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The Effect of Self-Focused Attention on Psychopathology

A Thesis For The Honors Program

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Fall 1997

Approved By

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Abstract

This study investigated whether self-focused attention is related to psychopathology in general or if, instead, specific types of self-focus are associated with specific disorders. Self-focus was measured as private self-consciousness, public self-consciousness, emotional self-reference, or performance self-reference. Personality measures included depression, phobias, health concern, obsessiveness, and disordered eating. Public self-consciousness was related to greater depression, obsessiveness, and disordered eating. Private self-consciousness was positively correlated with depression and obsessiveness. Performance self-reference was related to lower levels of depression and obsessiveness. The findings indicate that different types of self-focused attention are involved in different disorders. Results are interpreted with reference to self-awareness theories of psychopathology.

Acknowlegements

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Introduction

A growing body of research has shown a link between self-focused attention and psychopathology. This paper reviews several theories of self-focused attention in historical sequence and discusses limitations of previous research. Past studies used various instruments to measure self-focus, but a review of the literature reveals no studies in which multiple measures were used. It is possible that different instruments measure different types of self-focused attention and that different types of self-focus are associated with different emotional states. The present study investigates whether specific types of self-focused attention are associated with *specific disorders* or, conversely, if self-focused attention is related to psychopathology *in general*.

Theoretical Development

Research in this area began with Duval and Wicklund's Self-Awareness Theory (1972). They differentiated between self-awareness (attention focused inward) and externally focused attention. According to this theory, when a person is self-aware, he or she focuses on behavioral standards and any discrepancy between those standards and the present behavior. If the present behavior does not match the goal, then the person takes steps to reduce the gap. Self-awareness here is an

adaptive way to keep the self in line with goals. Once a person has met the standard, he or she becomes more externally focused.

Carver and Scheier (1977, 1981) expanded Self-Awareness Theory, finding that self-focused subjects reported greater elation in response to appealing stimuli and greater repulsion in response to aversive stimuli than did externally focused subjects (Carver & Scheier, 1977). They concluded that when people are self-aware, they focus not only on goals and behavior, but also on the emotion or mood present. Greater awareness of the emotion appears to intensify the subject's emotional experience. Carver and Scheier (1981) presented a theory of self-regulation similar to Self-Awareness Theory. According to this theory, a person engages in a feedback loop in which he or she compares the present behavior to personal goals. Any discrepancy causes negative feelings, motivating the person to take action to reach the goal. Then a reassessment is made. So long as there is a reasonable chance of meeting the goal, the person remains self-aware to monitor progress. If the probability of reaching the goal is low, the person normally exits the feedback loop and avoids self-awareness in order to avoid the negative feelings involved.

Some people, however, may not enter and exit the self-awareness loop at adaptive times, as in the case of learned helplessness. Learned Helplessness Theory states that after experiencing uncontrollable failures or losses, one develops low expectations for controlling other outcomes, even those that could be controlled (Maier, Seligman, & Solomon, 1969). The person who has learned to be helpless acquires motivational, cognitive, and affective deficits such as low self-esteem, sadness, and the inability to learn new responses to problems. This person may be self-focused and therefore acutely aware of the painful feelings involved in the loss or failure. But to be adaptive, the self-regulatory loop requires these feelings to motivate a change in behavior that

will help solve a problem or reach a goal. If a person who feels helpless is not motivated by these negative feelings or has impaired problem-solving ability, the heightened awareness of mood may only make things worse.

Abramson, Seligman, & Teasedale (1978) revised Learned Helplessness Theory to include the explanations people make for events. According to the Reformulated Learned Helplessness Theory, people who make global attributions for bad events will feel more helpless than people who make specific attributions. For example, a person who attributes failure on a test to the fact that "I am stupid" will feel more helpless than one who explains the failure by saying "I'm poor at math." People who attribute negative events to stable causes, such as believing that they are late for work because they are always late, will feel more helpless than those who explain their lateness by unstable causes, such as traffic being slow on the given day. Finally, people who make internal attributions, believing that bad things happen to them because of who they are, feel more helpless than those who make external attributions, believing that the problem is related to a specific situation.

