

Southern Illinois University Carbondale
OpenSIUC

Honors Theses

University Honors Program

5-1989

Self Complexity as a Buffer for Stress and Somatic Complaints

Jennifer Leigh Jett

Southern Illinois University Carbondale

Follow this and additional works at: http://opensiuc.lib.siu.edu/uhp_theses

Recommended Citation

Jett, Jennifer Leigh, "Self Complexity as a Buffer for Stress and Somatic Complaints" (1989). *Honors Theses*. Paper 280.

This Dissertation/Thesis is brought to you for free and open access by the University Honors Program at OpenSIUC. It has been accepted for inclusion in Honors Theses by an authorized administrator of OpenSIUC. For more information, please contact opensiuc@lib.siu.edu.

SELF COMPLEXITY
AS A BUFFER FOR STRESS AND
SOMATIC COMPLAINTS

Jennifer L. Herman

May 11, 1989

Southern Illinois University

SELF COMPLEXITY

ACKNOWLEDGEMENTS

I would like to give special thanks to:

Dr. Alan Vaux for all of his time, effort, and patience spent meeting with me and guiding me through the completion of this study.

Tracy Luchetta and Kelly Rhoades for all of the data collection and outside time helping me with this study.

Jerry Richards for his intellectual endeavor of writing the computer program for calculating the distinctiveness number.

Many situations produce stresses. How the stresses affect people differs from person to person. In the past several decades, increased attention has been addressed to the relationship of stress and psychosomatic illness. In some countries, psychosomatic phenomena are considered within the framework of general stress research.

Psychoanalytic observation of psychosomatic patients reveals that the inability to name, recognize, contain, or work through one's affective states are frequently manifestations of defense structures of a psychotic kind (McDougall, 1982). Glende (1982) expresses that as a result of their passive nature, illness and insanity create an illusion of nonresponsibility. She also states that illness, insanity, suicide, and homicide are techniques of escaping from unbearable tension. Therefore, the illness is presented as the somatic counterpart to "going crazy."

Larbig (1978) describes three psychotherapeutic procedures to understanding psychosomatic disorders: relaxation training combined with biofeedback, rational-emotive therapy, and social skills training. He makes reference to the clinical importance of slow cortical potentials (contingent negative variation) as the central nervous system correlates information processes in the treatment of anxiety and hyperactivation of the autonomic nervous system in stressful situations.

While researchers believe that there is a direct relationship between stress and illness, Mattila and Salokangas (1981) discuss

the concern that the effects of stress depend on an individual's adaptive capacity and on the presence of stressors. In addition to the external stressors, the individually determined effects of life changes often play a crucial role. Researchers need to address the more difficult and subtle area of coping and adaptational processes in terms of social, biological, and psychological constructs (Kimball, 1982). This brings about the concept of finding social settings and experiences, life events, that contribute to levels of stress.

Questions concerning the effect of stress-producing life events on methodological grounds and view of findings of subsequent psychosomatic research are presented as a theoretical model in which illness is considered only one of the several possible reactions to stress. Mariesse (1981) asserts that depression as a result of stress does exist, but is often hidden by somatic disorders. The patient's depression is often correlated with a state of classical depression in the patient's mother, if the patient is a child. When the child does not receive the needed attention from the mother, he/she expresses distress by presenting somatic disorders and extreme psychic withdrawal. Glende (1982) also holds that parental nurturing is a successful passive process to prevent diversion of energy to psychosomatic disturbance and to redirect energies to open the route to wellness.

Nemiah (1981) reviews systematic research regarding the influence of emotionally disturbing life events on psychosomatic illness. For the past 10-15 years, the significant advances in the

field of psychosomatic medicine have been in the attempt to refine and extend the nature of stressful precipitants of somatic illness. Examples of such research include Chattopadhyay (1979) and Cooke & Greene (1981). Chattopadhyay administered a self evaluation questionnaire to 80 subjects (mean age approximate 30 years) with psychotic, somatic, or psychosomatic disorders and controls. Results indicate that anxiety was prominent in all subjects and permanent in others. In the somatic subjects, anxiety seemed to be primarily due to subject's apprehension of a serious illness. Manifestations of somatic symptoms in psychosomatic subjects was seen as an expression of their basic anxiety.

