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THE UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

THE RELATIONSHIP BETWEEN SELF CONCEPT AND EMPIRICAL VARIABLES AS MEASURED BY THE TENNESSEE SELF CONCEPT SCALE FOR FOUR GROUPS OF PSYCHOPATHOLOGICALLY DISTURBED INDIVIDUALS

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JOANN IRWIN CLAYTOR

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THE RELATIONSHIP BETWEEN SELF CONCEPT AND EMPIRICAL VARIABLES AS MEASURED BY THE TENNESSEE SELF CONCEPT SCALE FOR FOUR GROUPS OF PSYCHOPATHOLOGICALLY DISTURBED INDIVIDUALS

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CHAPTER I

Introduction

Much has been accomplished to explain personality development that occurred between the end of the adolescent stage of development and the beginning of the fully mature adult. Rappoport equated this transition period to a funnel.

> As we progress through it, (the funnel), our freedom to maneuver is constantly being reduced. Regardless of whether we twist or turn, or take the line of least resistance, by about 25 years of age most of us are committed to a particular adult role (1972, p. 329).

This transition period, roughly between the ages of 18 and 25 years (Rappoport, 1972, p. 329; Farnsworth, 1966, p. 35; Blos, 1967, p. 158) was the time to reduce confusions that had been cultivating during a preceding developmental period, the adolescent years. Many writers presented theories to explain this period of postadolescent development. Madison (1969, pp. 371; 482-487) suggested that this time engulfed a psychological process involving the integration and reintegration of prior experiences. Blos (1967, p. 128) indicated that the primary responsibility of the emerging adult was one of sorting out the past in relation to one's present situation and

how it held hope for the future. This was a period of consolidation. Erikson (1967, p. 136) distinguished between developing a proper sense of intimacy or developing a weak ego quality that leads to a sense of isolation. The self-enhancement theorists such as Carl Rogers maintained that personality should be studied within a present-future framework. He proposed that the person was an actualizing organism; that any self-actualizing experience in the present enhanced the opportunity of realizing one's potential in the future (Koch, 1959, p. 184).

The commonality in all these theories focused on the problems of growth and change in the self concepts of the emerging adult. In any understanding of the role of the self concept in human adaptation, a determination of what was meant by the term self was necessary. This was best done by tracing the development of self-theory; the theory upon which this study was based.

Related Research

The Self

An interest in the self as a determiner of behavior was accorded a place in the scientific research of psychological constructs only since the fourth decade of the twentieth century. Psychological schools such as the functionalist and the behaviorists, which dominated the early twentieth century

American scene, did not give much attention to constructs concerning the self. However, beginning with Freud, many thousands of pages have been written expressing ideas concerned with the self.

Although much has been written about self theory, difficulties still abound because of the inconsistencies in the terms used, definitions expounded, and even instruments and methods used when trying to measure aspects of the self. Hall and Lindzey expressed their consternation with this state of affairs as follows:

> One could wish that it were possible to establish by fiat standard definitions of the self and the ego and make it illegal to use them in any other way (1970, p. 523).

The psychodynamic postulates that were developed by Freud that started the above debate and later expanded by the Neo Freudians implied a self-referent in order to facilitate an understanding of the theory, but more importantly, Freud relegated the ego (a close relation to the self) a second class status far behind the role of the id. Later in his writings, the ego had developed a place of greater importance, but never outdistanced the role of the id.

In the late thirties a systematic anthropological field study of a primitive society led Mead to write about a socially formed self (1950, p. 54). About that same time various modifications of Freud's psychoanalytic theory elaborated on

the self. Jung wrote of an unfolding of the original undifferentiated wholeness with which humans are born. The ultimate unfolding which he labeled the individuation process, was the realization of selfhood (Gorlow and Katkovsky, 1968, p. 153). Adler discussed the self striving for perfection that was the instigator of the drive for power and superiority (Di Caprio, 1974, pp. 252-256). Sullivan described the "self-system" as made up of experiences that were incorporated within it or excluded from it by recurrent social interactions (Lamberth, Rappoport, Rappoport, 1978, p. 268). In his development of structural constructs that are emphasized in his attention to personality development, Rogers rested his theory on the organism and the self. The totality of experience, he said, constituted the phenomenal field of the individual. The phenomenal field was a person's frame of reference and "can never be known to another except through empathic inference and then can never be perfectly known" (1959, p. 210).

Allport stressed the "sense of bodily self." He also referred to self-identity (1961, pp. 113-114). Horney referred to self-image and idealized self-image (1945, p. 96); Angyal was concerned with the symbolic self which was not always a reliable representation, as what a person thought about himself was rarely a true representation of reality (Hall and Lindzey, 1970, p. 320). Munroe talked of the self-image when

she said, "Most of us have several pictures of ourselves ... which serve as a dynamic focus under varying circumstances" (1955, p. 273).

Wylie, who has developed the most comprehensive compilation of studies of the self concept, asked the question, "What do we find in common among the definitions and descriptions?" Then she stated that, "They all refer to complex concepts or systems of concepts within a person, and as such they must be inferred from behavior." She recounted that these concepts were described by the various theorists in one or more of the following statements which she referred to as the generic self concept.

1. A person as an entity separated from others is experienced.

2. A sense of being the same person continues over time.

3. Physical characteristics as experienced are included in the concept.

4. One's behaviors as experienced and remembered are included, especially if associated with feelings of intent or being under the control of the experiencing person.

5. A degree of organization or unity among items included in the self concept is experienced. On the other hand, some theorists postulate semi-autonomous subdivisions which can be logically incomparable with one another.

6. Self percepts and self concepts are not distinguished by the theorists.

7. The self concept includes a person's evaluations as well as his cognitions.

8. The self concept is described as involving degrees of consciousness or unconsciousness (Wylie, 1968, p. 740).

Following this descriptive integration of the various theorists' constructs concerning the self, Wylie (1968, p. 741) proposed a figurative illustration (Figure 1) of an all inclusive description and definition of the self concept. Although the generic self concept encompasses both the actual self concept and the ideal self concept, disparity or incongruence between the two is frequently recognizable. The lack of disparity between the actual self concept and the ideal self concept is viewed by some as one measure of maturity.