Another important contribution to self-regulation literature is Kuhl's (1985) work on Action Control. Kuhl described two different types of self-focus: *action orientation*, a focus on a plan of action to bring about change, and *state orientation*, a focus on an emotional or physical state or situation. State orientation tends to inhibit change. Action Control Theory says that after experiencing uncontrollable negative events people switch to the state orientation. This focus on a person's state or situation rather than a plan of action leads to the symptoms of learned helplessness.

Pyszczynski and Greenberg (1987) integrated these theories into Self-Regulatory

Perseveration Theory, in which a unique self-focusing style emerges for depressed people. This theory begins with the elements of the self-regulatory feedback loop. When a person detects a discrepancy between real and ideal behavior, he or she initiates behavior to compensate. If one cannot obtain the goal, he or she normally exits the loop by refocusing on other goals. However, it is not always easy to exit the self-focus loop by changing or derogating one's goals. If the loss or failure is central to the person's self-esteem or identity, the person may not be able to compensate with alternatives or to deny the significance it had.

Pyszczynski and Greenberg suggested that depression occurs when a person cannot exit the control loop after an irreconcilable loss or failure. In this model, the loss or failure represents a gap between our *real* and *ideal* behavior or achievement. If, for example, a person's goal is to earn a doctoral degree but, in actuality, he or she is denied entrance to a graduate program, then there is a gap between real and ideal circumstances. If the person perceives that there is a reasonable chance of being admitted at a later date or to another program, then he or she will pay more attention to him or herself, making an evaluation of what is wrong and what must be done to gain admission, thereby changing the real circumstances to meet the ideal. If, however, the person does not believe that there is a reasonable chance of gaining admission, then the person may stop focusing on him or herself and change his or her career goals, thereby changing the ideal to meet the real. But if a doctoral degree is so important to the person that he or she cannot be satisfied with alternative goals, then there is a problem. The person will still focus on the self, evaluating what is wrong, but may not make a plan of action, because admission is no longer seen as a realistic possibility. This person's self-focus will intensify the feeling of failure. This person will also experience the symptoms of learned helplessness including low self-esteem, poor

motivation, and poor problem solving. These deficits make the person less likely to be successful at future admission attempts. At this point the person has fallen into a continuous cycle, the depressive self-focusing style.

Pyszczynski and Greenberg (1986) cited evidence to support this theory. They found that depressed subjects remained more self-focused after failure and more externally focused after success. Nondepressed subjects show the opposite pattern, self-focusing more after success than after failure. The researchers concluded that depressed subjects continue focusing on their failure in order to preserve their negative self-concept. They may do this for several reasons: maintaining a poor self-concept takes less effort than building a positive one; a poor self-concept also protects them from further disappointments; and a negative self-concept provides a safe, easy explanation for failures, promoting a belief in a just world.

Rumination

Building on the growing research on self focus and depression, Nolen-Hoeksema (1987) concentrated on one specific type of self-focused attention: rumination. Rumination is defined as "cognitions and behaviors that repetitively focus the depressed individual's attention on his or her symptoms and the possible causes and consequences of those symptoms" (Morrow and Nolen-Hoeksema, 1990, p.519). Rumination is somewhat different from Pyszczynski and Greenberg's depressive self-focusing style in that rumination focuses on the person's mood and depressive symptoms rather than the goals with which they interfere.

Several possible causes of rumination have been identified. Wood, Saltzberg, and Goldsamt (1990) found that inducing a negative mood leads subjects to increase self-focus and decrease external focus. They suggested three ways in which a negative mood may increase self-focus. First, a change in mood might trigger self-focus because of the salience of the change itself. Second, one might search the self to find a reason for the change, thereby directing attention inward. Finally, as Pyszczynski and Greenberg (1987) argued, negative affect signals a need for self-regulation. In addition to monitoring progress toward a goal, one might try to control the mood itself. Evidence that rumination increases depression (Morrow & Nolen-Hoeksema, 1991) and that depression increases rumination (Wood et al., 1990) supports the argument of several theories (e.g. Duval & Wicklund, 1972; Carver & Scheier, 1981; Lewinsohn et al., 1985; Pyszczynski & Greenberg, 1987) that the two processes may be cyclic. These studies have shown causation in both directions.

