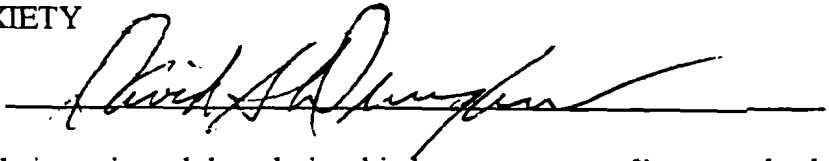AN ABSTRACT OF THE THESIS OF

Debby Sawyer for the Master of Science in clinical psychology presented on
March 8, 1993.

Title: PREMENSTRUAL SYNDROME IN RELATION TO PERSONALITY TYPE
AND DEATH ANXIETY

Abstract approved: _____

The present study investigated the relationship between personality type, death
anxiety and the number of premenstrual symptoms suffered by females. The effects of
age on premenstrual symptoms were also studied. There were 142 females who
participated in the study. The subjects were administered the Jenkins Activity Survey
(JAS) to assess Type A-B behavior and Templer's Death Anxiety Scale (DAS) to
measure the degree of fear regarding death and dying. Lastly, a Premenstrual Symptom
(PMS) checklist was administered to assess severity of PMS. Eighty-two females met
the criteria for Type A personality. The remaining 60 females met the criteria for the
Type B personality. Of the 82 Type A females, 22 manifested high death anxiety, 34,
moderate death anxiety and 26, low death anxiety. Of the 60 Type B females, 15
manifested high death anxiety, 30, moderate death anxiety and 15, low death anxiety.
The entire subject population ranged from age 18 to 24 and were enrolled in an
Introductory or Developmental Psychology course at Emporia State University.

A 2X3 analysis of covariance was employed to analyze the results. Results
indicated significant differences for personality type. Specifically, females who scored
as Type A individuals tended to have more PMS symptoms than females who scored as
Type B individuals. No significant differences were found between death anxiety and

PMS symptoms. In other words, females who scored high on the DAS reported no more PMS symptoms than females who scored moderately or low. Additionally, the interaction between personality type and level of death anxiety was not significant. Consequently, there were no differences between Type A females who experienced high, moderate or low death anxiety and Type B females who experienced high, moderate or low death anxiety. When PMS scores were adjusted for age, no significant differences were found.

PREMENSTRUAL SYNDROME IN RELATION TO

PERSONALITY TYPE AND DEATH ANXIETY

A Thesis

Presented to

the Division of Psychology and Special Education

EMPORIA STATE UNIVERSITY
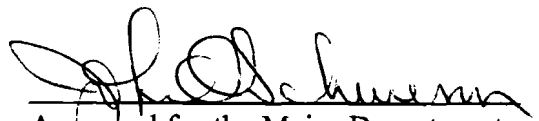
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of the Requirements for the Degree

Master of Science

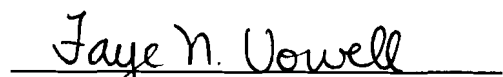--

by

Debby Sawyer

May 1994

Thesis
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Approved for the Major Department

Faye N. Vowell

Approved for the Graduate Council

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Lastly, I would like to deeply thank my children, Christian and Angel, and convey my deepest appreciation for their sacrifices and love. It is to them that I dedicate this study.

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CHAPTER 1

INTRODUCTION

Each of us knows what it feels like to have anxiety at least once in a lifetime. But does each of us know where this anxiety comes from or how to treat it? There are different types of anxiety, some more concrete than others. For instance, the fear of dying or death can cause great anxiety and appears to affect more women than men (Dattel & Neimeyer, 1990). However, other types of anxiety afflict both genders equally. Type A behavior, for instance, consists of a long standing personality trait. More specifically, Type A behavior has been defined as a pattern of chronic anxiety and pressured behaviors that result in stress which, in turn, increases the chance for illness and disease (Wade & Tarvis, 1990).

Anxiety seems to impair the immune system leaving the individual susceptible to various physical and/or psychological symptoms. One such cluster of physical and psychological symptoms, known as Premenstrual Syndrome (PMS), has been found to multiply as anxiety or stress levels increase. Therefore, it is possible that a relationship exists between Type A behavior and PMS symptoms, or death anxiety and PMS symptoms, or a combination thereof.

