



## ASSESSING EMOTIONAL EXPRESSION: SPANISH ADAPTATION OF THE RATIONALITY/EMOTIONAL DEFENSIVENESS SCALE\*

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**Summary**—Psychometric properties of the R/ED Scale were investigated in four samples of Spanish populations: male ( $n = 98$ ) and female ( $n = 239$ ) students, healthy women ( $n = 96$ ), women with benign breast disease ( $n = 90$ ), and women with breast cancer ( $n = 122$ ). Analyses reveal high inter-item consistency (Cronbach's alpha from 0.82 to 0.87), high item remainder correlations (ranking from 0.63 to 0.32), high test-retest reliability (15 days,  $r = 0.81$ ), and no significant correlations between R/ED Scale and Social Desirability ( $r = -0.17$ ) and faking ( $r = -0.09$ ) were found. In line with Spielberger and colleagues' results, factorial analysis reveals the stability (across samples) of two factors, so called, 'Rationality' and 'Emotional Defensiveness'. Finally, R/ED (R and ED Subscales) scores as well as item scores significantly differ between the breast cancer group and the other groups. These results are congruent with those obtained by Spielberger and associates as well as supporting the hypothesis that cancer patients have a specific behavioral pattern. © 1997 Elsevier Science Ltd.

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### INTRODUCTION

In the last 30 years, the contribution of psychosocial factors to cancer disease has been an important research topic. From 1974 through 1995 a search of the literature on *Psychlit* and *Medline* identified more than 300 journal articles and 68 books and book chapters. Following the same track as Type A (cardio-vascular risk factor), Type C (cancer prone) has emerged as an important behavioral pattern, coping type or personality factor. Eysenck (1994) has summarized Type C as:

Being over co-operative, appeasing, unassertive, overpatient, avoiding conflict, suppressing emotions like anger and anxiety, using repression and denial as coping mechanisms, self-sacrificing, rigid, predisposed to experience hopelessness and depression (p. 168).

One of the most important psychological characteristics emerging from this, and other, cancer risk factor descriptions is the way cancer patients cope with emotions by suppressing, repressing, denying and/or inhibiting negative emotions while using rational (logic and reason) mechanisms. Several studies pointed out that these are a cancer patient's main characteristics (among others: Bleiker, 1995; Greer & Morris, 1975; Grossarth-Maticek, Bastiaans & Kanazir, 1985; Grossarth-Maticek, Eysenck & Frentel-Beyme, 1988; Kneier & Temoshok, 1984; Temoshok, 1990; Temoshok & Dreher, 1992; Van der Ploeg *et al.*, 1989).

This concept was assessed in a 10-year prospective study by Grossarth-Maticek and colleagues (Grossarth-Maticek *et al.*, 1985) through 11 items of an interview/questionnaire in which Ss responded in a Yes/No format. They reported that the tendency to repress and/or deny emotions was strongly predictive of cancer mortality. Ss responding positively at least to 10 items on this rationality/anti-emotionality (R/A) interview-questionnaire had 40 times more cancer.

Based on this previous research, Grossarth-Maticek and Eysenck (1990) reported the construction of the Personality-Stress Inventory. Scores on this Inventory divide people into six personality

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types, selectively prone to different cancer and cardiovascular diseases. One of these types has been called Type I (cancer prone) as opposed to Type II (CHD-prone). The instrument was administered in a prospective study conducted in Heidelberg (Germany), proving a highly predictive power of cancer and coronary heart diseases (Eysenck, 1994; Grossarth-Maticek *et al.*, 1988; Grossarth-Maticek & Eysenck, 1990).

Other authors using similar instruments to that used by Grossarth-Maticek found similar results. For example, Van der Plog *et al.* (1989) administered the Rationality/Anti-emotionality Dutch adaptation (11 items) to several samples (students, healthy and cancer *Ss*) concluding that their finding “tentatively supports the view that rationality and anti-emotionality may be an important distinctive personality characteristic in patients with cancer” (p. 217).

Also, measuring 11 psychological characteristics in a sample of healthy women and women with breast cancer recruited in the Breast Cancer Prevention Program in the Netherlands, Bleiker (1995) reported that, between these 11 psychological characteristics, anti-emotionality was the best predictor of cancer.

From a revision of the literature, Greer and Watson (1985) concluded that “suppression of emotional responses . . . appears to be central to this behaviour pattern (Type C)” (p. 774).

The hypothesis that suppression, repression, inhibition and/or denial of negative emotions is a cancer patient’s behavioral pattern, has had other experimental support. For example, Kneier and Temoshok (1984) used an experimental design in order to test this hypothesis. They recruited cancer and cardiovascular patients and healthy *Ss*. During the experiment skin conductance response (SCR) was assessed for each *S* while 50 slides flashing anxiety-provoking statements were shown. The statements were designed to provoke anger, sadness, anxiety threatening self-esteem and interpersonal needs. Each time a slide was presented, the SCR was registered measuring the intensity of each person’s psychophysiological (internal) reaction. At the same time, the *S* was asked to mark on a scale indicating how much the statement “bothered” him/her. Results have shown that cancer patients reported far less upset than the other *S* groups while SCR records showed significantly higher physiological reactions.

Also, from an experimental perspective, several researchers have developed psychologically successful training programs. Although, in these programs, specific manipulations of “rationality/anti-emotionality” are not described, and as stated by Temoshok (in press) there is “no explanation for how such beneficial effects occur” (p. 3); results are highly promising. For example, Eysenck and Grossarth-Maticek (1991) conclude that “there is evidence from independent sources that even quite simple manipulations of behaviour in terminal cancer patients may have very marked results as far as survival is concerned” (p. 29–30).

Stimulated by all of these results and based on the original R/A interview-questionnaire, Spielberger (1988) developed the Rationality/Emotional Defensiveness (R/ED) Scale. A summary of the main results obtained in a first study (Swan *et al.*, 1991) were as follows:

the psychometric properties of the R/ED Scale were tested in 1236 male (mean age = 71.8 yr) and 863 female (mean age = 68.5 yr) participants in a 27-year follow-up of the Western Collaborative Group Study. Analysis reveals high inter-item consistency (Cronbach’s alpha coefficients = 0.77 and 0.78 for men and women respectively) and two independent and stable factors that were labeled ‘Anti-emotionality’ (27% of total variance) and ‘Rationality’ (21% of the total variance). Excluding cancer patients, significant gender differences were observed for individual items, total R/ED score, and the two subscales (1991, p. 545).

Other studies have been conducted in order to evaluate the discriminative power of the Scale as well as its factorial component (Swan *et al.*, 1992). A summary of the results is as follows:

An additional 157 males and 164 females with some form of cancer other than skin were also included in this study. Characteristics measured included self-reported emotional control, anger expression, trait personality, depressive and neurotic symptomatology, Type A behavior, hostility, and social desirability. Results indicate that Rationality/Emotional Defensiveness Scale is most strongly related to the suppression and control of emotions, especially anger. Scores on this scale also tend to be associated with less Type A behavior, hostility and with more social conformity. Analysis of the component subscales suggests that Anti-emotionality

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