Brogan hypothesized that ego functioning of a healthy person is marked by a pattern of adaptation which enhances the opportunity for a well synthesized ideal self (1977, pp. 229-234). This adaptation is contingent upon the individual learning values first from family members and later from significant others which he attaches to perceptions of himself. Maslow stressed the importance of self acceptance and adaptation as a necessary ingredient in the maturing process of the self. This was thought to be in relation to the tasks engendered during a particular developmental or life stage (McMahon, 1972, pp. 123-125). Adams and Fitts proposed that the self concept

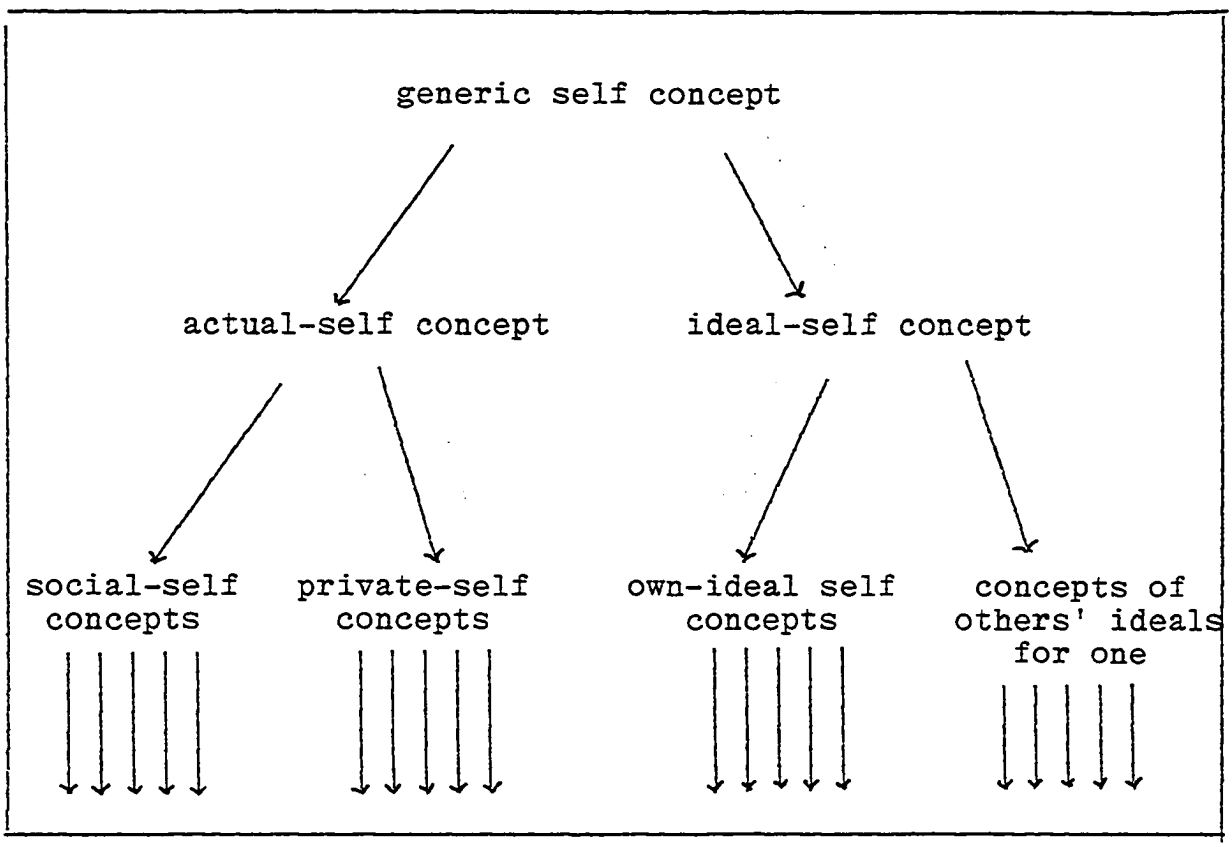

Figure 1. Wylie's all inclusive descriptions and definitions of self concept. (Wylie, 1978, p. 741)

is most strikingly affected and leads to self acceptance, during particular developmental stages by the following:

1. Experiences, especially interpersonal experiences which generate positive feelings and a sense of value and worth.

2. Competence in areas that are valued by the individual and others.

3. Self actualization, or the implementation of one's true personal potentialities--whatever they may be (1971, p. 38).

When this maturing process is limited, that often recognizable factor, self concept disparity has frequently occurred.

The Self and Pathology

Within the generic self concept an internal organization takes place which is influenced by the individual person's experiences. When a particular pathology ensues following this organization most theorists agree that some degree of incongruence has occurred between the ideal self concept and the actual self concept. In other words, a self concept disparity exists.

Adler indicated that the creative self searched for experiences that would aid in fulfilling a person's unique style of life; if these experiences were not found in the world, the self would try to create them. The neurotic person, for example, strives for self-esteem, power, and self-aggrandizement whereas the normal person strives for goals that are primarily

social in character (Hall and Lindzey, 1978, pp. 159-160). Mead proposed that the socially formed self in American adolescents can culminate in "perversion, homosexuality, promiscuity, and other sexual activity which because of their social and moral stigma divert emotional development toward neuroses" (Muus, 1968, p. 70). According to Spiegel, the onset of adolescence brings with it a diffuse physic dissolution and the "once placid sense of identity dissolves and an identity tremulousness sets in" (Lorand and Schneer, 1961, p. 11). He felt as did Erikson that this shifting or less stable sense of self should give way to a more constant one. When this does not happen, the individual may spend a lifetime trying to master this shifting sense of identity by various kinds of attachments or by means of acting out (1968, pp. 160-165). The development of a neurotic character or symptom formation in late adolescence was credited by Blos as an attempt at "self-healing" after a failure to resolve previously articulated instabilities (1962, p. 143). Incongruence within this generic self was postulated by Jersild as a conscious anxiety. "A characteristic of this anxiety is that it precipitates strategies or defenses for coping with the distress and inner conflict" (1963, p. 208).

Kagnoff, in a study of middle aged and elderly males investigated self concept disparity and self actualizing trends. The findings in this study suggested that differences between

actual self concept and ideal self concept could be non-linear and would fluctuate depending on life experiences (1975, p. 1392).

Wylie contended that,

> Self theorists think that by far the most important influence leading to incongruities between the self concept and the objectively judged characteristics of a person is the need to preserve approval and affection from others and from self. If one's actual characteristics and behaviors lead to a loss of approval, anxiety becomes attached to them. To minimize this anxiety, one ignores the characteristics or behaviors, so one acquires a conscious self concept which is incomplete (1968, p. 750).

Erikson, who influenced many with his treatise on the identity crisis of the adolescent, presumed that the pathological consequences of early conflicts may find expression in:

> Hysterical denial or self restriction which limits the individual from living up to his inner capacities or to the powers of his imagination and feelings, if not in relative sexual impotence or frigidity (1968, p. 120).

Rappoport established that as the adult world begins to close in the problems encountered make "a gauntlet of the path to maturity, and the stress they engender can be sufficient to expose any flaw in prior personality development" (1972, pp. 276-277).

Before this metamorphosis could be finalized into this adult role, however, numerous tasks had to be completed. Farnsworth recorded these tasks as follows:

a. Changing from relations of dependence upon one's parents and other older people to those of independence.

b. Dealing with authority.

c. Developing a mature sexuality.

d. Learning to deal with uncertainty and ambiguity, particularly in matters involving the balance between love and hatred.

e. Finding security, developing feelings of adequacy or competence, and attaining prestige or esteem.

f. Developing standards and value systems (1966, pp. 35-45).

Failure to achieve completion of these tasks, which was only possible if congruence existed within the individual's self concept, was strongly suggestive as being a source of fear, anxiety, or even an inadequate or inappropriate view of one's self. In 1976 Bond and Lader conducted a study on self concepts in anxiety states. They studied how psychiatric patients with severe anxiety imagined themselves to be without their symptoms. Self concepts of the patients were considerably lower than those for the controls. The patients saw themselves as significantly sadder, less successful, more passive, and more tense. Patients and controls did not differ, however, in their ratings of ideal self when describing "myself as I would like to be" (1976, pp. 275-279). Fitts affirmed that:

> The image the individual has of himself influences the way he perceives and interacts with

> the world around him, that many aspects of behavior are highly correlated with self concept, that knowledge of self concept provides a basis for understanding behavior and that the self concept is a valid index of mental health (1972, p. 1).