Review of Literature

Premenstrual Syndrome, or PMS as it is commonly referred to, has been defined as the cyclic repetition in the luteal phase of the menstrual cycle in which a combination of physical, psychological and/or behavioral alterations are enough to affect relationships

1

of all sorts and possibly hinder normal activities (Smith & Schiff, 1989). Such

psychological symptoms of PMS that may impair routine activities include, but are not

limited to, fatigue, irritability, mood swings, crying spells, outbursts of anger, as well as

cravings for certain foods. PMS may very well include such physical symptoms

as headaches, abdominal swelling, breast tenderness, breast swelling, weight gain,

frequent bowel movements, numbness in extremities, lower back pain, nausea, loss of

appetite, abdominal cramps and outbreaks of acne.

In the last 10 years, PMS has been the focus of much research and is now gaining

the recognition that it warrants by being included in the latest edition of The Diagnostic

and Statistical Manual of Mental Disorders, Third Edition - Revised (DSM III - R) as a

proposed diagnostic category needing further research. This disorder is said to afflict an

estimated 30-40% of American women (Smith & Schiff, 1989). However, other

research shows a much higher percentage than this. Wickes (1988) found that 90%

of females experienced some form of non debilitating PMS. Severe symptoms,

however, were found to occur in only 10% of the females.

The research thus far has primarily focused on treatment and possible causes of

PMS. One such study found that PMS was positively correlated with such variables as

working outside the home, toxemia, alcoholism and having children (Lurie &

Borenstein, 1990). This same study, however, found no correlation between marital

status, education level, race or culture and PMS.

Another study (Golub, 1976) found that anxiety and depression were common

among women who were premenstrual. This study also examined these same women

postmenstrually and found the anxiety and depression had been alleviated. Picone and Kirkby (1990), in their study of PMS, examined trait anxiety. This has been described as a "relatively stable" sign of anxiety inclination and was found to correlate moderately with a PMS symptoms checklist.

Along these same lines, Christensen and Oei (1989) assessed the relationship between PMS, depression and trait anxiety. They found that females who suffered the most with PMS also had higher levels of trait anxiety, more frequent negative self-statements, and higher levels of depression.

Keeping with these findings, Vanderploeg (1989) found females who were premenstrual differed significantly in their responses to the Depression Adjective Checklist and the State-Trait Anxiety Inventory when compared to females who were not premenstrual. More specifically, they found that females who were premenstrual had higher levels of anxiety and depression.

Yet, another study took the research one step further. These particular researchers examined the relationship between PMS and the State-Trait Anxiety Inventory and found that females who were premenstrual scored higher on the State-Trait Inventory and suffered more psychological symptoms of PMS as compared to the physical or behavioral symptoms of PMS (Warner & Bancroft, 1990).

Likewise, Abplanalp (1983) indicated in her review that PMS is reflective of stress and suggests that the more stress a female incurs, the more likely she is to experience PMS symptoms. To add to this list, Heilbrun & Frank (1989) found that females reported higher general stress before the onset of their menstrual periods and less

general stress during their menstrual periods.

However, a study by Beck, Gevirtz and Mortola (1990) found that psychosocial stress accounted for as little as 6% for physical symptoms of PMS and only 10% of mood symptoms of PMS. Evidence such as this would lead an individual to believe that anxiety is a prime suspect in PMS.

Type A behavior, on the other hand, has been defined as a pattern of long-standing anxiety and pressured behaviors that produces stress and increases the chance of illness and disease (Wade & Tarvis, 1990). This pattern of chronic anxiety and pressured behaviors is characteristic of an individual who eats and speaks fast, cannot relax, has a need to meet deadlines, tends to be impatient, is competitive and is often aggressive and hostile.

Due to the stressful life of the Type A individual, it is conceivable that Type A individuals suffer many more psychological and/or physical difficulties than Type B individuals, who tend to be more relaxed and easy-going. One such physical sign of stress is that of the headache. Hicks and Campbell (1983) found a significant correlation between frequency of headaches and the Type A college student. Since headaches are just one of the many symptoms of PMS, Hicks, Olsen and Smith (1986) set out to examine the relationship between Type A females and PMS symptoms and indeed established a link between Type A females and PMS symptoms. More specifically, they determined that Type A females experienced 50% more PMS symptoms than Type B females.

By the same token, Tramill, Kleinhammer-Tramill, Davis, Parks and Alexander

(1985) looked at death anxiety and the Type A individual. They determined that Type A personalities had higher death anxiety than did Type B personalities.