Cooke & Greene's research was done to find what kind of life events were most stressful and how they combined to cause the disease. They suggest that both additive and multiplicative relationships may hold between life events. They derived their conclusions by having 131 females aged 25-64 years old complete a 21 item symptom rating scale and assessed them for total life stress. An increase in life events at menopause was shown to be almost exclusively due to an increase in the departure of persons from the subject's social field (exits), mostly through death. Different classes of life events were shown to correlate differentially with psychological and somatic symptoms. While psychological symptoms were directly related to stress arising from miscellaneous sources, somatic symptoms were elevated only if such stress was accompanied by stress arising from exits.

These exits, also known as life events, need to be closely

studied in order to truly find the relationship between them and somatic disorders. The stressful life events of most importance are those that occur near in time to the onset of a specific disorder. Data has shown that there is a definite relationship between life events and specific disorders. There is, however, no conclusive evidence to whether such disorders are results of stress produced by undesirable life events or desirable life events as well (Dohrenwend,1984).

Researchers may view the idea of desirable events as also leading to somatic illness. However, many times undesirable and desirable events occur concurrently. In connection with this idea is the concept of how important it is to distinguish between the perception of an event by a specific individual after he/she has experienced it and become ill in comparison to its meaning prior to its actual occurrence. Through the experiencing of certain events, many interpretations are changed. However, it is known that much of the learning that takes place is during vicarious experience in a social context, not direct. Many times, such interactions take place with others or are conveyed by others which means that an individual may not have to actually experience an event for it to have a stressful expectancy (Dohrenwend,1984).

Therefore, it is important to consider personal dispositions, but also the social contexts in which the experience occurs. For example, if a person receives a promotion and an increase in salary, it may also mean that he/she will have more deadlines to meet and increased pressure as well as higher prestige. In such a

case it is difficult to separate which might be the stress causing agent.

With this in mind, a researcher must take the types of events as a whole and emphasize that there may be a confounding of the psychiatric/physical conditions of the subject and those events that involve injury to the subject in the attempt to separate predispositions from those causal agents. Once attempted, the stressfulness of any single event needs to be determined. Holmes & Rahe (1967) devised the Social Readjustment Rating Scale (SRRS) to perform this task simply. By quantifying stressfulness, the researcher may be able to correlate those events high on the SRRS with disorders that occur closest in time. This scale also allows for person-specific stressors.

How each person perceives and reacts to any single life event is going to be quite different. However, is it possible that the reactions to major disasters would be more similar than those of less severity amongst larger populations? Personal characteristics would be more important to examine in dealing with everyday life events. These everyday events, microstressors, are potentially potent sources of stress even though they are considered less important than major life events. Minor life events act summatively and in the absence of compensatory positive experience which produce a higher risk for becoming a stress agent (Kanner et al, 1981), therefore, increasing the possibility of them having more of an effect on an individual.

It is true that research does support the life event scores

and their validity. However, Monroe (1983) found that a more sensitive depiction of the psychological experiences and stresses was necessary to better define the relationship between stress and illness. He felt that the extension needed was to move from major life events to the inclusion of daily experiences and minor incidents, those common to everyday life.

Kanner et al (1981) with the same intention, devised a Hassles & Uplifts Scale. It was found that this scale was "a better predictor of concurrent and subsequent psychological symptoms than were the life events scores, and that the scale shared most of the variance in symptoms accounted for by life events." (p.775) As is the importance of the appraisal of major life events, so is the appraisal of minor life events or hassles.

Hassles are associated with distress, frustration etc. that to some extent change interactions with the environment. Uplifts are positive experiences that include experiences of joy, love, pleasure, etc. (Kanner, 1981). Both hassles and uplifts may be determined by their setting or as separate from external events. Basically, if a person considers an incident as a hassle or uplift, it helps describe that person's style, normal setting, or the interaction of the two. Research has been completed, examining how hassles compare to major life events in their relation to specific outcomes and whether life events really do have a part in the occurrence of psychological symptoms.

