METHOD

DESIGN

The objective of the present investigation was to determine the impact of environmental stressors i.e. residential density and noise sensitivity on perceived stress, health and subjective well-being. Gender differences on perceived stress, health and subjective well-being were also investigated.

Residential density was calculated by dividing the number of people living in the home by the number of rooms in the house (Evans et al., 1989). The Noise Sensitivity Scale developed by Weinstein (1978) was used to measure noise sensitivity. Perceived stress was measured using the Perceived Stress Scale developed by Cohen, Kamarck, and Mermelstein (1983). Smith and Stansfeld's (1986) Everyday Errors Questionnaire based on Broadbent's (1982) Cognitive Failures Questionnaire was used to measure everyday errors made by people in their daily lives. The Adult Health Checklist devised by Forgays (1994) was used to measure health complaints. The State-Trait Anger Expression Inventory constructed by Spielberger (1988) was used to measure state anger, trait anger, anger expression, anger-in, anger out and anger control. The Mental Health Inventory constructed by Veit and Ware (1983) was used to measure subjective well-being. It yields an overall mental health index; global measures of psychological well-being and psychological distress; and six measures of anxiety, depression, loss of behavioural/emotional control, general positive affect, emotional ties and life satisfaction. To measure the
cognitive component of subjective well-being, the Satisfaction with Life Scale devised by Diener et al. (1985) was used. To measure the affective component of subjective well-being, the Positive and Negative Affect Schedule developed by Watson, Clark, and Tellegen (1988) was used.

SAMPLE

The sample for the present investigation consisted of 320 subjects (160 males and 160 females) living within a 500 meters radius of the main railway track in Ambala City. The age range of the subjects was 25 to 40 years. Only those individuals who had a minimum of two years continuous stay in that residential area were included in the present study. All the subjects belonged to the urban area and were at least graduates. The majority of them belonged to the middle socioeconomic income group.

TESTS

The following standardized tests were used for the present investigation:

2. Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983).
3. Everyday Errors Questionnaire (Smith & Stansfeld, 1986).
5. State Trait Anger Expression Inventory (Spielberger, 1988).
6. Mental Health Inventory (Veit & Ware, 1983).
7. Satisfaction with Life Scale (Diener et al., 1985).
8. Positive and Negative Affect Schedule (Watson, Clark, & Tellegen, 1988).
BRIEF DESCRIPTION OF TESTS

1. The Noise Sensitivity Scale (NSS) (Weinstein, 1978)

The Noise Sensitivity Scale was developed by Weinstein (1978). It is a self-report measure of sensitivity to noise. The items in the scale emphasize affective reactions to noise and avoid general inquiries about noise as an environmental problem. Although some items refer to studying, they are not limited to situations a student would encounter.

The scale consists of 21 items using a 6-point Likert format ranging from 'agree strongly, agree, agree mildly to disagree mildly, disagree, disagree strongly'. The respondents are required to indicate their degree of agreement / disagreement for each item. The range of scores is from 0 to 105 with lower scores indicating higher noise sensitivity.

Kuder-Richardson reliability of the scale has been found to range from 0.84 to 0.87 in three samples of students and adults (Weinstein, 1978). Nine-week test retest reliability in a sample of 72 students was found to be 0.75 (Weinstein, 1978).

An Indian adaptation of the scale has been developed in Hindi by Bhatia, Shipra, and Muhar (1991). The test retest reliability of the scale was found to be 0.79 and the validity coefficient was 0.89. A Japanese adaptation of the scale has been developed by Iwata (1986) and it has been found to have high internal consistency reliability.

2. Perceived Stress Scale (PSS) (Cohen, Kamarck, & Merlstein, 1983)

The Perceived Stress Scale has been developed by Cohen et al. (1983). It is designed to measure the degree to which situations in
one's life are appraised as stressful. This test is based on the premise that perceived stress will provide a better predictor of health outcomes than does a global measure of objective stressors such as life-event scales. This is because a perceived stress instrument provides a more direct measure of the level of appraised stress, not the objective occurrence of the events, that determines one's response to a stressor(s) (Lazarus, 1977, 1966).

The scale comprises 14 items in a 5-point Likert format ranging from 'never, almost never, sometimes, fairly often, to very often'. The scale consists of an equal number of positive and negative worded items, distributed randomly throughout the questionnaire. The range of scores is from 0 to 56 with higher scores indicating higher perceived stress.