Current diagnostic practices in the mental health field tended to describe the individual in terms of what he was doing and how others saw him, with a lesser focus on how the individual saw himself. Combs and Snygg declared that:

> To understand the behavior of another person it is necessary to understand how things seem to him, to have some grasp of the nature of his phenomenal field. In particular, we need to know how he perceives himself and the world in which he operates (1959, p. 5).

Fitts suggested we refer to this phenomenal field as an "internal frame of reference."

> It is one thing for the diagnostician to see an individual as appearing to be depressed, compulsive, or manic, or for the layman to see him as strange, deviant, and frightening - the external frame of reference; it is a different matter to the individual himself who feels inadequate and frightened - the internal frame of reference (1972, p. 5).

In a study of timidity as related to intelligence, achievement, and self concept, Hedrick found that teachers did not show the ability to perceive timidity in children with the same insight that the children themselves perceived timidity in themselves. This group of 5th and 6th grade children reported generally weaker self concepts than did their non-timid peers. The timid children saw themselves as less intellectual, with

less school status, more anxious and fearful, and less popular with both their peers and adults as compared with the non-timid children.

All too often mental health professionals and auxillary workers are unaware of or inadequately educated about unique characteristics of the client who falls in the age group following the adolescent years and the beginning of the customarily accepted adult years. To be an agent of change in the process toward becoming a fully functional postadolescent, many presuppositions need to be considered. Farnsworth (1966), Blos (1967), and Rappoport (1972) presupposed numerous tasks that had to reach completion in the developmental process of the 18 to 25 year old. The self theorists such as Freud, Jung, Adler, Sullivan, Rogers, Allport, Angyal and Munroe all sustained the proposition that the idea of the self was paramount in this developmental process. This developmental process, if interfered with, established the possibility of pathology. Concomitant with this interruption, such things as anxiety, neuroses, self doubt, or confusion could emerge. This study was concerned with the development of the self concept and the emergence of psychopathology in four groups of emerging adults.

Summary of Related Literature

The search of the related literature covered a synopsis of the various theorists' constructs concerning the self and

the role the self played in the developmental process. A summary of the commonality within these constructs was presented.

Disagreement seemed to exist also in the role of the self in the formation of pathology. Some of the main theoretical propositions were shared. However much the approach to understanding the emergence of pathology was in disagreement, more of a consensus was achieved concerning the belief that various developmental tasks for the emerging adult were necessary for attainment of an ideal self concept. These tasks were summarized. The need for understanding one's phenomenological field concluded this section of Chapter I.

Statement of Problem

The client between the ages of 18 and 25 years is often considered a late adolescent or a young adult by many psychiatrists, psychologists, and other mental health professionals. Less thought is given to the inclusion of this group as having processes unique to this age.

The problem of this study was to identify certain aspects of the self concept that were peculiar to the psychopathologically defined post adolescent. By looking at this emerging adult from an internal frame of reference, a new dimension might be added that could contribute to the understanding of the way this particular group of persons functions.

There was general agreement among psychiatrists and psychologists that the psychopathological postadolescent was at least partially responsible for his non-coping behavior and with the proper intervention he could improve. The facilitation of this assistance was contingent, however, upon the helping agent being knowledgeable about the population in question.

This study was undertaken in an attempt to define some of the aspects of the self concept and some dimensions of pathology which were only partially understood by those contracted and committed to assisting the postadolescent psychiatric patient. More specifically this study was concerned with attempting to answer the following questions:

1. Is there a relationship between particular aspects of self concept measures and particular indicators of pathology as measured by the Tennessee Self Concept Scale for a group of psychiatric clients 18 to 25 years of age?
2. Do clients 18 through 25 years of age who sought psychiatric intervention at the Central Oklahoma Community Mental Health Center characteristically possess low self concepts as measured by the Tennessee Self Concept Scale?

3. Do all clients between 18 and 25 years of age who sought psychiatric intervention at the Central Oklahoma Community Mental Health Center show evidence of a psychological pathology as measured by the Tennessee Self Concept Scale?
4. Do the measures obtained on the Tennessee Self Concept Scale's empirical scales tend to support the diagnosis given by the mental health professionals at the Central Oklahoma Community Mental Health Center?

Statement of Purpose

The possibility had been considered that standards of personal pathological functioning were cut across more than the generally accepted American Psychiatric Associations' approved taxonomy of diagnostic categories (1968). This taxonomy appeared to be formulated using external criteria from which diagnostic categories emerge, but limited itself in the description of the internal referenced criteria of the client. When the diagnostic categorization was formulated within the framework of the pathological viewpoint, i. e. external criteria, a large segment of informational data was excluded. The data cited in this study indicated that psychological processes

among the emerging adult was more than a characterization based upon others' perceptions of that individual's behavior.

Looking at a group of 18 to 25 year old psychiatric patients from an internal frame of reference led to this investigation. With this added bit of knowledge it may be possible to substantiate that which is already available and facilitate a more efficient and therapeutically meaningful disposition in the treatment of this group of persons. An understanding of how a client views himself (his self concept) is essential to a total understanding of that person.

Definition of Terms

For purposes of this investigation important terms were defined in the following manner:

Court Commitment: The process whereby concerned others seek aid through the public courts in obtaining psychiatric hospitalization for the disturbed individual.

Diagnostic classification system: Those diagnoses appearing in the 1968 edition of the Diagnostic and Statistical Manual of Mental Disorders, Second Edition (DSM II), the official nomenclature of the American Psychiatric Association.

Holding patient: An involuntary patient who has been brought to a psychiatric hospital for care

and is awaiting his opportunity for a court hearing. This waiting period is limited to twenty-four to forty-eight hours.

Non-coping emerging adult: Persons 18 through 25 years of age who, for various reasons, have sought, either voluntarily or involuntarily, the assistance of the staff at the Community Mental Health Center.

Postadolescent: Can be used interchangeably with the term emerging adult. Denotes one who has successfully completed the developmental tasks expected of the adolescent. Operationally, this person is between the ages of 18 and 25 years of age.

Psychopathology: An official psychiatric diagnosis by qualified mental health professionals. These official diagnoses were obtained from the diagnostic manual of the American Psychiatric Association (1968).

Self: Operationally, the constructs in previous writings referring to the self point to no clear agreement. A summary of them was given in this study.

Self concept: Used here meaning the conscious

perceptions the client has of his self in relation to his environment.

Limitations of Study

This study was limited to all first admission clients who came to the Central Oklahoma Community Mental Health Center during the period July through October, 1977. Limitations were placed on selection by age (over 17 years and less than 25), sufficient reality orientation to be tested, and willingness to be tested. This study was also limited to the study of the self concept and psychopathology as measured by the Tennessee Self Concept Scale.

Organization of Study

This chapter dealt with an introduction to the study with subsequent related search of the literature. This was followed by the statement of the problem including the specific questions to be answered by the investigation. Definition of terms that were pertinent to the study, and the limitations of the study concluded this chapter.