Furthermore, Lazarus (1985) stated that even though many clinicians believe hassles do not directly indicate

psychopathology, they have been shown as strongly related to psychological symptoms. Therefore, in order to look more closely at the possible relationship, Lazarus proceeded to do a factor analysis of the hassles scale which separated the events into 8 categories: household hassles, health hassles, time pressure hassles, inner concern hassles, environment hassles, financial responsibility hassles, work hassles, and future security hassles. To be able to categorize all of the events listed in the hassles portion of the scale into only 8 groups, it became apparent that further investigation into the validity of the scale was necessary.

Dohrenwend & ShROUT (1985) state that nothing would have a stronger correlation to symptoms than other symptoms. Therefore, the confounds of such symptoms and those items on the scale were examined. It was shown that some of the life events used in the scale could also describe psychological symptoms, not only events that produce such symptoms.

Upon further dissection of the scale by Lazarus (1985), it was found that many of the items were redundant or may have some basis in a psychological setting which would change an individual's view on the item. However, one cannot totally separate the item environmentally and psychologically when determining its potential as a hassle or an uplift. Even if one attempts to do so, there is no substantiated proof that the life event is the only thing affecting whether it is perceived as an uplift or hassle or if there is some psychological background which could change the perception.

The late Barbara Dohrenwend was mentioned to have devised theoretical models to portray means by which stressful life processes and adverse health conditions may be related. These models include the idea that cumulations of stressful life events cause psychopathology, the idea that preexisting personal dispositions and social conditions serve as a buffer between the stress and health conditions, and the idea that personal dispositions and health conditions are independent in making causal contributions (Dohrenwend & Shrout, p.783).

An important issue that Dohrenwend introduces here is that of the "buffer." Other factors are to be considered when discussing the effects of stressful life events. There are several variables that may potentially buffer such effects on a cognitive or physical level. The most common buffer reported is social support. However, other moderators include locus of control, private self consciousness, and cognitive coping strategies (Linville, 1987).

More recently, research has looked at the buffer hypothesis of self complexity models. This hypothesis stated that greater self complexity moderates the adverse impact of stress on depression and illness. Greater self complexity involves separating the cognitive self into a greater number of groups of self aspects and having little overlap among self aspects (Linville, 1987).

According to Linville, self aspects are defined as each role, relationship, goal, activity, etc. that has its own features and affects. These aspects all are combined into a larger network to produce the whole person. However, not all aspects are in use at

any specific time. Instead, they are activated depending on the impact of emotional experiences. With respect to this, there is an assumption that once an aspect is activated, other associated aspects may also be activated. The more related these aspects are, the higher the chance for a "spillover" effect from one to the next. The hypothesis gives states that if the groups are numerous and distinct, the aspects will be less subject to spillover effects.

This model explains how, if an individual has greater self complexity and one aspect is affected, fewer of the rest will be affected. In effect, this may serve to moderate the impact of the original event. What is assumed that greater self complexity is a protection for people under stress as the stress will affect only controlled immediately relevant self aspects, thus leaving the remaining self aspects virtually unaffected. It has been shown that subjects higher in self complexity were less likely to be depressed, perceive stress, and have physical symptoms following high levels of stress (Linville, 1987). The self complexity model includes aspects that are related to major and minor life events. Although the strength of the buffer may differ to the extent of the importance of the life event.

Both major and minor life events are known to be associated with physical and mental health problems. Not a lot of research has been done on distinguishing these life events as positive or negative and how that distinction changes the problems incurred by them. The current research will be alert to the diversity of other

factors influencing a person's perception of stress as having occurred and as to how aversive it is. Such input leads the research into seeking the relationship that may decrease the perception of stress and its aversiveness.

The purpose of the present study, therefore, was to build upon the conceptual foundation provided by Linville (1987). Through addressing potential problematic life events and their connection with self knowledge, the current research sought to examine whether complex cognitive representation acted as a buffer in situations of major and minor life events in relation to psychosomatic illness.