Coefficient alpha reliability for the Perceived Stress Scale was reported to range from 0.84 to 0.86 (Cohen et al., 1983). The test retest reliability coefficient has been found to be 0.85 for a two-day retest interval; and 0.55 when the retesting was done after six weeks (Cohen et al., 1983).

For establishing the validity of the Perceived Stress Scale, Cohen et al. (1983) correlated the scores of PSS with life event scores, depressive and physical symptomatology, utilisation of health services, social anxiety, and smoking reduction maintenance. In all comparisons, the PSS was found to be a better predictor of the outcome in question than were life-event scores. PSS correlations with symptomatological measures have been found to be in the range of 0.52 to 0.76; and with Social Anxiety Scale to range from 0.37 to 0.48. Cohen et al. (1983) have recommended the use of the PSS for examining the role of non-specific appraised stress in the etiology of disease and behavioural disorders and as an outcome measure of experienced levels of stress.
The scale has been used by Buntrock and Reddy (1992) and Di Clemente et al. (1991). In India, it has been used by Thapar (2002), Rajput (2001) and Maini (2001).

3. Everyday Errors Questionnaire (EEQ)  
(Smith & Stansfeld, 1986)

The Everyday Errors Questionnaire has been developed by Smith and Stansfeld (1986). Everyday errors refer to minor problems that everyone has from time to time but some of them happen more often than others. The EEQ is a 20-item self-report device designed to measure failures in perception, memory and motor action.

Respondents are required to indicate how often the errors occur in their everyday life along a 5-point Likert scale ranging from 'never, seldom, sometimes, fairly often to very often'. The range of scores is from 0 to 80 with higher scores indicating more everyday errors.

The questionnaire has satisfactory reliability and validity (Smith & Stansfeld, 1986). The split-half reliability in the present study was computed for 50 subjects and found to be 0.75.

4. Adult Health Checklist (AHC)  
(Forgays, 1994)

The Adult Health Checklist has been developed by Forgays (1994). It is a self-report device comprising 26 health complaints / illnesses that happen at least once in a while to many individuals. The respondents are required to indicate the frequency and intensity of each illness in the past six months. Frequency of each illness is rated along a 6-point Likert response scale, ranging from 'does not happen, not a problem, to happens daily'. For indicating the intensity, respondents rate each illness along a 4-point Likert scale, ranging from 'does not bother me, not a problem, to bothers me a lot when it happens'. Further, the respondents are also required to specify
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whether they undertook medical care, that is, whether they visited a
doctor for the illness. Frequency scores range from 0 to 130 with
higher scores indicating greater frequency of occurrence of health
complaints. Intensity scores range from 0 to 78 with higher scores
indicating a greater degree of intensity of health complaints. Possible
range of total scores is 0 to 390 with higher total scores indicating an
overall higher incidence of health complaints.

In the present study, the test retest reliability has been found to
be 0.76 when the retesting was done after two weeks.

The scale has been used in India by Maini (2001) on adult
smokers and non-smokers and by Rajput (2001) on professional adults
and it has been found to be reliable and valid.

5. State Trait Anger Expression Inventory (STAXI)
   (Spielberger, 1988)

The State Trait Anger Expression Inventory (STAXI) was
developed by Spielberger (1988). It is a self-report device that
measures the experience, expression and control of anger (Kassinove
et al., 1997). Anger is a frequently experienced negative emotion that
is most often associated with disruptive intrapersonal and interpersonal
consequences (Ellis, 1977).

The 44-item STAXI comprises six subscales viz. state anger,
trait anger, anger-in, anger-out, anger control and anger expression.
The scale is an important advancement in anger assessment. It
separates anger from related constructs such as hostility and
aggression; and separates the felt experiences from the modes of
expression of anger (Kassinove et al., 1997).

State Anger refers to an emotional state marked by subjective
feelings that vary in intensity from mild annoyance or irritation to
intense fury and rage. Individuals with high scores experience relatively intense angry feelings at the time the test is administered, the range of scores being 10 to 40 with higher scores indicating higher state-anger.

**Trait Anger** refers to the tendency to experience states of anger more frequently in response to various provocations, to perceive a wider range of situations as frustrating or annoying. High trait anger individuals frequently experience angry feelings, especially when they feel they are treated unfairly by others. The range of scores is from 10 to 40 with higher scores indicating higher trait-anger.