Chapter II was organized into basically three parts. The method of approach out of which two testable hypotheses emerged began the chapter. The population and the data gathering instruments were described as was the procedure used in gathering the data. The final section outlined the statistical

treatment used in the analysis of the obtained data followed by a summary of the chapter.

The testable hypotheses were restated in Chapter III. The results of an analysis of the demographic data and the statistical treatment of the data obtained from the administration of the Tennessee Self Concept Scale follows. A summary concludes Chapter III.

An overall summary of this study prefaces Chapter IV. This was followed by the findings that were reached following testing of the stated hypotheses. A discussion of the conclusions reached and their implications is followed by the recommentations which grew out of the study.

CHAPTER II

Method

In order to better understand the 18 to 25 year old, four groups of postadolescent psychiatric patients were examined to determine if differences existed among these groups on self concept measures and pathological indicators as measured by the Tennessee Self Concept Scale. Also, the question was studied to determine whether a relationship existed between the self concept measures and the empirical scales for the four groups as measured by the Tennessee Self Concept Scale. A look at these particulars of the self concept and at some of the empirical dimensions of the presenting pathology provided a means whereby two emerging hypotheses could be studied.

Hypotheses

The hypotheses posed were stated in the form of specific null hypotheses for statistical analysis:

> Hypothesis I: There is no statistically significant difference in behavior performance, self concepts, and empirical variables on the Tennessee Self Concept Scale among the various diagnostic

groups: schizophrenics, neurotic disorders, adjustment reactions, and personality disorders, respectively.

Hypothesis II: There is no statistically significant relationship between the self concept measures and empirical scales as measured by the Tennessee Self Concept Scale for each of the diagnostic groups: schizophrenic, neurotic disorders, adjustment reactions, and personality disorders, respectively.

The Population

The subjects for this investigation were 50 clients admitted to the Central Oklahoma Community Mental Health Center during the period July through October, 1977. Limitations were placed on selection by age (over 17 and less than 26), absence of previous admissions to this center, sufficient reality orientation to permit testing, and willingness to be tested. No client refused testing. Those without sufficient reality orientation to permit testing were all tested within two to three days following initial contact when it was ascertained they were able to proceed with testing.

Twenty-six of the clients were male and 24 were female. Educational levels completed ranged from less than a high school education to clients who were currently enrolled in

graduate school at a nearby State University. One subject was eliminated when a determination was made that he could not read. Two potential subjects were missed due to a staff replacement who was not familiar with the study. One other client was not tested as she remained too ill during the time period allowed for testing. The majority of the clients were white. One of the clients was black and seven were American Indian. A more detailed description of the population tested is available in Chapter III.

Data Gathering Instruments

Tennessee Self Concept Scale:

The instrument used to obtain measures of the self concept and evidences of pathology in this investigation was the Tennessee Self Concept Scale, Clinical and Research Form, computer scored edition. The scale consists of 100 self-descriptive statements which persons use to portray their own description of themselves. The instrument is self-administering for either individuals or groups and can be used with persons twelve years or older who have at least a sixth-grade reading level.

The Tennessee Self Concept Scale was developed by Fitts (1965). The original intent of the instrument was for use in mental health research but has, since its original development in 1955, been used in various other settings and for various purposes.

Norms: The standardization group from which the norms were developed was a broad sample of 626 people from various parts of the country. The age range of the sample was 12 years to 68 years with approximately equal numbers of both sexes, both black and white subjects. There were representatives of all social, economic, and intellectual and educational levels. The educational levels ranged from 6th grade through the Ph. D. degree. The sample included subjects from high school, college classes, employees at state institutions, and various other sources. The norms are over-represented in the number of college students, white subjects, and persons in the 12 to 30 year age group. With the exception of the NDS score, the scores yield raw score distributions that conform fairly closely to the normal curve. Because of the distinctive features of the NDS score, (L curve) conventional parametric statistics are meaningless for any analysis of the NDS score. With a group of 570 non-patients, the median time to complete the inventory was 12.4 minutes. With a group of 300 psychiatric patients, the median time was 15.7 minutes.

Reliability: The test-retest reliability coefficients of the scores reported by Fitts are as follows:

Self Concept Scores	Mean	Standard Deviation	Reliability
Row 1	127.10	9.96	.91
Row 2	103.67	13.79	.88
Row 3	115.01	11.22	.88

Col. A	71.78	7.67	.87
Col. B	70.33	8.70	.80
Col. C	64.55	7.41	.85
Col. D	70.83	8.43	.89
Col. E	68.14	7.86	.90

Empirical Scores	Mean	Standard Deviation	Reliability
DP	54.40	12.38	.90
GM	98.80	9.15	.87
Psy.	46.10	6.49	.92
PD	76.39	11.72	.89
N	84.31	11.10	.91
PI	10.42	3.88	.90

(1965, p.14).

These reliability data were based on test-retest with 60 college students over a two-week period. A relevant concern in looking for inter-item consistency in those measures of self concept was their heterogeneity. This would be a desirable characteristic to possess. Fitts (1965, manual, p. 15) indicated that the major dimensions of self perception (self esteem, self criticism, variability, certainty, and conflict) were all relatively independent of each other. However, Bentler related two major defects in the scale. The first defect was that there was a complete absence of information regarding the internal structure of the scale; the second was the high degree of overinterpretation made from the available data (Buros, 1972). The manual cited a table of correlation coefficients delineating the intercorrelation of scores within the scale. Notice should be taken that no less than 77 correlation coefficients were deemed spuriously high because of overlap of

items. These 77 correlation coefficients were within those measuring relationships between self concept measures and the empirical scales measures.

Validity: The validity measures available for the Tennessee Self Concept Scale were content validity, discrimination between groups, correlation with other personality measures, and personality changes under particular conditions. Content validity was determined by unanimous agreement of the six clinical psychologists that an item was classified correctly and that they were logically meaningful. According to Suinn the test's usefulness in differentiating normals from non-normals was adequate (Buros, 1972, p. 368). He said that the manual cited cross-validation data which strongly indicated that the empirical scales did a competent job of aiding in group discrimination. Several scores from the scale have, according to Bentler, "remarkably high correlations with other measures of personality functioning" (Buros, 1972, p. 366). The Taylor Anxiety Scale correlated -.70 with the Total Positive Score of the Tennessee Self Concept Scale. Correlations with various MMPI scales were frequently in the 50's and 60's. Bentler indicated that "it seems safe to conclude that the scale overlaps sufficiently with well-known measures, to consider it a possible alternative for these measures in various applied situations." Fitts has assumed that personality changes under

particular conditions take place and could be measured as such by the Tennessee Self Concept Scale. In general, this did seem to be true. However, even though, according to Suinn psychotherapy, hospitalization, or membership in certain groups has been followed by a change, sensitivity training did not lead to significant changes (Buros, 1972, p. 369).

Individual Scores: Because of the complexity of the Clinical and Research form of the Tennessee Self Concept Scale, and its relevance to the present study, some explanation of the scores that were used was deemed useful. For a more complete description of the instrument, the reader is referred to the test manual (Fitts, 1965). The Tennessee Self Concept Scale provided a profile sheet for each person which delineated 28 variables. Only 14 variables were under consideration in this study. They included three scales measuring identity, self satisfaction, and behavior, respectively. Five scores measured self concept. The remaining six scales were the empirical scales which were aimed at differentiating one group from all other groups. They were described as follows:

In the original analysis of the item pool three scores emerged that represented an internal frame of reference within which the individual described himself. These three scores appear on the individual profile labeled Row 1, Row 2, and Row 3.