The most heavily studied aspect of self-focused attention has been rumination and its role in depression. Morrow & Nolen-Hoeksema (1991) found that ruminative coping predicts longer

episodes of depression. They described several ways in which it may contribute. First, rumination among depressed people increases negative inferences. Depressive ruminators are more likely to infer pessimistic beliefs from ambiguous information. Second, rumination increases recall of negative memories. A depressed person may literally not be able to recall many happy memories but can think of numerous sad experiences. Third, rumination interferes with concentration and problem solving that might otherwise improve a person's mood. The depressed ruminator may base decisions on the pessimistic thoughts of the moment rather than more objective information (Morrow & Nolen-Hoeksema, 1990). In addition, rumination increases pessimistic attributions and worsens interpersonal problem solving (Lyubomirski & Nolen-Hoeksema, 1995). Depressed ruminators are more likely to explain negative events in terms of global, stable, internal causes, leading to learned helplessness. Finally, poor problem solving in social situations may make dealing with other people very difficult, decreasing social support. Social support has been shown to be negatively correlated with depression (Nolen-Hoeksema, Parker, & Larson, 1994). The research on self-focused attention converges to make a strong case that it contributes to depression.

A Broader View Of Self Focused Attention

Most studies in this area have used the terms *self-focused attention* and *rumination* interchangeably. Rumination, however, is only one kind of self-focused attention. There are many aspects of the self. Self-regulation theories, for example, emphasize goals and behavioral standards as the targets of self-focus. There are likely other aspects of the self involved in self-focused attention. One commonly studied type of self-focus is *Self - consciousness*, which refers to awareness of the self in both public and private situations. It includes *Public Self-*

consciousness, defined as awareness of the self as an object of social scrutiny, and *Private Self-consciousness*, which is awareness of one's internal states and attributes (Carver & Scheier, 1977). Another type of self-focus studied has been self-reference. *Self- reference* is the tendency of a person to refer to aspects of the self, and may be broken down into emotional, personality, physical, and performance self-reference (Pyszczynski & Greenberg, 1986).

Though most research has focused on depression, there is evidence that self-focus is also related to a range of other disorders. Streigel-Moore, Silberstein, & Rodin (1993) found that bulemic women tend to display higher than normal Public Self-consciousness. High Public-self Consciousness is also correlated with greater shame and neuroticism (Darvill, Johnson, & Danko, 1992). Wood et al. (1990) reported that self-focused attention is associated with general anxiety in individuals. Finally, Ingram (1990) found that self-focused attention is higher in people with depression, anxiety, schizophrenia, and other pathological states. Ingram suggested that since heightened self-focus is found in such a wide array of disorders, it may simply be an artifact of negative emotion. If this is so, he argued, it may not be useful to study self-focused attention in developing theoretical models of psychopathology. Other researchers have argued that self-focused attention plays an important role in the onset and maintenance of psychological disorders (Carver & Scheier, 1981; Pyszczynski & Greenberg, 1987; Nolen-Hoeksema, 1987).

The literature commonly generalizes from specific measures to self-focused attention in general. For example, Carver & Scheier (1975, 1977) used a mirror to induce self-focused attention. Does such an experimental manipulation increase public *and* private self-focus? Rumination? Performance or emotional self-reference? Wood et al. (1990) measured general self-reference. Do their findings generalize to other types of attention directed at the self? This

study aims to determine how generalizable the correlations between self-focused attention and different disorders are.

Wood et al. (1990) suggest two possible explanations for how self-focus is related to psychopathology. Self-focused attention may be related to negative affect in general, which is reflected in a wide range of psychological disorders. Or, while self-focused attention is associated with many disorders, specific types of self-focus may be related to specific disorders.

The present study tests two competing hypotheses derived from these explanations. Hypothesis 1 is that specific types of self-focused attention are related to specific disorders. Hypothesis 2 is that self-focused attention is related to psychopathology in general, regardless of the type of self-focus or disorder measured.

Method

Subjects

Ninety-nine students at Western Kentucky University were recruited through psychology courses and given class credit for participation. The sample included 63 females and 35 males, with one subject omitting the answer to the question of gender. Ages ranged from "under 18" to "over 38" with a modal response of "18-22," n = 83.