METHODOLOGY

Subjects and Procedure

The data was collected from 77 male and female undergraduate students enrolled in an introductory psychology course. The students received partial course credit for their participation in the study. The subjects were tested in small groups. Subjects were required to complete the Hassles & Uplifts Scale, Physical Symptoms Survey, and a Self Complexity Task, described below.

Instruments

Hassles & Uplifts - The Hassles & Uplifts Scale consists of 53 everyday events that may affect an individual's life, such as "your relatives," "your work load," and "exercise." The subject was required to rate each as to how often it has been a hassle or an uplift in the previous two weeks. The ratings are from "rarely or not at all" to "most of the time." This scale is modified from one developed by Kanner et al (1981) so as to remove items that may be redundant or related to psychological problems or symptoms. Only those that appear to be relatively minor everyday life events remain. Three scores were derived from this scale. They consist

of the total number of hassle (uplift) items endorsed, the frequency of hassles (uplifts) endorsed, and the chronicity of hassles (uplifts) endorsed.

PSS - The Physical Symptom Survey (Cuevas & Vaux, 1984) consists of a list of 25 somatic complaints. This self report measure provides a response format for frequency, "never" to "everyday," and intensity, "does not bother" to "bothers very much." The PSS is reliable in that it is stable over 2 and 4 week intervals ($r > .70$) and valid in that the score is significantly higher among students reporting illness than for their peers and for students relative to alcoholics admitted for treatment.

SC - Self Complexity is measured through a procedure developed by Linville (1987). Students received a list of 33 features that students typically use to describe themselves. The subject was required to sort these features into groups that describe some aspect of their life. They were able form as many groups as they like and can include as many features in any group as they pleased. From these groups, 3 scores were derived to compute the distinctiveness score:

Subtotal 1 = Intersection/union

Subtotal 2 = Subtotal 1/ # of pairs compared

Distinctiveness score = 1 - Subtotal 2

For example:

Group 1: 1 3 5

Group 2: 2 4 6

Group 3: 1 2 3 4 6

Subtotal 1 = .933

Subtotal 2 = .933/ 3 = .311

Distinctiveness score = 1 - .311 = .689

Self Complexity was computed by the use of the Z scores of the Distinctiveness score (DR), the total number of different features selected (NADJ), and the total number of groups formed by each subject (NGRP). These numbers were then placed into the formula:

$$SC = ((ZDR*10)+100)*((ZNADJ*10)+100)*((ZNGRP*10)+100)$$

Thus, an individual would receive a lower SC score to the extent that he/she would sort the features into few groups where there is a lot of overlap. In turn, a high SC score would be given if there were a greater number of self aspects and greater distinction.

Data Analysis

The data collected was tested by looking at the correlation between the Hassles & Uplifts and PSS. This correlation was then compared for subjects scoring high versus low in self complexity to test whether greater self complexity acts to buffer the effects of hassles and/or uplifts.

RESULTS

Table 1: Correlations Between Physical Symptoms and Hassles & Uplifts

	<u>Hassles</u>			<u>Uplifts</u>		
	<u>endorsed</u>	<u>frequency</u>	<u>chronicity</u>	<u>endorsed</u>	<u>frequency</u>	<u>chronicity</u>
PSS	.46**	.57**	.59**	.13	.06	.04
low SC	.41*	.54**	.55**	-.04	-.08	-.05
high SC	.53**	.63**	.64**	.26	.17	.12

* p<.01 ** p<.001

Preliminary results of the study showed very high correlations among the hassles, reaching $r = .97$ ($p < .001$) and among the uplifts, reaching $r = .96$ ($p < .001$), which suggests that respectively they measure the same things.

To test the hypothesis, correlations were computed between the Physical Symptom Survey and the Hassles & Uplifts Scale (See table 1). The statistics confirmed the hypothesis that hassles would be

highly correlated with physical symptoms, positively and significantly. The table also shows little to no correlation between physical symptoms and uplifts.

The sample was then divided into two groups of high versus low self complexity and these analyses repeated. Again, all of the hassles correlations were positive and significant where there was very little correlation for the uplifts. This was the case for both self complexity groups.