**Anger-In** refers to the frequency with which angry feelings are held up or suppressed. Persons with high anger-in scores frequently experience intense angry feelings, but tend to suppress these feelings rather than to express them either physically or in verbal behaviour. The range of scores is from 8 to 32 with higher scores indicating higher anger-in.

**Anger-Out** refers to the extent to which an individual expresses anger toward other people or objects in the environment. Persons with high anger-out scores frequently experience anger, which they express in aggressive behaviour. Anger-out may be expressed in physical acts such as assaulting other persons or slamming doors, or verbally in the form of criticism, sarcasm, insults, threats and the extreme use of profanity. The range of scores is from 8 to 32 with higher scores indicating greater outward expression of anger.

**Anger Control** refers to the effective control or reduction of anger. Persons with high scores on the anger-control scale tend to invest a great deal of energy in monitoring and preventing the expression of anger. The range of scores is from 8 to 32 with higher scores indicating greater control of anger.
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**Anger Expression** is a general index of the frequency of anger expression, regardless of direction, and comprises the anger-out subscales while adjusting for anger control. The range of scores is from 16 to 72 with higher scores indicating greater expression of anger.

Respondents are required to describe themselves in response to "how they feel right now", for the state anger; "how they generally feel", for the trait anger; and "how they react when angry or furious", for the anger-in, anger-out, and anger-control subscales respectively. The angry or furious", for the anger-in, anger-out and anger control subscales respectively. The response format is a 4-point Likert scale ranging from 'not at all, somewhat, moderately to very much so' for Part-1; and from 'almost never, sometimes, often to almost always', for Part-2 and Part-3 respectively.

The factor structure of the STAXI has received strong empirical support in a number of studies (Spielberger, Reheisser, & Sydeman, 1995; Fuqua et al., 1991; Spielberger, 1988). Internal consistency coefficients for the subscales range from 0.62 to 0.91 indicating strong relationships among the scales' items (Cornell, Peterson, & Richards, 1999). The anger experience and expression scales have good test retest reliability, internal consistency, content, concurrent and discriminant validity and have a factor structure which is relatively uniform across criterion groups (Deffenbacher, 1992; Fuqua et al., 1991; Spielberger, 1988; Crane, 1981).

The STAXI has proved useful for assessing the experience, expression and control of anger in normal and abnormal individuals (Deffenbacher, 1992; Moses, 1992) and for evaluating the role of these components in a variety of disorders including alcoholism, hypertension, coronary heart disease and cancer (Spielberger, 1988). The scale has also been used to examine relations between
hardiness, well-being and coping with stress (Schlosser & Sheeley, 1985a; 1985b) and to investigate the role of anger in Type A behaviour (Croyle et al., 1988; Spielberger et al., 1988; Booth-Kewley & Friedman, 1987; Goffaux et al., 1987). The STAXI scales have also been used in research on the effects of situational factors on the experience and expression of anger (Buck, 1987; Pape, 1986). Significant correlations have been reported between the STAXI scales and physical and verbal aggression.

The scale has been used by Cackowski and Nasar (2003) on architecture students. It has been used in India by Sharma, Krishna, and Spielberger (1996), Shajfha, Ghosh, and Spielberger (1995) and Bhandari and Maini (2002) on adult smokers and non-smokers.

6. Mental Health Inventory (MHI) (Veit & Ware, 1983)

The Mental Health Inventory has been developed by Veit and Ware (1983). It is a 38-item measure of subjective well-being, developed for use in general populations. It yields six subscales viz. anxiety, depression, loss of behavioural/emotional control, general positive affect, emotional ties and life satisfaction; two global scales viz. psychological distress and psychological well-being and an overall mental health index.

**Anxiety** refers to feelings of nervousness, restlessness and being high-strung.

**Depression** indicates being moody, downhearted, in very low spirits and depressed.

**Loss of Behavioural / Emotional Control** refers to concern about losing control of mind, being down in the dumps and thoughts of taking one’s own life.
General Positive Affect refers to feelings of happiness, satisfaction, cheerfulness and the future looking hopeful and promising.

Emotional Ties refer to feelings of being loved and wanted and of love relationships being full and complete.