Self-Focus Measures

Two types of self-focus were measured: *self-consciousness* and *self-reference*. Self-consciousness was operationalized as the score on the Self-consciousness Scale (Scheier, 1977). The Self-consciousness Scale includes three subscales. Two of these are considered to be separate types of self-focused attention. These are *private self-consciousness* (awareness of one's own internal state and attributes) and *public self-consciousness* (awareness of oneself as perceived by others). Scheier reports test-retest stability for private self-consciousness, $r = .76$ as well as internal consistency, $\alpha = .75$. For public self-consciousness, $r = .74$ and $\alpha = .84$ (1977).

Self-reference was defined as the tendency to refer to aspects of the self. This type of self-focused attention was measured with a content analysis method developed by Pyszczynski and Greenberg (1986). Subjects were asked in a written, free-response format to describe "the most

bothersome event or issue of the day." They could describe something that had happened during the day, something that happened in the past and was still bothering them, or something they anticipated as a future problem. Three judges blind to other measures were trained to content analyze responses by dividing response statements into independent clauses, then counting the number of clauses that referred to the respondent. Judges were trained in two sessions in which they scored responses from a pilot study. Agreement among the judges was above 80%. The self-focus score was computed as the number of self-references per independent clause. Self-referent clauses were separated into four categories: emotion-focused, performance-focused, personality-focused, and physically focused. Emotion-focused clauses referred to the respondent's positive or negative feelings. Performance-focused clauses referred to present, past or possible success or failure at some task. Personality-focused clauses included references to the respondent's own personality traits, and physically focused clauses referred to his or her own bodily condition, concerning either health or appearance. Wood et al. (1990) showed evidence of stability for this content analysis measure of self-reference, finding an Intraclass Correlation Coefficient (ICC) of .79 across 30 days.

Measures of Disorders

Pathology measures included measures of depression, fears, obsessiveness, health concerns, and disordered eating patterns. Depression, fears, obsessiveness, and health concerns were assessed using clinical scales from the Minnesota Multiphasic Personality Inventory II (Minnesota Press, 1989). MMPI 2 reports test-retest stability ranging from r= .87 to .88 for depression, r= .84 to .87 for fears, r= .83 to .85 for obsessiveness, and r= .82 to .85 for health concern. Internal consistencies range from α= .85 to .86 for depression, α= .72 to .75 for fears, α= .74 to .77 for

obsessiveness, and α= .76 to .80 for health concern.

Disordered eating patterns were measured by the Concern Over Weight and Dieting Scale. The COWDS shows known-groups validity with low, intermediate, and high scores correlating with subjects categorized as normal eaters, borderline eaters, and disordered eaters, respectively. The COWDS reports an internal consistency of α= .88 (Kagan & Squires, 1984). All scales are reproduced in Appendix A.

Procedure

Subjects were tested in four groups during class periods. They were told that the researcher was trying to "learn more about attention, mood, and anxiety." After giving informed consent, subjects were asked to mark their answers on the answer sheets provided, and were reminded that there were no right or wrong answers. For the free-response section, subjects were asked to write "a paragraph or two." Self-consciousness, self-reference, and clinical scales were counterbalanced to control for order effects. Verbatim instructions are presented in Appendix B.

Results

Reliability of Measures

Reliability analysis of the present sample showed a Cronbach's alpha of .53 for Private Self-consciousness and $\alpha = .81$ for Public Self-consciousness. For the self-reference measure, interrater reliability was computed by the formula $r = 1 - (1/F)$ where F is Fisher's ratio from a one way ANOVA. Interrater reliability was .92 for total self-references, .85 for emotion self-references, and .84 for performance self-references. Physical and personality references were dropped from the analyses because they showed reliability coefficients below .20.

Internal consistency coefficients were $\alpha = .80$ for the depression scale, $\alpha = .80$ for the obsessiveness scale, and $\alpha = .52$ for the health concerns scale. For the Concern Over Weight and Dieting Scale, $\alpha = .87$. The fears scale was dropped because of low internal consistency, $\alpha = .32$.

General Results

Mean scores for self-focus and psychopathology measures are shown in Table 1.