Contrary to the hypothesis, the associations between PSS and Hassles & Uplifts were not greater for the low self complexity subject pool than for that of high self complexity. For hassles, the associations were more or less equivalent. Although the differences were not great, it is interesting to note that for uplifts, the correlations at the low self complexity were negative and opposite for high self complexity.

DISCUSSION

The results showed that in accordance with the hypothesis, hassles were highly related to physical symptoms. One interpretation of this is that hassles lead to stress related physical complaints. However, there was little association between uplifts and physical symptoms. Therefore, a subject's PSS score is an indicator of hassles where low PSS predicts fewer hassles. It

was not apparent that PSS scores are indicative at all of uplifts though.

Linville's model predicted that self complexity acts as a buffer for physical symptoms. The effect of such a buffer is interpreted as resulting in fewer spillover effects that would increase the effects of hassles on somatic complaints. Even though the hypothesis that those subjects lower in self complexity would have a stronger association between physical symptoms and hassles seemed so reasonable, the present data showed otherwise. In other words, the data suggested that self complexity does not act as a moderator of physical complaints for subjects under stress.

While looking at the results, one cannot ignore the fact that the self complexity measure was changed for this particular study. Problems were encountered while deciphering Linville's formula. Her formula was supposedly representative of the number of self aspects viewed and the relatedness of their characteristics. Working through several examples, distinctions were not found between groups that were apparently very different just by sight. However, the new self complexity measure appears to be closer to Linville's theory than her measure of showing greater self complexity by having more self aspects and greater distinctions between their contents. The adapted measure utilizes three components: the number of separate groups, the number of descriptors used, and the distinctiveness of their features. The difference in the derivation of this score may account for the inconsistency of the results.

It is doubtful that any problems arose from the use of the PSS and the Hassles & Uplifts scales. These have been previously tested for validity and reliability and appear to be quite strong. One limitation in the instruments is the possibility of error in the use of the distinctiveness number or the calculations of self complexity being that both were newly introduced in the present study.

Statistically, problems may have arisen due to the fact that the present study is purely correlational. Therefore, it is lacking any confident statements regarding causality. Even though hassles were interpreted as leading to physical symptoms, the opposite may in fact be true or there could be some relation to a third variable, i.e. personality, involved.

The use of an undergraduate student population that agreed to participate in the study for reasons of receiving course credit may have affected the results also. It is possible that many students may not have responded as accurately as they could have due to hurriedness to complete the presented tasks as quickly as possible.

The findings suggest several different directions for future research. One possible area to consider would be a population more stable in their life situations than that of undergraduate university students, for example working adults.

A second area to study might be to seek further into the proposed idea of self complexity. Perhaps the use of different characteristics would result in different findings. There may still be another way altogether to measure the variable than by

distinctiveness and number of groups.

The physical symptom survey consisted of mostly negative effects which were highly correlated to hassles. Other hassle correlations that might be of interest may be computed using depression, sociability, or perceived stress and may prove to differ for subjects in high versus low self complexity.

General research may need to be conducted regarding spillover effects to find if there is a difference in the effects for hassles versus uplifts and if there is a difference, to measure its strength.

REFERENCES

- Chattopadhyay, Prabal. (1979). State and trait anxiety in psychotic, somatic, and psychosomatic patients and normal subjects. Indian Journal of Clinical Psychology 6:
- Cooke, D.J., and Greene, J.G. (1980). Life stress and symptoms at the Climacterium. British Journal of Psychiatry 136:486-491.
- Deutsch, F. (1986). Calling a freeze on "stress wars": There is a hope for adaptational outcomes. American Psychologist 41:713-714.
- Dohrenwend, B.P., and Shrout, P.E. (1985). "Hassles" in the conceptualization and measurement of life stress variables. American Psychologist 40:780-785.
- Dohrenwend, B.S., et al. (1978). Exemplification of a method for scaling life events: The PERI Life Events Scale. Journal of Health and Social Behavior 19:205-229.