Additionally, Tramill, Kleinhammer-Tramill, Davis and Parks (1984) found that extreme Type A individuals displayed higher death anxiety and manifest anxiety scores than did Type B individuals. Another study conducted by Pfost, Peters & Stevens (1985) found that Type A subjects did not differ significantly from Type B subjects on Templer's Death Anxiety Scale (DAS), but did report more repression toward threatening stimuli in general. This, in itself, may have several implications concerning anxiety and more specifically, death anxiety, with regard to Type A-B behavior. Death anxiety in part consists of being overly concerned or afraid of death or dying and encompasses several personality traits. Some of these traits include, but are not limited to, possessing an external locus of control, bouts of depression and being high in succorance.

Possessing an external locus of control means an individual believes his or her perceived successes or failures are a result of outside influences. In other words, the individual takes no responsibility for his or her behavior. Patton and Freitag (1977) found that individuals who possessed an external locus of control also tended to score high on death anxiety. The reasoning behind the findings suggests the individuals with an external locus of control come to realize they are not in control and that factors outside them are more in control, and since death is beyond control, it should prompt anxiety levels.

Bouts of depression also tend to be linked to death anxiety. Templer (1970) found that chronically depressed individuals tend to have a high level of death anxiety

when compared to individuals who have no history of chronic depression.

Lastly, death anxiety appears to relate to individuals high in succorance. Thorson (1977) found that females who were high in succorance, that is, were helpful and assisted or aided others, tended to have higher death anxiety than those females low in succorance.

What do these three characteristics (external locus of control, bouts of depression and high succorance) have in common? The common element here is gender. More females than males tend to have an external locus of control, bouts of depression and high succorance. With this in mind, many studies have been conducted on death anxiety and gender. Research shows that without a doubt, females score higher on death anxiety than males. For instance, Dattel and Neimeyer (1990) and Thorson (1977) found that females tended to score higher than males on Templer's Death Anxiety Scale (DAS).

Since it has long been recognized that males tend to have higher levels of self-esteem than females, (Davis, Martin, Wille & Voorhees, 1978), it seems likely that death anxiety and self-esteem are related. These particular researchers examined several factors including sex and self-esteem. They found that males tended to have higher self-esteem than females. They also concluded that females tended to score significantly higher on Templer's DAS than males. Subsequently, the interaction between these two factors was significant. That is, students who scored low in self-esteem scored high on Templer's DAS.

Likewise, Davis, Bremer, Anderson and Tramill (1983) found males displayed a higher score on the Texas Social Behavior Inventory (TSBI), which measures

self-esteem, than did females. It was also found that females who scored low on the TSBI, scored high on the DAS. Lastly, Buzzanga, Miller, Perne, Sander and Davis (1989) found similar results. In addition to their conclusion that subjects with low self-esteem scored high on the DAS, they also discovered that regardless of the level of self-esteem, females reported higher levels of death anxiety than did males.

Since the diagnosis of PMS requires the presence of various psychological and/or physical symptoms and since numerous studies have shown that PMS has been linked to stress and that stress is produced by anxiety of all forms, it would be relevant then to examine the relationships between different factors of Type A behavior, such as anxiety and/or death anxiety and PMS. It is hypothesized that a relationship exists between Type A females with their hectic stressful lifestyles and who are consciously or unconsciously afflicted with death anxiety and the amount of PMS symptoms a female tends to have.

With PMS afflicting an estimated 30- 40% or more of American women, it seems warranted to examine possible causes and viable solutions to this disorder. By targeting some of the causes of PMS, females may gain insight into how to reduce or eliminate various symptoms. Instead of using over-the-counter medication such as Midol or Pamprin which may have side effects or prescribed medications such as Fluoxetine, an antidepressant, females may be able to find relief through natural types of treatment plans. Such treatment plans might include exercise, biofeedback, cognitive therapy, stress management or stress inoculation, if indeed anxiety or stress is found to be a major cause of PMS symptoms. In turn, by taking advantage of these natural types of treatments, a

more peaceful, personal well being may be the benefit. Consequently, fewer days at

work may be missed accompanied by less interpersonal conflict with co-workers,

family and/or friends.

CHAPTER 2

METHOD

Subjects

The sample for this study included 142 undergraduate females ranging in age from

18 to 24, who were enrolled in Introductory or Developmental Psychology courses at

Emporia State University. Each was asked to participate on a purely volunteer basis.