Life Satisfaction refers to feelings of satisfaction and happiness with one's personal life.

Psychological Distress comprises anxiety, depression, and loss of behavioural/emotional control. It refers to all the items that describe negative mental health states.

Psychological Well-being comprises general positive affect, emotional ties and life satisfaction. It refers to all the items that describe positive mental health states.

Mental Health Index is the single MHI summary score defining the general mental health factor.

Respondents are required to indicate the frequency and intensity of a psychological symptom during the past months along a 6-point response scale (except for two items that are accompanied by a 5-point response scale).

Scoring options for this test range from six distinct mental health constructs to reliance on one summary index. An intermediate scoring option is two higher order psychological distress and well-being constructs. Manning, Newhouse, & Ware (1982) rejected a single factor in favour of a two-factor specification (psychological distress and psychological well-being) for predicting ambulatory medical expenditures. Scores can range from 9 to 54 for anxiety, from 4 to 23 for depression, from 9 to 53 for loss of behavioural/emotional control, from 10 to 60 for general positive affect, from 2 to 12 for emotional ties, from 1 to 6 for life satisfaction, from 24 to 142 for psychological
distress, from 14 to 84 for psychological well-being and from 38 to 226 for mental health index with higher scores indicating more of the construct named by the scale.

Internal consistency (Cronbach alpha) estimates were reported to range from 0.81 to 0.90 for the six subscales and from 0.92 to 0.94 for scales based on the global scales viz., psychological well-being and psychological distress and 0.96 for the overall mental health index (Veit & Ware, 1983). The one-year test retest reliability coefficient ranged from 0.56 to 0.63 for the six subscales, 0.62 to 0.63 for the two global scales and 0.64 for the mental health index (Veit & Ware, 1983).

Factor analytic studies of the MHI have demonstrated that the subscales are distinct from physical and social health factors (Ware et al., 1979). The hierarchical factor structure has been confirmed in cross validation tests using samples of populations with quite different characteristics, thereby supporting the model's generalisability. Tanuka and Huba (1984) using confirmatory factor analytic methods, provided evidence in support of the factor structure proposed by Veit and Ware (1983).

The validity of the scale has been established on the basis of the relationship between the MHI and other conceptually related variables. The MHI subscales have been linked to life events, social contacts and resources, chronic diseases, acute physical symptoms and general health perceptions (Williams et al., 1988; Donald & Ware, 1982; Manning et al., 1982). Mental health subscales have been found to be a significant predictor of medical expenditures (Manning et al., 1982) and out patient mental health expenditures (Ware et al., 1984).

The scale has been used by Kemp et al. (1999), Manne (1999) and Zika and Chamberlain (1992). It has been used in India by Bhandari and Goyal (2004), Rajput (2001) and Maini (2001).
7. **Satisfaction With Life Scale (SWLS)**
   (Diener, Emmons, Larsen, & Griffin, 1985).

The Satisfaction With Life Scale (SWLS) has been developed by Diener et al. (1985). SWLS is a self-report measure designed to assess a person's global judgement of life satisfaction which is theoretically predicted to depend on a comparison of life circumstances to one's standards. Life satisfaction is a conscious cognitive judgement of one's life in which the criteria for judgement are up to the person (Pavot & Diener, 1993).

The SWLS is a 5-item scale, assessing satisfaction with the respondent's life as a whole. The items of the scale are global rather than specific in nature, allowing respondents to weigh domains of their lives in terms of their own values, in arriving at a global judgement of life satisfaction.

Respondents are required to rate their responses along a 7-point scale, ranging from 'strongly disagree, disagree, slightly disagree, neither agree nor disagree, slightly agree, agree to strongly agree'. The range of scores is from 5 to 35, with higher scores indicating a greater degree of satisfaction with life.

The test has highly favourable psychometric properties (Pavot & Diener, 1993; Diener et al., 1985). Alpha coefficient of the test has been reported to be 0.81 across 40 nations (Suh et al., 1998). The test retest reliability of the scale was found to be 0.83 (two weeks; Alfonso & Allison, 1992a); 0.84 (one month; Pavot et al., 1991); 0.82 (two months; Diener et al., 1985) and 0.54 (four years; Magnus et al., 1992).