- Dohrenwend, B.S., and Dohrenwend, B.P. (1984). Life Stress and Illness: Formulation of the Issues. Stressful Life Events and Their Contexts 2:1-27.
- Glende, Nancy. (1982). Get-sick as an escape hatch. Transactional Analysis Journal 12:197-198.
- Kanner, A., Coyne, J.C., Schaefer, C., and Lazarus, R.S. (1981) Comparison of two models of stress measurement: Daily hassles and uplifts versus major life events. Journal of Behavior Medicine 4:1-39.
- Kimball, Chase P. (1982). Stress and Psychosomatic Illness. Journal of Psychosomatic Research 26:63-71
- Larbig, Wolfgang (1978). Psychophysiological approach to etiology and the therapy of psychosomatic disorders. Journal for Psychosomatic Medicine and Psychoanalysis 24:
- Lazarus, R.S., DeLongis, A., Folkman, S., and Gruen, R. (1985) Stress and adaptational outcomes: The problem of confounding measures. American Psychologist 40:770-779.

- Lefcourt, Herbert M. (1984). Locus of control and stressful life events. Stressful Life Events and Their Contexts 2:157-166.
- Linville, Patricia (1987). Self complexity as a cognitive buffer against stress related illness and depression. Journal of Personality and Social Psychology 52:663-676.
- Marijessse, Anne-Marie (1981). Psychosomatic disorders of young children and depression. Review of Psychosomatic Medicine and of Medical Psychology 23:
- Mattila, Vilho J., and Sakalongs, Raimo K. (1981). Stress caused by life changes and their role as factors predisposing to illness. Psychiatria Fennica.
- McDougall, Joyce (1952). Alexthemia: A psychoanalytic viewpoint. Psychotherapy and Psychosomatics 38:81-90.
- Monroe, S.M. (1983). Major and minor life events as predictors of psychological stress: Further issues and findings. Journal of Behavioral Medicine 6:189-205.
- Nemiah, John C. (1981). Psychosomatic Medicine: A theoretical backdrop. Hillside Journal of Clinical Psychiatry 3:

Watson, David, et al (1988). Development and validation of brief measures of positive and negative affect: The PANAS Scales. Journal of Personality and Social Psychology 54(6):1063-1070.

Watson, David (1988). Intraindividual and Interindividual analysis of positive and negative affect: Their relation to health complaints, perceived stress, and daily activities. Journal of Personality and Social Psychology 54(6):

Below is a list of physical complaints which sometimes bother people. Think about the past two weeks. During the PAST TWO WEEKS,

- A. How often did you have each of these complaints?
- B. How much did the complaint bother you (for example, on the average, how serious was it, and how much discomfort was involved)?

Using the scales below, for each item, circle a number

in Column A to indicate how often you had that complaint:

in Column B to indicate how bothered you were by that complaint.