Regarding the ethnic composition of the subjects, the groups consisted of the

following: Type A with high death anxiety scores, 21 white, 1 Hispanic; Type A with

moderate death anxiety scores, 30 white, 1 Hispanic, 2 Asian; Type A with low death

anxiety scores, 25 white, 1 black; Type B with high death anxiety scores, 14 white, 1

Hispanic; Type B with moderate death anxiety scores, 27 white, 1 black, 1 Hispanic, 1

other; Type B with low death anxiety scores, 12 white, 1 black, 2 Hispanic. There were

140 full-time students and 2 part-time students.

The Type B's consisted of 1 married, 1 separated and 58 single subjects. The Type

A's consisted of 6 married and 76 single subjects. Five subjects designated as Type B

individuals had children, with the average being 1 child. Three subjects designated as

Type A individuals had children, with the average again, being 1 child. Of the Type B's,

16 were on prescribed medication and 4 were on non-prescribed medication for PMS

symptoms. Of the Type A's, 20 were on prescribed medication and 6 were on non-

prescribed medication for PMS symptoms.

Questionnaires

All subjects were given three questionnaires. The first questionnaire consisted of

the modified Jenkins Activity Survey (JAS) (see APPENDIX A) to assess Type A-B

behavior. This scale is composed of a 21 item, multiple-choice questionnaire, rating

various perceived behaviors such as "I frequently set deadlines for myself in courses or

other things." The original JAS consisted of a 54 item test which yields several scores

including an A-B scale, based on 21 of the items. The test-retest reliability of this

original scale, based on a separation of 1 year, is .66 (Krantz, Glass & Snyder, 1974).

It has a normative mean of 8 and a standard deviation of 4 (McGregor, Eveleigh, Syler

& Davis, 1991). The original validation sample for the JAS consisted of nearly 2800

men. An easy scoring system identified the behavior pattern of 72 % of the sample,

where the criterion was the diagnostic interview created by Friedman and Rosenman

(1977). In addition, they reported the A-B scale scores differentiate significantly

between coronary and matched noncoronary controls.

The second questionnaire consisted of Templer's Death Anxiety Scale (DAS) (see

APPENDIX B) that measures the fear of dying or death and is composed of 15 true-false

questions such as, "I fear dying a painful death." Although no actual means or standard

deviations have ever been established, means of normal subjects, that is, subjects scoring

moderately on the DAS, tend to be roughly from 4.5 to 7.0, and the standard deviations

are somewhat over 3.0 (Templer & Ruff, 1971).

The test-retest reliability for this instrument is .83 (Templer, 1970). Criterion

validity was established by correlating the DAS with Boyar's Fear Of Death Scale. A

product-moment correlation coefficient of .74 was obtained between the DAS and FODS

(Templer, 1970). Cut-off points for high, moderate and low death anxiety were

determined by numbers higher and lower than the norm. For this particular sample, high

scores were indicated by scores higher than 9, while low scores were indicated by scores

lower than 6.

The third questionnaire consisted of a PMS symptoms checklist (see APPENDIX C),

composed of 18 physical and/or psychological symptoms of PMS, such as headaches,

abdominal swelling, breast tenderness, crying spells and outbursts of anger. This

instrument is relatively new, and reliability and validity are unknown at this time. The

instrument most commonly utilized is that of the modified Menstrual Distress

Questionnaire (Picone & Kirkby, 1990). However, since this instrument is

relatively time consuming and since the researcher focused on replicating the Hicks,

Olsen and Smith-Robinson (1976) research, the same PMS symptoms checklist was

utilized in the assessment process.

Procedure

A consent form and cover letter describing the purpose of the research (see

APPENDIX D) along with a demographic questionnaire (see APPENDIX E), were

attached to the questionnaires and were administered in each of the individual

classrooms. The consent form and cover letter were read by the researcher before the

class instructor distributed the final test. The researcher described the purpose of the

research and gave any female the opportunity to leave after the final test was given,

if she was not interested or comfortable in participating. After the final test was taken,

females who wished to participate, handed in their final test, took the packet of

questionnaires back to their seat, filled it out and left it on a table as they exited the

classroom. The entire process took approximately 15 minutes.

Since it was hypothesized earlier that Type A females who scored higher for death anxiety would suffer more PMS symptoms than Type B females who had scored lower for death anxiety, a 2X3 analysis of covariance was implemented to examine the data involving the independent variables of personality type and death anxiety and the dependent variable consisting of PMS symptoms. A covariant of age was employed to adjust scores for the checklist, due to the six-year age range.