Row 1 score was the "What I am" items. With these items the individual was describing his basic identity--what he is as he sees himself. Row 2 score came from those items that enabled the individual to describe how he feels about the self he perceives himself to be. It was a measure of his self satisfaction or self acceptance. Fitts affirms that an individual may have very high scores on Row 1 and Row 3 yet still score low on Row 2 because of very high standards and expectations he has for himself. Row 3 score says "this is what I do or this is the way I act". Therefore, this score measures the perception the individual has of the way he behaves or the way he functions (Fitts, 1965, p. 3).

Self measures emerged which were later labeled as Column A through E. Each reflects a different aspect of the self.

Column A - Physical Self: This score is indicative of the individual's view of his body, his state of health, his physical appearance, skills, and sexuality.

Column B - Moral-Ethical Self: This score reflects the individual's self from a moral-ethical

frame of reference. It reflects his feelings of being a good or a bad person and satisfaction with one's religion or lack of it.

Column C - Personal Self: This score is an indication of the individual's sense of personal worth and his feelings of adequacy as a person.

Column D - Family Self: This score reflects how this individual perceives himself as a family member. It reflects the person's perception of self in relation to his most immediate circle of associates.

Column E - Social Self: This score echoes the individual's perception of self in relation to his sense of adequacy and worth in his social interaction with other people in general (Fitts, 1965, p. 3).

The Empirical Scales were all derived by item analysis, with a resulting selection of those items which differentiated one group of subjects from all others. The six empirical scales, in order of their appearance on the profile sheet, are as follows:

The Defensive Positive Scale (DP): A significantly high DP score indicates a positive description stemming from defensive distortion. A

significantly low DP score means that the person is lacking in the usual defenses for maintaining even minimal self esteem.

The General Maladjustment Scale (GM): This scale differentiates psychiatric patients from non-patients but does not differentiate one patient group from another. It serves as a general index of adjustment-maladjustment.

The Psychosis Scale (Psy): This scale differentiates psychotic patients from other groups.

The Personality Disorder Scale (PD): This scale differentiates those people with basic personality defects and weaknesses in contrast to psychotic states or the various neurotic reactions.

The Neurosis Scale (N): This scale differentiates the neurotic person from other groups.

The Personality Integration Scale (PI): This scale differentiates those persons who are judged as average or better in terms of level of adjustment or degree of personality integration (Fitts, 1965, p. 5).

Central Oklahoma Community Mental Health Center Intake Questionnaire:

This non-standardized intake questionnaire was designed by a committee of well-qualified mental health professionals at the Center. This questionnaire consisted of five pages. The first page of questions was designed to obtain demographic data from each client. Page two allowed the client an opportunity to verbalize in his own words those situations and family relationships which may have precipitated his seeking services at the Center. Pages three and four were concerned with obtaining social, family, vocational, and medical information from the client. Page five specified a check list of 80 complaints, symptoms, or difficulties that people with psychological and related problems often have (see Appendix A). These 80 questions were later classified into twelve categories, each item appearing in only one category. The selection of the categories was based upon two considerations: (1) the categories were purely descriptive of the sorts of items included, with minimal theory or inference, (2) the attempt was made to develop eight to twelve categories of approximately equal size, so that each category would include as nearly as possible the same number of items. Thus, the derivation of categories involved clinical judgment, and other sets of categories could be made with equal justification. The delineated categories included the following headings:

1. Depressed, anxious or confused
2. Withdrawn
3. Unusual or psychotic symptoms
4. Interpersonal problems
5. Financial or vocational problems
6. Somatic problems
7. Relatives, family, and opposite sex problems
8. Sex problems
9. Self concept difficulties
10. Impulse control problems
11. Alcohol problems (and/or drug abuse)
12. Problems concerning hospitalization

Procedure for Gathering Data

Fifty clients were administered the Tennessee Self Concept Scale, computer scored edition and an intake questionnaire that was routinely given to all clients who sought assistance at the Central Oklahoma Community Mental Health Center. The instruments were administered by a qualified psychometrist and two assistants who had been trained for the task. One assistant was the outpatient secretary who regularly made the initial contact with any client making his first appointment at the Center. The other assistant was the psychiatric attendant in charge of the admissions area who first had contact with all patients admitted other than regular Center hours. The

clients included all court commitments or patients disturbed enough to be admitted at other than regular Center hours. Back-up examiners were available but their services were never needed.

Standardized instructions for testing procedures were used. Each client was given the intake packet to be filled out in individual surroundings. The instructions for the regular intake packet were as follows:

> Fill in your name and other information on these forms. If you need assistance, my name is _____ and I'll be nearby to help you.

The Tennessee Self Concept Scale was given to the client at the same time as the regular intake questionnaire with standardized instructions as follows:

> On this form, fill in your name on the separate answer sheet, then fill in the spaces provided for the inventory.
>
> The 100 statements in this inventory are to help you describe yourself as you see yourself. Please answer them as if you were describing yourself to yourself. Read each item carefully; then select one of the five responses below and fill in the space on the separate answer sheet.
>
> Don't skip any items. Answer each one. Use the pencil that is provided. Pens won't work. If you change an answer, you must erase the old answer completely and enter the new one. The responses can be (1) meaning the statement is completely false; (2) meaning the statement is mostly false; (3) meaning the statement is partly false and partly true; (4) meaning the statement is mostly true; or (5) meaning the statement is completely true.

All clients, except those too disturbed to do so, were tested during their first hour at the Center. The more disturbed patients were tested within two to three days when the examiner determined they were amenable to testing.

Statistical Treatment of Data

The raw scores obtained from the administration of the Tennessee Self Concept Scale were tabulated and group means and standard deviations for all the variables were calculated. All raw scores were converted to T scores and an individual profile (see Appendix B) was plotted for each individual (Downey and Heath, 1970, pp. 42-71). The Mann-Whitney U test was used to determine if a statistically significant difference in basic identity, self satisfaction, behavior perception, self concepts, and empirical variables on the Tennessee Self Concept Scale existed among the various diagnostic groups (Senter, 1969, p. 213). All possible combinations of comparisons for all variables were calculated. There was a total of fourteen variables and four groups. Thus, 84 Mann-Whitney U tests were necessary. In all instances, the .05 level of significance was used to reject the previously stated null hypothesis (Popham, 1967, p. 413). The fourteen different variables in each group were compared as follows: Adjustment Reaction with Neurotic Disorders, Adjustment Reaction with Personality Disorders, Adjustment Reaction with Schizophrenics, Neurotic Disorders with

Personality Disorders, Neurotic Disorders with Schizophrenics, and Personality Disorders with Schizophrenics.