	<u>Column A - FREQUENCY</u>					<u>Column B - INTENSITY</u>					
	0	1	2	3	4	5	0	1	2	3	4
	0 - never						0 - did not really bother me				
	1 - once in two weeks						1 - bothered me a little				
	2 - once a week						2 - bothered me moderately				
	3 - 2 or 3 times a week						3 - bothered me quite a bit				
	4 - 4-6 times a week						4 - bothered me very much				
	5 - every day										
1. Headache.....	0	1	2	3	4	5	0	1	2	3	4
2. Upset stomach.....	0	1	2	3	4	5	0	1	2	3	4
3. Difficulties in breathing.....	0	1	2	3	4	5	0	1	2	3	4
4. Backache.....	0	1	2	3	4	5	0	1	2	3	4
5. Feeling fatigued.....	0	1	2	3	4	5	0	1	2	3	4
6. Diarrhea.....	0	1	2	3	4	5	0	1	2	3	4
7. Nausea.....	0	1	2	3	4	5	0	1	2	3	4
8. Feeling dizzy or faint.	0	1	2	3	4	5	0	1	2	3	4
9. Constipation.....	0	1	2	3	4	5	0	1	2	3	4
10. Feeling stiff all over.	0	1	2	3	4	5	0	1	2	3	4
11. Pain in your chest.....	0	1	2	3	4	5	0	1	2	3	4
12. Itching of the skin....	0	1	2	3	4	5	0	1	2	3	4
13. Poor appetite.....	0	1	2	3	4	5	0	1	2	3	4
14. Waking up tired in the morning.....	0	1	2	3	4	5	0	1	2	3	4
15. Flushed in the face....	0	1	2	3	4	5	0	1	2	3	4
16. Shaking or trembling...	0	1	2	3	4	5	0	1	2	3	4
17. Sweating.....	0	1	2	3	4	5	0	1	2	3	4
18. Cold hands or feet.....	0	1	2	3	4	5	0	1	2	3	4
19. Racing heart.....	0	1	2	3	4	5	0	1	2	3	4
20. Feeling weak.....	0	1	2	3	4	5	0	1	2	3	4
21. Shortness of breath....	0	1	2	3	4	5	0	1	2	3	4
22. Gnashing of teeth.....	0	1	2	3	4	5	0	1	2	3	4
23. Heaviness in arms or legs.....	0	1	2	3	4	5	0	1	2	3	4
24. Numbness or tingling in a part of your body....	0	1	2	3	4	5	0	1	2	3	4
25. Trouble getting to sleep or staying asleep	0	1	2	3	4	5	0	1	2	3	4

HASSLES are irritants--things that annoy or bother you; they can make you upset or angry. UPLIFTS are events that make you feel good; they can make you joyful, glad, or satisfied. Some hassles and uplifts occur on a fairly regular basis and others are relatively rare. Some have only a slight effect, others have a strong effect.

This questionnaire lists things that can be hassles and uplifts in day-to-day life. You will find that during the course of a day some of these things will have been only a hassle for you and some will have been only an uplift. Others will have been both a hassle AND an uplift.

DIRECTIONS: Please think about how often each item was a hassle and how often an uplift for you in the past two weeks. Please indicate on the left-hand side of the page (under "HASSLES") how often the item was a hassle by circling the appropriate number. Then indicate on the right-hand side of the page (under "UPLIFTS") often the item was an uplift by circling the appropriate number.

Remember, circle one number on the left-hand side of the page and one number on the right-hand side of the page for each item.

How often was this item
a hassle for you in the
past two weeks?

How often was this item an
uplift for you in the past
two weeks?

HASSLES

0 = RARELY OR NOT AT ALL
1 = SOMETIMES
2 = OFTEN
3 = MOST OF THE TIME

UPLIFTS

0 = RARELY OR NOT AT ALL
1 = SOMETIMES
2 = OFTEN
3 = MOST OF THE TIME

DIRECTIONS: Please circle one number on the left-hand side and one number on the right-hand side for each item.

0 1 2 3	Your child(ren)	0 1 2 3
0 1 2 3	Your parents or parents-in-law	0 1 2 3
0 1 2 3	Other relative(s)	0 1 2 3
0 1 2 3	Your spouse	0 1 2 3
0 1 2 3	Time spent with family	0 1 2 3
0 1 2 3	Health or well-being of a family member	0 1 2 3
0 1 2 3	Sex	0 1 2 3
0 1 2 3	Intimacy	0 1 2 3
0 1 2 3	Family-related obligations	0 1 2 3
0 1 2 3	Your friend(s)	0 1 2 3
0 1 2 3	Fellow workers	0 1 2 3
0 1 2 3	Clients, customers, patients, etc.	0 1 2 3
0 1 2 3	Your supervisor or employer	0 1 2 3
0 1 2 3	The nature of your work	0 1 2 3
0 1 2 3	Your work load	0 1 2 3
0 1 2 3	Your job security	0 1 2 3
0 1 2 3	Meeting deadlines or goals on the job	0 1 2 3

How often was this item
a hassle for you in the
past two weeks?

How often was this item an
uplift for you in the past
two weeks?