CHAPTER 3

RESULTS

The primary purpose of the present study was to investigate the number of PMS

symptoms experienced by females with Type A personalities, suffering from high,

moderate and low death anxiety, and Type B personalities, also suffering from high,

moderate and low death anxiety. Age was used as a covariant to adjust for PMS scores.

The subjects were grouped into Type A or B categories by utiliziling the four levels

of the Jenkins Activity Survey. The possibilities are as follows: Type A+

(for females scoring 12 and higher), A- (for females scoring 9-12), B- (for females

scoring 5-7) and B+ (for females scoring 0-4). Type A+ and A- subjects were collapsed

into Type A and consisted of 82 females. Type B+ and B- subjects were collapsed into

Type B and consisted of 60 females. All females who scored at the normative mean of

8 were excluded from further analysis.

Following this procedure, the subjects were grouped even further into those having

high death anxiety scores (females scoring 10-15), moderate death anxiety scores

(females scoring 6-9), and low death anxiety scores (0-5). Of the 82 Type A females,

22 manifested high death anxiety scores, 34, moderate death anxiety scores and 26, low

death anxiety scores. Of the 60 Type B females, 15 manifested high death anxiety

scores, 30, moderate death anxiety scores and 15, low death anxiety scores. The mean

age of the six groups was as follows: Type A with high death anxiety scores, 18.5;

Type A with moderate death anxiety scores, 19.9; Type A with low death anxiety scores,

19.6; Type B with high death anxiety scores, 19.3; Type B with moderate death anxiety

scores, 19.5; and Type B with low death anxiety scores, 19.9.

The means and standard deviations for the ages and amount of PMS symptoms experienced are presented in Table 1. An analysis of covariance was computed with age being the covariant. A 2X3, Type A versus Type B by high versus moderate versus low death anxiety scores, design was used to analyze the results.

The analysis of covariance resulted in significant differences between Type A females and Type B females. That is, Type A females experienced significantly more PMS symptoms than Type B females, F (1, 135) = 4.75, p < .05 (see Table 2).

However, no significant differences were found for level of death anxiety, which implies that high, moderate or low death anxiety was not an issue in the amount of PMS symptoms experienced by females. In other words, females who scored high on the DAS reported no more PMS symptoms than females who scored moderately or low on the DAS, F (2, 135) = .48, p > .05 (See Table 2). Subsequently, no specific comparison procedure was required.

The interaction between personality type and level of death anxiety was also not significant, F (2, 135) = 1.11, p > .05 (See Table 2). In other words, there were no differences between Type A females who experienced high, moderate or low death anxiety and Type B females who experienced high, moderate or low death anxiety. Here again, no probing for differences was warranted. Age was used as a covariant to adjust for PMS scores.

Table 1

Mean Ages and PMS Scores and Standard Deviations by Personality Type and Level

of Death Anxiety

Group	AGE		PMS SCORE	
	Means	SD	Means	SD
Type A				
High	18.50	1.29	9.81	4.41
Moderate	19.88	1.29	10.23	3.33
Low	19.61	1.44	9.00	3.48
Type B				
High	19.26	1.22	9.06	3.43
Moderate	19.53	1.22	7.53	3.86
Low	19.93	1.66	8.13	4.03

Table 2

Summary of Analysis of Covariance of PMS Covaried With Age

SOURCE	SS	df	MS	F	p
Personality Type	66.99	1	66.99	4.75	.05
Death Anxiety	13.52	2	6.76	.48	NS
Personality Type X Death Anxiety	31.19	2	15.60	1.11	NS
Regression	.78	1	.78	.06	
Error	1904.74	135	14.11		
Total	2017.22	141			

CHAPTER 4

DISCUSSION

One of the purposes of this study was to examine the number of PMS symptoms

experienced by Type A females suffering from high, moderate and low death anxiety

and Type B females, also suffering from high, moderate and low death anxiety. Another

purpose of this study was to investigate age in relation to experienced PMS symptoms.

This study seems to indicate Type A females tend to experience more PMS

symptoms than Type B females. Therefore, the original hypothesis was partially

supported. As stated earlier, Type A individuals tend to display a pattern of long-

standing anxiety and pressured behaviors that produces stress. Type B individuals

however, tend to be more relaxed and display less stress. Additionally, PMS has been

found to co-exist with anxiety and depression (Golub, 1976). This study examined

females premenstrually as well as postmenstrually. They found that the anxiety and

depression experienced premenstrually had completely dissipated postmenstrually.