The Kendall rank correlation coefficient, tau, was calculated to determine if a statistically significant relationship existed between the self concept measures and empirical scales as measured by the Tennessee Self Concept Scale for each of the diagnostic groups: schizophrenics, neurotic disorders, adjustment reactions, and personality disorders, respectively. (Seigel, 1956, pp. 213-219). These results were displayed in a correlation matrix for each group. To determine the probability associated with the occurrence under H_o of any value as extreme as an observed tau, Z values were calculated for all tau coefficients (Seigel, 1956, pp. 220-222). The normal table was used to determine the significance of the 30 possibilities for each group (Glass and Stanley, 1970, pp. 513-519). The information obtained from the intake questionnaire, including the problem check list was indexed into a frequency distribution for easy perusal.

Summary

This chapter has postulated two testable hypotheses to be investigated by this study. The population was described as were the data gathering instruments used in this study. A more detailed description was given of the specific scales within one of the instruments used, the Tennessee Self Concept

Scale. The procedure for gathering data was outlined with the explicit instructions given to each subject prior to obtaining the data. This was followed by a description of the statistical treatment used with the obtained data. The results of this statistical treatment of the data follows in Chapter III.

CHAPTER III

Results

This investigation was undertaken in an attempt to identify certain aspects of the self concept which were peculiar to the psychopathologically disturbed postadolescent where an internal frame of reference was used as opposed to an external criteria in describing him. An attempt was also made to define some of those areas heretofore only partially understood by those contracted and committed to assisting the postadolescent psychiatric patient to become a functional member of society.

An analysis of the demographic data available on the subjects used in the study indicated some diversity within the sample tested. An inspection of Table 1 revealed that of the 50 initial contacts which took place from July 29, 1977 through October 21, 1977, there were 24 females and 26 males. Of these, three males and two females did not return to complete the intake process and thus were eliminated from the study which resulted in a sample of 22 female and 23 male subjects.

Table 1

Identification Numbers and Demographic Data for Subjects Tested with the Tennessee Self Concept Scale

(N=50)

Subject Number	Sex	Age	County	Type of Commitment	Diagnosis
1001	F	18	Clev.	Voluntary	Adjustment reaction of adolescence
1002	F	19	Clev.	Voluntary	1) Psychosis associated with drug abuse 2) Drug dependence
1003	M	17	Okla.	Voluntary	Poly drug abuse
1004	F	23	Clev.	Voluntary	Anxiety Neurosis
1005	M	21	Clev.	Voluntary	Explosive personality
1006[a]	F	19	Okla.	Voluntary	Deferred
1007	F	21	Clev.	Voluntary	Anxiety Neurosis
1008	M	25	Clev.	Voluntary	Obsessive-compulsive personality
1009[a]	M	24	Okla.	Voluntary	Did not show for intake
1010	F	21	Clev.	Voluntary	Adjustment reaction of adult life
1011	F	24	Okla.	Voluntary	Schizoid personality
1012	M	24	Clev.	Voluntary	Schizophrenia, unspecified type
1013	M	18	Okla.	Voluntary	Habitual excessive drinking

Table 1, (continued) page 2

Subject Number	Sex	Age	County	Type of Commitment	Diagnosis
1014	F	21	Clev.	Voluntary	Adjustment reaction of adolescence
1015[a]	M	18	Clev.	Voluntary	Deferred
1016	F	20	Clev.	Voluntary	1) Depressive neurosis 2) Habitual excessive drinking
1017	F	24	Clev.	Voluntary	Anxiety neurosis
1018	F	25	Clev.	Voluntary	Adjustment reaction of late adolescence
1019	F	19	Okla.	Voluntary	1) Adjustment reaction to adult life 2) Inadequate personality
1020	F	20	Okla.	Voluntary	Adjustment reaction of adolescence
1021	F	19	Clev.	Voluntary	Hysterical neurosis
1022	F	23	McCl.	Voluntary	Depressive neurosis
1023	M	20	Clev.	Voluntary	Gender reassignment; referred to Health Sciences Center
1024	F	24	Clev.	Voluntary	Depressive neurosis
1025	F	22	Clev.	Voluntary	Adjustment reaction of adult life
1026	M	24	Clev.	Voluntary	Anxiety neurosis
1027	F	22	Clev.	Voluntary	Inadequate Personality

Table 1, (continued) page 3

Subject Number	Sex	Age	County	Type of Commitment	Diagnosis
1028	F	22	Okla.	Voluntary	Hysterical personality
1029	M	24	Okla.	Voluntary	Schizophrenia, paranoid type
1030	M	24	Clev.	Voluntary	Adjustment reaction of adult life
1031	M	21	Okla.	Court Certified	Alcoholism
1032	M	24	McCl.	Voluntary	Explosive personality
1033	M	21	Clev.	Voluntary	Explosive personality
1034	F	25	Okla.	Voluntary	Inadequate personality
1035	M	19	Clev.	Voluntary	1) Drug dependence 2) Adjustment reaction of adult life
1036[a]	F	19	Clev.	Voluntary	Deferred
1037	M	18	Okla.	Voluntary	Adjustment reaction of adolescence
1038	M	23	Okla.	Voluntary	Marital maladjustment
1039[a]	M	25	Okla.	Voluntary	Deferred
1040	M	20	Okla.	Voluntary	1) Depressive neurosis 2) Schizoid personality

Table 1, (continued) page 4

Subject Number	Sex	Age	County	Type of Commitment	Diagnosis
1041	F	23	Okla.	Court Certified	Schizophrenia, paranoid type
1042	M	25	Okla.	Court Certified	Marital maladjustment
1043	M	21	Okla.	Voluntary	Schizophrenia, paranoid type
1044	M	25	Clev.	Voluntary	Schizoid personality
1045	M	21	Okla.	Voluntary	Depressive neurosis
1046	M	25	Okla.	Voluntary	Drug dependence; Placidyl, Valium, Demeral
1047	F	18	Clev.	Voluntary	1) Antisocial personality 2) Drug dependence, Preludin 3) Alcohol addiction
1048	M	18	Okla.	Holding	Drug dependence, poly drugs
1049	M	21	Okla.	Voluntary	Non-psychotic organic brain syndrome associated with drugs (THC)
1050	F	22	Okla.	Voluntary	Schizophrenia, chronic undifferentiated type

[a] Excluded from sample as they did not stay long enough to complete the intake interview.

The ages of the subjects ranged from a low of 18 years to a high of 25 years. There were six 18-year-olds; four 19-year-olds; four 20-year-olds; nine 21-year-olds; four 22-year-olds; four 23-year-olds; eight 24-year-olds; and six 25-year-olds, which showed a relatively even distribution across the ages represented.

The place of residence of 23 of the subjects was Cleveland County, the location of a large state university and site of the entering institution. Twenty of the subjects resided in Oklahoma City, a large neighboring metropolitan city. The remaining two subjects were from the rural area of McLain County.

All but four of the clients were voluntary first admissions to the Mental Health Center. Of the remaining four, three were court certified and one declared a holding patient. This overwhelming proportion of voluntary status reflects not a decrease in the severity of the presenting problem, but rather, a growing acceptance of the treatment available and a decrease, in more recent years, of the courts indiscriminate willingness to court-certify patients for admission.

The 45 final subjects presented a diversity of problems that appeared to accommodate particular diagnostic categories. The overwhelming responses to the intake problem check list, a check list of 80 complaints, symptoms, or difficulties, was that of lacking self-confidence and feeling blue and moody.