The validity of SWLS has been established on the basis of a relationship between SWLS and measures of subjective well-being. Blais et al. (1989) reported a strong negative correlation (r = -0.72) between the SWLS and the Beck Depression Inventory (Beck et al.,
1961). Larsen et al. (1985) found a correlation of -0.31 between the SWLS and measures of negative affect. Smead (1991) correlated the scores on SWLS with PANAS scales (Watson et al., 1988). It has been found that SWLS correlated positively ($r = 0.44$) with PANAS positive affect scales and negatively ($r = -0.48$) with PANAS negative affect scales.

The scale has been used by McCullough et al. (2004) on adults with congenital or adult-onset neuromuscular diseases and Sheldon and Elliot (1999). In India, it has been used by Bhandari and Goyal (2004), Bhandari, Upmanyu and Rattan (2004), and Thapar (2002).

8. Positive and Negative Affect Schedule (PANAS)
(Watson, Clark, & Tellegen, 1988)

PANAS is a self-report measure designed for assessing the structure of affect. It is based on the two-factor model of Watson and Tellegen (1985). The scale measures the two dominant and relatively independent dimensions of affect that is positive affect and negative affect.

PANAS is a 20-item scale, consisting of two 10-item mood scales—PANAS positive affect scale and PANAS negative affect scale.

**Positive Affect** reflects the extent to which a person feels enthusiastic, active and alert.

**Negative Affect** is a general dimension of subjective distress and unpleasurable engagement that subsumes a variety of aversive mood states, including anger, contempt, disgust, guilt, fear and nervousness, with low negative affect being a state of calmness and serenity.

The PANAS positive affect and negative affect items are randomly distributed throughout the questionnaire. The subjects are asked to indicate the extent to which they have experienced each
mood state during the past few weeks. Respondents rate each of the mood descriptors along a 5-point response format ranging from 'very slightly or not at all, a little, moderately, quite a bit, to extremely'.

The PANAS scales are highly internally consistent, largely uncorrelated and stable at appropriate levels over a two-month time period (Watson et al., 1988). The alpha reliabilities of the PANAS range from 0.86 to 0.90 for positive affect and from 0.84 to 0.87 for negative affect. The correlation between the PANAS positive affect scale and the PANAS negative affect scale is reported to be low, ranging from -0.12 to -0.23. The eight-week test retest reliability has been reported to range from 0.47 to 0.68 for positive affect; and from 0.39 to 0.71 for negative affect.

The external validity of the PANAS has been established by correlating PANAS scales with measures of related constructs. The PANAS was correlated with Hopkins Symptoms Checklist (HSCL: Derogatis et al., 1974) and it was found that PANAS negative affect scores correlated positively \( (r = 0.74) \) and positive affect scores correlated negatively \( (r = -0.19) \) with the scores on HSCL. The PANAS scales were correlated with Beck Depression Inventory (BDI: Beck et al., 1961). It was found that PANAS negative affect scale correlated substantially \( (r = 0.58) \) and PANAS positive affect scale correlated negatively \( (r = -0.36) \) with the scores on BDI. State Trait Anxiety Inventory-State Anxiety Scale (A-State: Spielberger et al., 1970) exhibited strong correlations \( (r = 0.51) \) with PANAS negative affect scales and negative \( (r = -0.35) \) correlations with PANAS positive affect scales (Watson et al., 1988).

The PANAS scales have been used by McCullough et al. (2004), Tugade and Fredrickson (2004), Lonigan et al. (1999), Wetter et al. (1999), Knez and Enmarker (1998) and Williams et al. (1988). It has also been used by Bhandari and Goyal (2004), Bhandari and Maini
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PROCEDURE

A careful survey was carried out to identify residential areas in Ambala City that were within a 500m radius of the main railway track. People living in this area were contacted randomly to ascertain whether railway traffic noise was clearly audible and a potential source of disturbance. All the respondents thus contacted confirmed that railway traffic noise was a source of disturbance.

The subjects in the age range of 25-40 years living in this area were contacted and requested to volunteer for the study. Rapport was established with each subject and they were assured that the results and any information that they give would be kept strictly confidential. They were requested to cooperate and respond to the questions truthfully.

In the first session, the subjects were administered a brief questionnaire to obtain demographic information regarding age, gender, education, occupation, family structure, residential density and noise sensitivity. They were also administered the Perceived Stress Scale, Noise Sensitivity Scale, the Mental Health Inventory and the Positive and Negative Affect Schedule.