Table 1

Scores for Self-focus and Psychopathology Scales

Scale	M	SD	n
Self-Focus Scales			
Private Self-Consciousness	23.37	3.90	97
Public Self-Consciousness	20.92	4.42	98
Emotional Self-Reference	.18	.19	91
Performance Self-Reference	.21	.28	91
Psychopathology Scales			
Depression	8.72	4.54	98
Obsessiveness	6.77	3.72	97
Health Concerns	17.60	3.44	93
Disordered Eating	34.26	12.07	99

Table 2, below, presents the correlations between self-focus measures and pathology measures. No sex differences emerged in these correlations so all analyses were performed across sex. A significance level of $p = .05$ was used for all analyses.

Table 2

Correlations Between Self-focus and Psychopathology Scores

Self Focus Measure	Psychopathology Measure			
	Depression	Obsessiveness	Disordered Eating	Health Concern
Public Self-Consciousness	.23*	.21*	.23*	-.10
Private Self-Consciousness	.22*	.27*	.17	-.03
[a]Emotional Self-Reference	-.05	.01	.03	-.08
[a]Performance Self-Reference	-.24*	-.28*	-.07	.03

Note. n= 83.
[a]Because Performance and Emotional Self-Reference scores were not normally distributed, Spearman Correlation Coefficients were computed for these measures. Pearson Correlation Coefficients are used for all other measures.
*$p < .05$.

Public Self-consciousness was related to greater depression ($r = .23$, $p < .05$), obsessiveness ($r = .21$, $p < .05$), and disordered eating ($r = .23$, $p < .05$). Private Self-consciousness was positively correlated with depression ($r = .22$, $p < .05$) and obsessiveness ($r = .27$, $p < .05$).

Emotional Self-reference was unrelated to any psychopathology scores. Performance Self-reference, however, was associated with less depression ($r = -.24$, $p < .05$) and less obsessiveness ($r = -.31$, $p < .05$). Health concern was not related to any type of self-focus measured.

Discussion

The results show some overlap among types of self-focus and the disorders with which they correlate. However, this overlap is not enough to support the view that focusing on oneself is characteristic of psychopathology in general. Rather, results support hypothesis one: some types of self-focus appear related to certain disorders but not others. Further, not all types of self-focus correlated to disorders in the same direction.

Public self-consciousness

Subjects high in public self-consciousness scored higher in depression. Public self-consciousness is essentially awareness of the self as being evaluated by others in a social context. If depressed people make pessimistic inferences from ambiguous information (see Morrow & Nolen-Hoeksema, 1991), then they may assume people are evaluating them badly, and so pay more attention to themselves as the object of scrutiny. Heightened public self-consciousness might also interfere with interpersonal problem solving as rumination does (1991). People who become very nervous in social situations may have difficulty forming relationships, a difficulty that may lead to a lack of social support and increased risk of depression.

Subjects high in public self-consciousness also scored higher on obsessiveness. There are at least two ways public self-consciousness and obsessiveness might contribute to each other. First,

awareness of being evaluated by others could heighten the perfectionism characteristic of many obsessive disorders. Second, self-consciousness might actually be a symptom of obsessiveness. That is, the intrusive and uncontrollable thoughts we call obsessions might sometimes concern one's public appearance.

Public self-consciousness and disordered eating were also positively correlated. This is consistent with results from Streigel-Moore et al. (1993) who found that bulemic women were higher than normal in public self-consciousness. They interpreted this finding to mean that body dissatisfaction is linked to concerns with the social self. It appears that disordered eating patterns, for both men and women, are related to concern over how the individual is seen by others.

Private self-consciousness

Private self-consciousness was positively correlated with depression. Private self-consciousness is awareness of one's internal states or qualities. Kuhl (1985) found that the state orientation, focusing on one's emotional or physical state or situation, leads to learned helplessness. To the extent that they are similar, then, private self-consciousness might lead to the same symptoms, increasing the risk of depression. Namely, the person might experience lowered self-esteem, sadness, and an inability to learn new responses to problems. Wood et al. (1990) found that a change in one's mood for the worse can induce self-focused attention. The researchers suggest that the person may search him or herself for qualities or characteristics that caused the change in mood. Also, a decline in mood may signal the need for self-regulation, triggering a self-focused feedback loop aimed at returning the person to a better mood. Finally, if one is depressed, paying attention to one's inner feelings worsens the symptoms by intensifying the experience of the mood (Carver & Scheier, 1975).