A more detailed frequency distribution of the intake check list responses of the subjects can be seen in Table 2. Following an intake interview a diagnosis was given. This information then allowed the examiner to group the subjects into four general categories consistent with DSM II guidelines. The composition of these groups included eleven subjects with adjustment reactions; ten subjects with neurotic disorders; nineteen subjects with personality disorders; and five schizophrenics.

Table 3 depicts the combined group raw score means with the corresponding standard deviations. Figure 2 portrays this information in addition to the sub-group profile for the individual groups. It may be noted that in presenting the data in figure form, the reader is provided with illustrative information that enables an easy access to a comparison of the various measures. The format of the figure also enables the reader to observe the general configuration of the scores both in percentiles and standard scores.

The racial composition of the subjects included seven American Indians, one black, and 33 white subjects. Four of the subjects did not give this information. The American Indian population ranged from one-half Indian to one-sixty-fourth. The educational level of the subjects included 10 persons who had not completed high school; eight who had finished the twelfth grade; nine who had completed some college; one

Table 2

Frequency Distribution of Responses to the Problem Checklist by a Group of Postadolescent First Admission Psychiatric Patients

(N=45)

Problem	Frequency	
	No.	%
Depressed, Anxious, or Confused:		
Confused in my religious beliefs	15	33
Having a poor memory	15	33
Having trouble understanding what I read	13	29
Feeling blue and moody	31	69
Feeling life is not worthwhile	18	40
Trying to forget an unpleasant experience	22	49
Constantly worrying	24	53
Having difficulty in making decisions	19	42
Unhappy too much of the time	23	51
Bothered for thoughts of suicide	12	27
Needing a philosophy of life	11	24
Withdrawn:		
Daydreaming	19	42
Feeling ill at ease with other people	19	42
Not really having any friends	18	40

Table 2, (continued) page 2

Problem	Frequency No.	Frequency %
Being left out of things	17	38
Feeling I am too different	15	33
Not having enough social life	16	36
Unusual or Psychotic Symptoms:		
Sometimes afraid of going insane	18	40
Bothered by thoughts running through my head	14	31
Hearing voices	6	13
Strange experiences	9	20
Life may be in danger	1	2
Others trying to control my thoughts	7	16
Interpersonal Problems:		
Being led too easily by others	18	40
Not getting along well with people	12	27
Being disliked by someone	15	33
Being treated unfairly	15	33
Troubled by lack of religious faith in others	2	4
Disliking certain persons	12	27
People finding fault with me	14	31

Table 2, (continued) page 3

Problem	Frequency	
	No.	%
Feeling no one cares for me	13	29
Being too jealous	16	36
Financial or Vocational Problems:		
Poor living conditions	8	18
Needing a job	18	40
Getting into debt	18	40
No steady income	18	40
Not knowing how to look for a job	3	7
Not knowing my vocational abilities	13	29
Working too hard	4	9
Finding my work too boring	10	22
Needing legal advice	5	11
Lacking ambition	14	31
Somatic Problems:		
Poor appetite	15	33
Stomach trouble	18	40
Having trouble with my speech	4	9
Headaches	14	31
Muscular aches and pains	6	13

Table 2, (continued) page 4

Problem	Frequency No.	Frequency %
Relatives, Family and Opposite Sex Problems:		
Having to live with relatives	12	27
Too much quarreling at home	26	58
Afraid of marriage	13	29
Not being understood by my family	21	47
Feeling forgotten by my family	10	22
Having an unhappy home life	17	38
Disappointed in a love affair	15	33
Too much interfering by relatives	16	36
Wishing I had a different family	4	9
Needing advice about marriage	7	16
Sex Problems:		
Finding sex hard to control	10	22
Needing information about sex	4	9
Thinking too much about sex	14	31
Having unusual sex desires	3	7
Sexual desires unsatisfied	9	20
Self Concept Difficulties:		
Lacking self-confidence	31	69

Table 2, (continued) page 5

Problem	Frequency	
	No.	%
Not being really smart enough	12	27
Being physically unattractive	11	24
Feeling I am a failure	17	38
Having a guilty conscience	19	42
Feeling inferior	18	40
Worrying how I impress people	23	51
Impulse Control Problems:		
Speaking or acting without thinking	20	44
Being stubborn	20	44
Too emotional	26	58
Too nervous or high strung	29	64
Giving into temptation	14	31
In trouble with the law	3	7
Getting into arguments or fights	21	47
Sometimes feeling forced to do things	20	44
Alcohol Problem:		
Drinking too much	3	7
Hospitalization:		
Shouldn't be in the hospital	3	7
Committed unjustly	2	4

Table 3

Group Raw Score Means and Standard Deviations for the Tennessee Self Concept Scale

(N=45)

Scale	Mean	Standard Deviation
Identity (Row 1)	104.80	18.18
Self-Satisfaction (Row 2)	85.46	18.56
Behavior (Row 3)	91.60	16.82
Physical Self (Col. A)	57.52	11.07
Moral-Ethical Self (Col. B)	59.42	11.36
Personal Self (Col. C)	51.88	12.93
Family Self (Col. D)	54.44	11.37
Social Self (Col. E)	58.60	10.80
Defensive Positive (DP)	41.66	14.94
General Maladjustment (GM)	77.14	15.29
Psychosis (Psy)	51.84	6.97
Personality Disorders (PD)	58.72	13.77
Neurosis (N)	60.96	15.02
Personality Integration (PI)	5.94	4.37

