating effect of negative emotions such as depression and anxiety on the pathogenic nature of