Subjects higher in private self-consciousness were also higher in obsessiveness. One reason may be that the intrusive thoughts we call *obsessions* trigger the need for self-regulation. A person may ask him or herself, "Why can't I push this thought out of my head? What's wrong with me?" And so a feedback loop may ensue, in which the individual searches for the attributes causing the problem. Once attention is focused inward for this or other reasons, the cognitive rigidity common in obsessive disorders may maintain the self-focus.

Performance self-reference

Performance self-reference is a focus on how one has or will perform on some task. The finding that people high in performance self-reference are less depressed and less obsessive is surprising because the literature consistently associates self-focused attention with causes or symptoms of psychopathology (e.g. Carver & Scheier, 1981; Pyszczynski & Greenberg, 1987; Wood et al., 1990; Ingram, 1990; Darvill et al., 1992; Streigel-Moore, et al., 1993). The exception is Kuhl's (1985) action orientation, which has been shown to be adaptive. Action orientation is a tendency to cope with problems by forming a plan of action. Both performance self-reference and the action orientation have in common an emphasis on the performance of an action. It may be that people who are high in performance self-reference use active coping skills that protect them from depressive and obsessive disorders.

Directions for future research

The results of this study suggest several further questions. Each correlation between a type of self-focus and a type of pathology bears further investigation. Some speculations have been made as to how the correlations found might fit into self-awareness models. Further study is clearly needed to test these hypotheses. Relationships between certain types of self-focus and particular

disorders are not necessarily generalizable to other types of self-focused attention. However, it is not clear *why* certain kinds of self-focus are associated with some disorders and not others. For example, if a person engages in self-focus, asking "what is wrong with me?" because he or she is experiencing obsessions, why wouldn't he or she do the same in response to disordered eating behaviors or excessive health concern?

Another interesting direction for research lies in the findings on performance self-reference. Is this type of self-focus correlated with the action orientation? If this is an adaptive form of self-focused attention, can people inclined to self-focus be trained to focus on performance rather than less adaptive areas?

Carver & Scheier ignited this line of research in 1977 by asking what aspects of the self we attend to when we are self-aware. The question is still relevant. This study investigated four aspects to which we attend: the self as seen by others (public self-consciousness), one's internal states and attributes (private self-consciousness), one's own feelings (emotion self-reference), and one's performance (performance self-reference). There are likely many other ways of focusing on the self that await detailed study.

Conclusions

Previous research has demonstrated that self-focused attention is related to several types of psychopathology. The current study suggests, first of all, that distinct types of self-focused attention are related to specific types of psychopathology. Second, at least one type of self-focused attention (performance self-reference) appears to be adaptive and is associated with lower levels of depression and obsessiveness. The correlations found generally support self-awareness theories of depression and anxiety-related disorders. Self-focused attention and personality

measures appear to be related with enough specificity to justify continued study of self-focus in developing models of psychological disorders.

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Appendix A

This inventory consists of numbered statements. Read each statement and decide whether it is true as applied to you or false as applied to you. You are to mark your answers on the answer sheet you have. If a statement is true or mostly true, as applied to you, blacken the circle marked A. If a statement is false or not usually true, as applied to you, blacken the circle marked B. If a statement does not apply to you or if it is something that you don't know about, make no mark on the answer sheet. But try to give a response to every statement.

1. The sight of blood doesn't frighten me or make me sick.
2. I am afraid when I look down from a high place.
3. I do not have a great fear of snakes.
4. I am not afraid to handle money.
5. I get anxious and upset when I have to make a short trip away from home.
6. I am afraid of using a knife or anything very sharp or pointed.
7. Almost every day something happens to frighten me.
8. I feel uneasy indoors.
9. I am not afraid of fire.
10. Lightning is one of my fears.
11. I am afraid to be alone in the dark.
12. A windstorm terrifies me.
13. I have no fear of water.
14. I am often afraid of the dark.
15. I dread the thought of an earthquake.
16. I am afraid of finding myself in a closet or small closed place.
17. Dirt frightens or disgusts me.
18. I have no fear of spiders.
19. I am made nervous by certain animals.
20. I am not afraid of mice.
21. I am afraid of being alone in a wide-open place.
22. I have often been frightened in the middle of the night.
23. I can't go into a dark room alone even in my own home.
24. I sometimes keep on with a thing until others lose patience with me.
25. I have met problems so full of possibilities that I have been unable to make up my mind about them.
26. I have often lost out on things because I couldn't make up my mind soon enough.
27. I frequently find myself worrying about something.
28. I usually have to stop and think before I act even in small matters.
29. I have a habit of counting things that are not important such as bulbs on electric signs and so forth.
30. Bad words, often terrible words, come into my mind and I cannot get rid of them.
31. Sometimes some unimportant thought will run through my mind and bother me for days.
32. My plans have frequently seemed so full of difficulties that I have had to give them up.