In the second session, the Adult Health Checklist, State Trait Anger Expression Inventory, Satisfaction with Life Scale and the Everyday Errors Questionnaire were administered.

INSTRUCTIONS

1. Instructions for Noise Sensitivity Scale

The instructions for Noise Sensitivity Scale were as follows: - 
"Given below are 21 statements. You are requested to go through
each statement carefully and tick the number next to the answer which best describes your feelings”.

2. **Instructions for Perceived Stress Scale**

   The instructions for Perceived Stress Scale were as follows:-
   “The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. For each question choose from the following alternatives:

   Never = 0, Almost Never = 1, Sometimes = 2, Fairly Often = 3, and Very Often = 4”.

3. **Instructions for Everyday Errors Questionnaire**

   The instructions for Everyday Errors Questionnaire were as follows: “We want to know how often these things happen to you. By each question is a 5-point scale with alternatives ranging from:

   Never = 0, Seldom = 1, Sometimes = 2, Fairly Often = 3, and Very Often = 4. Kindly underline the appropriate number for each question”.

4. **Instructions for Adult Health Checklist**

   The instructions for Adult Health Checklist were as follows: “This scale lists health complaints that happen once in a while to many individuals. For each illness please indicate the frequency and intensity of each illness by using the scales below :

   Frequency Score: Happens Daily = 5, Happens several times a week = 4, Happens about once a week = 3, Happens about once a month = 2, Happens, but less than once a month =1, and Doesn’t happen, not a problem = 0.

   Intensity Score : Bothers me a lot when it happens = 3, Bothers
me a fair amount when it happens = 2, Bothers me only a little when it happens = 1, and Doesn't bother me, not a problem = 0.

Under the heading medical care, circle 'Yes' or 'No' to indicate whether you went to the doctor for this illness.

5. Instructions for State Trait Anger Expression Inventory

The State Trait Anger Expression Inventory consists of three parts. The instructions for 'Part-1' were as follows: "A number of statements that people use to describe themselves are given below. Read each statement and then indicate how you feel right now. Remember that there are no right or wrong answers. Do not spend too much time on any one statement, but give the answer that seems to best describe your present feelings. Choose from the following alternatives:

Not at all = 1, Somewhat = 2, Moderately so = 3, and Very much so = 4".

The instructions for 'Part-2' were as follows: "A number of statements that people use to describe themselves are given below. Read each statement and then indicate how you generally feel. Remember that there are no right or wrong answers. Do not spend too much time on any one statement, but give the answer that seems to best describe how you generally feel. Choose from the following alternatives:

Almost Never = 1, Sometimes = 2, Often = 3, and Almost Always = 4".

The instructions for 'Part-3' were as follows: "Everyone feels angry or furious from time to time, but people differ in the ways they react when they are angry. A number of statements are listed below which people use to describe their reactions when they feel angry or furious. Read each statement and then fill the blank with the number,
which indicates how often you generally react or behave in the manner described when you are feeling angry or furious. Remember that there are no right or wrong answers. Do not spend too much time on any one statement. Choose from the following alternatives:

Almost Never = 1, Sometimes = 2, Often = 3, and Almost Always = 4”.

6. Instructions for Mental Health Inventory

The instructions for Mental Health Inventory were as follows: "Below are several statements with which you may agree or disagree. Using the options following each item, indicate your agreement with the item by ticking the appropriate option. Please be open and honest in your responding”.

7. Instructions for Satisfaction with Life Scale

The instructions for Satisfaction with Life scale were as follows: "Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding. The 7-item scale is as follows:

Strongly Disagree = 1, Disagree = 2, Slightly Disagree = 3, Neither agree nor disagree = 4, Slightly Agree = 5, Agree = 6, and Strongly Agree = 7”.

8. Instructions for Positive and Negative Affect Schedule

The instructions for Positive and Negative Affect Schedule were as follows: "This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to that word. Indicate to what extent you have felt this way during the past weeks. Use the following scale to record your answers:"
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Very slightly or not at all = 1, A little = 2, Moderately = 3, Quite a bit = 4, and Extremely = 5".

SCORING

Scoring for all the tests was done as per the instructions provided in the scoring manuals of the tests. These raw scores were then subjected to various statistical treatments and analyses.