Other studies such as Picone and Kirkby (1990), Christensen and Oei (1989) and

Vanderploeg (1989) all found that depression and anxiety were common among females

who were premenstrual. The stress and anxiety then, produced by the onset of PMS,

may exacerbate PMS symptoms more for Type A females, who tend to be in a state of

continual stress, than for Type B females, who tend to be more relaxed. This is

precisely what Hicks, Olsen and Smith-Robinson (1986) found. Results indicated that

Type A females tended to experience 50% more PMS symptoms than Type B females.

While the data seem to support a relationship between Type A and PMS symptoms,

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it is possible that Type A females feel chronically stressed, which in turn would lend itself to tension throughout the body and more severe pain than that experienced by relaxed Type B females. It is conceivable that PMS symptoms for Type A females could be more intense, promoting easier recall ability. This alternative should be considered in subsequent research.

This study examined not only personality type, but also death anxiety. This aspect of the original hypothesis was not supported. In other words, PMS symptoms existed, regardless of whether females suffered from high, moderate or low levels of death anxiety. Also relevant to this was the fact that Type A females who suffered high, moderate and low levels of death anxiety experienced no more PMS symptoms than Type B females who suffered from high, moderate or low levels of death anxiety. Thus the interaction effect was not significant.

One possible reason for not finding any differences with regard to death anxiety is the fact that only females were utilized. Other studies that have used the Death Anxiety Scale utilized females and males alike. In general, it has been found time and time again that females tend to have higher levels of death anxiety than males. However, utilizing only females could possibly effect the outcome of the levels of death anxiety. Death anxiety has been described as universal with defenses of it, varying in number (Pfost, Peters & Stevens, 1985). Given this speculation, females might also defend against death anxiety but in ways different from males, that were not measured in this study. Pfost, Peters and Stevens (1985) also found that Type A individuals did not differ significantly from Type B individuals on Templer's Death Anxiety Scale.

However, it was found that Type A subjects reported significantly more repression

toward threatening stimuli than Type B subjects when the DAS was embedded in the

MMPI Repression-Sensitization Scale. This finding suggests that Type A behavior

serves in part, as a defense. It also suggests that death-related stimuli may not represent

a category of stimuli which is differentially threatening for Type A and Type B

individuals. This could possibly explain the lack of effect on the interaction.

In conclusion, the results and implications described above certainly seem

to warrant future research. It is not altogether clear whether Type A females tend to

experience more PMS symptoms than Type B females. Further exploration of such a

relationship may be beneficial. Further research concerning death anxiety in relation

to females seems also warranted, since the majority of research has been conducted

on males versus females, rather than primarily females.

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APPENDIX A

JENKINS ACTIVITY SURVEY

Please circle the answer in each question that best describes you.

1. How would your husband/wife (or closest friend) rate you?

    a. Definitely hard-driving and competitive.

    b. Probably hard-driving and competitive.

    c. Probably relaxed and easy-going.

    d. Definitely relaxed and easy-going.

2. How would you rate yourself?

    a. Definitely hard-driving and competitive.

    b. Probably hard-driving and competitive.

    c. Probably relaxed and easy-going.

    d. Definitely relaxed and easy-going.

3. How do you consider yourself?

    a. More responsible than the average student.

    b. As responsible as the average student.

    c. Less responsible than the average student.

4. Compared to the average student, I give:

    a. much more effort.

    b. an average amount of effort.

    c. less effort.

5. College has _____ me into action.

    a. stirred

    b. not stirred

6. Compared to the average student, I am:

    a. more precise.

    b. as precise.

    c. less precise.

7. Compared to the average student, I approach life:

    a. much more seriously.

    b. as seriously.

    c. less seriously.

8. How would most people rate you?

    a. Definitely hard-driving and competitive.

    b. Probably hard-driving and competitive.

    c. Probably relaxed and easy-going.

    d. Definitely relaxed and easy-going.

9. How would you rate you?

    a. Definitely not having less energy than most people.

    b. Probably not having less energy than most people.

    c. Probably having less energy than most people.

    d. Definitely having less energy than most people.

10. I frequently set deadlines for myself in courses or other things.

    a. Yes.

    b. No.

11. Do you maintain a regular study schedule during vacations?

    a. Yes.

    b. No.