33. I must admit that I have at times been worried beyond reason over something that really did not matter.
34. I usually have a hard time deciding what to do.
35. I feel helpless when I have to make some important decisions.
36. It bothers me greatly to think of making changes in my life.
37. Having to make important decisions makes me nervous.
38. I often keep and save things that I will probably never use.
39. Much of what is happening to me now seems to have happened to me before.
40. I wake up fresh and rested most mornings.
41. My daily life is full of things that keep me interested.
42. I have had periods of days, weeks, or months when I couldn't take care of things because I couldn't "get going."
43. I have not lived the right kind of life.
44. I wish I could be as happy as others seem to be.
45. Most of the time I feel blue.
46. These days I find it hard not to give up hope of amounting to something.
47. I usually feel that life is worthwhile.
48. I do many things which I regret afterwards (I regret things more than others seem to).
49. I don't seem to care what happens to me.
50. I am happy most of the time.
51. I certainly feel useless at times.
52. I cry easily.
53. I brood a great deal.
54. I believe I am a condemned person.
55. I believe my sins are unpardonable.
56. Even when I am with people I feel lonely much of the time.
57. Most of the time I wish I were dead.
58. No one cares much what happens to you.
59. I am inclined to take things hard.
60. I am not happy with myself the way I am.
61. I very seldom have spells of the blues.
62. The future is too uncertain for a person to make serious plans.
63. Often, even though everything is going fine for me, I feel that I don't care about anything.
64. At times I think I am no good at all.
65. The future seems hopeless to me.
66. I have recently considered killing myself.
67. I have had a tragic loss in my life that I know I'll never get over.
68. My life is empty and meaningless.
69. Lately I have thought a lot about killing myself.
70. Lately I have lost my desire to work out my problems.
71. My thoughts these days turn more and more to death and the life hereafter.
72. When my life gets difficult, it makes me want to just give up.
73. There seems to be a lump in my throat most of the time.

74. I am troubled by attacks of nausea and vomiting.
75. I am very seldom troubled by constipation.
76. I am bothered by an upset stomach several times a week.
77. I seldom worry about my health.
78. I have a cough most of the time.
79. Much of the time my head seems to hurt all over.
80. Once a week or oftener I suddenly feel hot all over, for no real reason.
81. I am in just as good physical health as most of my friends.
82. I am almost never bothered by pains over my heart or in my chest.
83. Parts of my body often have feelings like burning, tingling, crawling, or like "going to sleep"
84. I hardly ever feel pain in the back of my neck.
85. I am troubled by discomfort in the pit of my stomach every few days or oftener.
86. I have little or no trouble with my muscles twitching or jumping.
87. There seems to be a fullness in my head or nose most of the time.
88. Often I feel as if there is a tight band around my head.
89. I have a great deal of stomach trouble.
90. I have never vomited blood or coughed up blood.
91. I do not worry about catching diseases.
92. During the past few years I have been well most of the time.
93. I have never had a fit or convulsion.
94. The top of my head sometimes feels tender.
95. I have never had a fainting spell.
96. I seldom or never have dizzy spells.
97. I feel weak all over much of the time.
98. I have very few headaches.
99. I have had no difficulty in keeping my balance in walking.
100. I do not have spells of hay fever or asthma.
101. I have never had any breaking out on my skin that has worried me.
102. My hearing is apparently as good as that of most people.
103. I have few or no pains.
104. I have numbness in one or more places on my skin.
105. My eyesight is as good as it has been for years.
106. I do not often notice my ears ringing or buzzing.
107. I have never been paralyzed or had any unusual weakness of any of my muscles.
108. I have no trouble swallowing.

For each of the following questions please answer each by marking on the answer sheet the alternative that is most true for you.