HASSLES

UPLIFTS

- 0 = RARELY OR NOT AT ALL
- 1 = SOMETIMES
- 2 = OFTEN
- 3 = MOST OF THE TIME

- 0 = RARELY OR NOT AT ALL
- 1 = SOMETIMES
- 2 = OFTEN
- 3 = MOST OF THE TIME

DIRECTIONS: Please circle one number on the left-hand side and one number on the right-hand side for each item.

0 1 2 3	Enough money for necessities (e.g., food, clothing, housing, health care, taxes, insurance)	0 1 2 3
0 1 2 3	Enough money for education	0 1 2 3
0 1 2 3	Enough money for emergencies	0 1 2 3
0 1 2 3	Enough money for extras (e.g., entertainment, recreation, vacations)	0 1 2 3
0 1 2 3	Financial care for someone who doesn't live with you	0 1 2 3
0 1 2 3	Investments	0 1 2 3
0 1 2 3	Your smoking	0 1 2 3
0 1 2 3	Your drinking	0 1 2 3
0 1 2 3	Mood-altering drugs	0 1 2 3
0 1 2 3	Your physical appearance	0 1 2 3
0 1 2 3	Contraception	0 1 2 3
0 1 2 3	Exercise(s)	0 1 2 3
0 1 2 3	Your medical care	0 1 2 3
0 1 2 3	Your health	0 1 2 3
0 1 2 3	Your physical abilities	0 1 2 3
0 1 2 3	The weather	0 1 2 3
0 1 2 3	News events	0 1 2 3
0 1 2 3	Your environment (e.g., quality of air, noise level, greenery)	0 1 2 3
0 1 2 3	Political or social issues	0 1 2 3
0 1 2 3	Your neighborhood (e.g., neighbors, setting)	0 1 2 3
0 1 2 3	Conserving (gas, electricity, water, gasoline etc.)	0 1 2 3
0 1 2 3	Pets	0 1 2 3
0 1 2 3	Cooking	0 1 2 3
0 1 2 3	Housework	0 1 2 3

24

How often was this item
a hassle for you in the
past two weeks?

How often was this item an
uplift for you in the past
two weeks?

HASSLES

- 0 = RARELY OR NOT AT ALL
- 1 = SOMETIMES
- 2 = OFTEN
- 3 = MOST OF THE TIME

UPLIFTS

- 0 = RARELY OR NOT AT ALL
- 1 = SOMETIMES
- 2 = OFTEN
- 3 = MOST OF THE TIME

DIRECTIONS: Please circle one number on the left-hand side and one number on the right-hand side for each item.

0 1 2 3	Home repairs	0 1 2 3
0 1 2 3	Yardwork	0 1 2 3
0 1 2 3	Car maintenance	0 1 2 3
0 1 2 3	Taking care of paperwork (e.g., paying bills, filling out forms)	0 1 2 3
0 1 2 3	Home entertainment (e.g., TV, music, reading)	0 1 2 3
0 1 2 3	Amount of free time	0 1 2 3
0 1 2 3	Recreation and entertainment outside the home (e.g., movies, sports, eating out, walking)	0 1 2 3
0 1 2 3	Eating (at home)	0 1 2 3
0 1 2 3	Church or community organizations	0 1 2 3
0 1 2 3	legal matters	0 1 2 3
0 1 2 3	Being organized	0 1 2 3
0 1 2 3	Social commitments	0 1 2 3

12

13 IMPULSIVE

17 CONFORMIST

14 SHALLOW

16 UNORGANIZED

8 STUDIOUS

6 UNFRIENDLY

19 HUMOROUS

10 SOFT-HEARTED

21 ANXIOUS

22 INDIVIDUALISTIC

5 ORGANIZED

2 QUIET

25 IMAGINATIVE

9 REFLECTIVE

11 NOT STUDIOUS

7 AFFECTIONATE

18 IRRESPONSIBLE

24 MATURE

26 LAZY

4 RUDE

31 SOPHISTICATED

15 RESERVED

20 RECKLESS

30 PLAYFUL

12 UNCONVENTIONAL

23 INSECURE

32 REBELLIOUS

29 ASSERTIVE

28 OUTGOING

27 INDUSTRIOUS

3 RELAXED

33 EMOTIONAL

1 COMPETITIVE