12. I hurry even when there is plenty of time.

    a. Often.

    b. Once in a while.

    c. Never.

13. I have been told of eating too fast.

    a. Often.

    b. Once in a while.

    c. Never.

14. How would you rate yourself?

    a. I eat more rapidly than most people.

    b. I eat as rapidly than most people.

    c. I eat less rapidly than most people.

15. I hurry a speaker to the point.

    a. Frequently.

    b. Once in a while.

    c. I never hurry a speaker.

16. How would most people rate you?

    a. Definitely not doing most things in a hurry.

    b. Probably not doing most things in a hurry.

    c. Probably doing most things in a hurry.

    d. Definitely doing most things in a hurry.

17. Compared to the average student, I hurry:

    a. much less.

    b. as much.

    c. much more.

18. How often are there deadlines in your courses?

    a. Frequently.

    b. Once in a while.

    c. Never.

19. Everyday life is filled with challenges to be met.

    a. Yes.

    b. No.

20. I have held an office in an activity group or held a part-time job when in school.

    a. Frequently.

    b. Once in a while.

    c. Never.

21. I stay in the library at night while studying until closing.

    a. Frequently.

    b. Once in a while.

    c. Never.

APPENDIX B

TEMPLER'S DEATH ANXIETY SCALE

Please mark (T) for true or (F) for false for each of the following statements.

1. _____ I am very much afraid to die.

2. _____ The thought of death seldom enters my mind.

3. _____ It doesn't make me nervous when people talk about death.

4. _____ I dread to think about having to have an operation.

5. _____ I am not at all afraid to die.

6. _____ I am not particularly afraid of getting cancer.

7. _____ The thought of death never bothers me.

8. _____ I am often distressed by the way time flies so very rapidly.

9. _____ I fear dying a painful death.

10. _____ The subject of life after death troubles me greatly.

11. _____ I am really scared of having a heart attack.

12. _____ I often think about how short life really is.

13. _____ I shudder when I hear people talking about a World War III.

14. _____ The sight of a dead body is horrifying to me.

15. _____ I feel that the future holds nothing for me to fear.

APPENDIX C

PREMENSTRUAL SYMPTOMS CHECKLIST

.

Anywhere from 2 to 14 days before the onset of your menstrual period, do you experience any of the following? Please check all that apply.

1. Headache   ____

2. Abdominal swelling   ____

3. Breast tenderness   ____

4. Breast swelling   ____

5. Fatigue   ____

6. Irritability   ____

7. Moodswings   ____

8. Crying spells   ____

9. Sudden outbursts of anger   ____

10. Cravings for certain foods   ____

11. Weight gain   ____

12. Frequent bowel movements   ____

13. Numbness in legs or arms   ____

14. Lower backache   ____

15. Nausea   ____

16. Loss of Appetite   ____

17. Abdominal cramps   ____

18. Outbreaks of acne   ____

APPENDIX D

INFORMED CONSENT FORM

.

The Department of Psychology supports the practice of protection for human subjects participating in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

In order to investigate certain personality characteristics in college students, you are asked to complete a series of questionnaires. As these questionnaires will be completed anonymously, your identity will not be known.

"I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask questions, I had concerning the procedures and possible risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach."

_____   _____

Subject and/or authorized representative   Date

APPENDIX E

DEMOGRAPHIC QUESTIONNAIRE

Please check the appropriate response:

1. Age _____

2. Race

      a. Caucasian

      b. Black

      c. Hispanic

      d. Asian

      e. Native American

      f. Other

3. Full time student _____

   Part time student _____

4. Marital Status

      a. Married

      b. Single

      c. Divorced

      d. Widowed
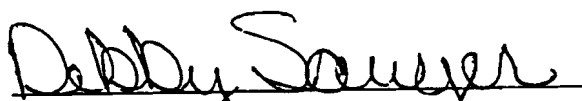
      e. Separated

5. Age of first menstrual period _____

6. How many children do you have? _____
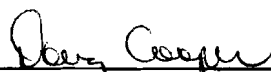
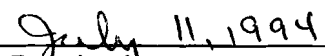7. Are you currently on any medication? _____

   If so, what kind? _____

I, Debby Sawyer, hereby submit this thesis to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available for use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without written permission of the author.

Signature of Author

June 1, 1994

PREMENSTRUAL SYNDROME IN
RELATION TO PERSONALITY TYPE
AND DEATH ANXIETY

Signature of Graduate Office Staff Member

Date Received