1. The worst thing about being fat is:
   a. No opinion b. Getting teased c. Feeling unsexy
   d. Being unpopular e. Feeling bad about yourself

2. What is the greatest amount of weight you ever lost on a diet?
   a. Never on a diet b. 10 lbs c. 11-19 lbs
   d. 20-29 lbs e. 30 lbs or more

3. Do you think you are overweight now?
   a. Don't know b. No c. Yes: by less than 10 lbs
   d. Yes: 10-19 lbs e. Yes: by 20 lbs or more

4. How often do you skip one meal so you can lose weight?
   a. Never b. Once or twice a year c. Once a month
   d. Once a week e. More than once a week

5. How often do you avoid eating fattening foods like candy so you will lose weight?
   a. Never b. Once or twice a year c. Once a month
   d. Once a week e. More than once a week

6. How often do you hate yourself or feel guilty because you cannot stop overeating?
   a. Never b. Once or twice a year c. Once a month
   d. Once a week e. More than once a week

7. How often do you go without eating solid food for 24 hours or more so you will lose weight?
   a. Never b. Once or twice a year c. Once a month
   d. Once a week e. More than once a week

8. If a special weight-control course were offered at this school, would you take it?
   a. No opinion b. No c. Probably no
   d. Probably yes e. Definitely yes

9. How often do you feel guilty after eating?
   a. Never b. Once in a while c. Frequently
   d. Very frequently e. All the time

10. How often are you aware of the calorie content of the food you eat?
   a. Never b. Once in a while c. Frequently
   d. Very frequently e. All the time

11. How old are you when you first started worrying about your weight?
   a. Never b. 12 years or less c. 13-14 years
   d. 15-16 years e. 17-18 years

How many times have you tried each of the weight-loss methods listed below?

12. Diet medicine (pills, liquids, or powders).
   a. Never b. Once c. Twice d. Three times

e. More than three times

13. Health spa or exercise class (including aerobic dancing).
a. Never b. Once c. Twice d. Three times
e. More than three times

14. Diet published in a book or magazine or recommended by a friend or relative.
a. Never b. Once c. Twice d. Three times
e. More than three times

Please describe, in a paragraph or two, the most bothersome event or issue of the day. You may describe something that has occurred today, something that has happened in the past that still troubles you, or an anticipated problem. You may use this sheet and the back, if needed.

Please mark the letter on your answer sheet indicating the extent to which each item is like you.

A = Not at all like me
B = A little like me
C = Somewhat like me
D = A lot like me

1. I'm always trying to figure myself out.
2. I'm concerned about my style of doing things.
3. It takes me time to get over my shyness in new situations.
4. I think about myself a lot.
5. I care a lot about how I present myself to others.
6. I often daydream about myself.
7. It's hard for me to work when someone is watching me.
8. I never take a hard look at myself.
9. I get embarrassed very easily.
10. I'm self-conscious about the way I look.
11. It's easy for me to talk to strangers.
12. I generally pay attention to my inner feelings.
13. I usually worry about making a good impression.
14. I'm constantly thinking about my reasons for doing things.
15. I feel nervous when I speak in front of a group.
16. Before I leave my house, I check how I look.
17. I sometimes step back (in my mind) in order to examine myself from a distance.
18. I'm concerned about what other people think of me.
19. I'm quick to notice changes in my mood.
20. I'm usually aware of my appearance.
21. I know the way my mind works when I work through a problem.
22. Large groups make me nervous.

Appendix B

Group Instructions For Thesis Inventory Administration

My name is Keith Payne, and I'm doing research for my undergraduate thesis in psychology. Your professor has offered to let me use class time so that anyone who wants to participate can. I appreciate your participation, but you are free to choose not to participate. The point of this study is to learn more about how attention relates to mood and anxiety. There are a number of questionnaires in the packets I will pass out to you. Please mark answers on the scantron sheets, not the forms themselves. There are no right or wrong answers to any of the questions. Remember: the first answer that comes to mind is usually the best. There is one free response question. Please write a paragraph or two in the space provided. The forms have been randomly ordered in the packs, so please answer them in the order provided. There is a number in the corner of each form. This is to keep the packets together; your name will not be matched with any responses, and all information you give will remain confidential. Please fill these out honestly and carefully, and try not to omit any answers. It is better not to participate than to give false answers. Thank you.