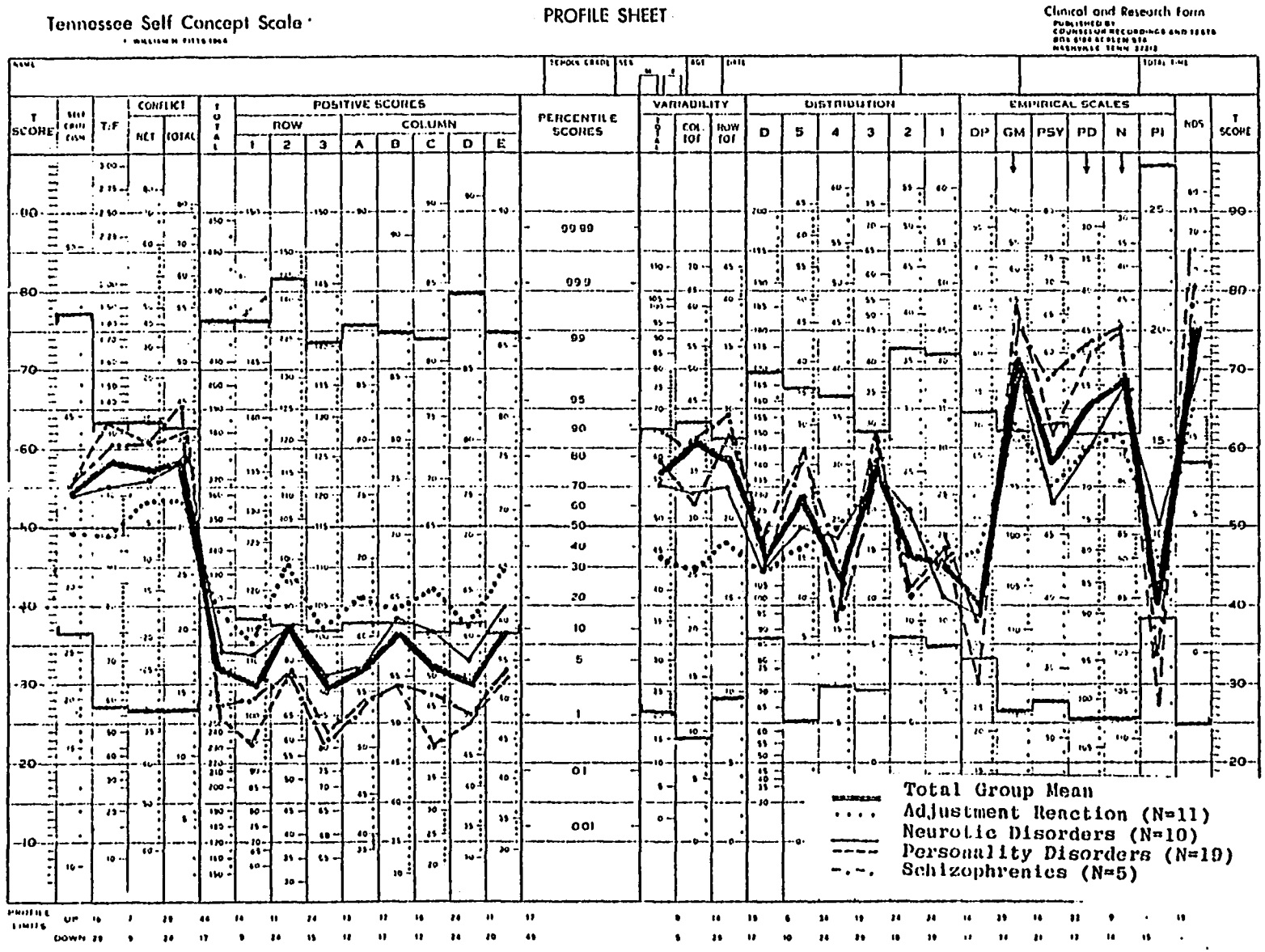

Figure 2 Mean Score Profiles for Four Groups of Psychologically Disturbed Post Adolescents. (N=45)

in vocational-technical training; four who had completed college; and two who were presently in graduate school. There were 11 subjects who did not make available this information. Ten of the subjects had already experienced an unsuccessful marriage; eight were married at the time of admission, and 26 had never married. The median income for this group was $48.00 per week. The range of income was zero to $600.00 per week. One subject had a monthly income of $2500.00 while nine subjects had no income and were still dependent on others for their care.

In presenting the results of the statistical analysis, each hypothesis is restated and then evaluated.

Hypothesis 1: There is no statistically significant difference in behavior performance, self concepts, and empirical variables on the Tennessee Self Concept Scale among the various diagnostic groups: schizophrenics, neurotic disorders, adjustment reactions, and personality disorders, respectively.

Hypothesis 2: There is no statistically significant relationship between the self concept measures and empirical scales as measured by the Tennessee Self Concept Scale for each of the diagnostic groups: schizophrenics, neurotic disorders, adjustment reactions, and personality disorders, respectively.

The Mann-Whitney U test was calculated for all combinations of comparisons for all variables to test Hypothesis 1. In other words, six tests for each of the 14 variables was computed which yielded 84 U tests. An inspection of Tables 4, 5, 6, 7, 8, and 9 provides those results.

Table 4 revealed that all 14 obtained U values were greater than the critical U values in Table K (Siegel, 1956, p. 276) so the null hypothesis of no statistically significant difference between the 14 measured variables for the schizophrenic group and the 14 measured variables for the adjustment reaction group was rejected. The adjustment reaction group scored significantly higher than the schizophrenic group on all the self concept measures and significantly lower on all the empirical scales except the Defensive Positive and the Personality Integration. On these scales the schizophrenic group scored significantly lower.

Table 5 revealed that all 14 obtained U values were greater than the critical U values in Table K (Siegel, 1956, p. 276) so the null hypothesis of no statistically significant difference between the 14 measured variables for the schizophrenic group and the 14 measured variables for the neurotic group was rejected. The neurotic group scored significantly higher than the schizophrenic group on all the self concept measures and significantly lower on all the empirical scales except the Defensive Positive and the Personality Integration

Table 4

Mann-Whitney U Values for Two Groups of Psychiatric Patients; the Schizophrenic Group (N=5) and the Adjustment Reaction Group (N=11)

	Row			Column					Empirical Scales					
	1	2	3	A	B	C	D	E	DP	GM	Psy	PD	N	PI
Row														
1	*35.5													
2		*49.5												
3			*45											
Col.														
A				*45										
B					*40.5									
C						*40.5								
D							*42							
E								*45						
DP									*46					
GM										*39				
Psy											*13			
PD												*48		
N													*48.5	
PI														*43

*Significant at the .05 level

Table 5

Mann-Whitney U Values for Two Groups of Psychiatric Patients; the Schizophrenic Group (N=5) and the Neurotic Disorder Group (N=10)

	Row			Column					Empirical Scales					
	1	2	3	A	B	C	D	E	DP	GM	Psy	PD	N	PI
Row														
1	*34													
2		*39												
3			*39											
Col.														
A				*36										
B					*35									
C						*35								
D							*32.5							
E								*39.5						
DP									*28.5					
GM										*32				
Psy											*9			
PD												*43.5		
N													*33.5	
PI														*37.5

*Significant at the .05 level

scales. On these scales the schizophrenic group scored significantly lower.

Table 6 revealed that all 14 obtained U values were greater than the critical U values in Table K (Siegel, 1956, p. 276) so the null hypothesis of no statistically significant difference between the 14 measured variables for the adjustment reaction group and the 14 measured variables for the neurotic group was rejected. The adjustment reaction group scored significantly higher than the neurotic on all the self concept measures and significantly lower on the General Maladjustment, Personality Disorders, and Neurosis scales. The neurotic group scored significantly lower on the Defensive Positive, Psychosis, and Personality Integration scales.

Table 7 revealed that all 14 obtained U values were greater than the critical U values in Table K (Siegel, 1956, p. 276) so the null hypothesis of no statistically significant difference between the 14 measured variables for the schizophrenic group and the 14 measured variables for the personality disorders group was rejected. The personality disorder group scored significantly higher than the schizophrenic group on all the self concept scales. The schizophrenic group scored significantly higher than the personality disorder group on the Defensive Positive, Psychotic, Personality Disorder, Neurosis, and Personal Integration scales. The personality

Table 6

Mann-Whitney U Values for Two Groups of Psychiatric Patients; the Adjustment Reaction Group (N=11) and the Neurotic Disorder Group (N=10)

	Row			Column					Empirical Scales					
	1	2	3	A	B	C	D	E	DP	GM	Psy	PD	N	PI
Row														
1	*63													
2		*81.5												
3			*71											
Col.														
A				*70										
B					*55.5									
C						*68								
D							*65							
E								*61.5						
DP									*83					
GM										*67.5				
Psy											*50.5			
PD												*55.5		
N													*78	
PI														*50.5

*Significant at the .05 level

Table 7

Mann-Whitney U Values for Two Groups of Psychiatric Patients; the Schizophrenic Group (N=5) and the Personality Disorder Group (N=19)

	Row			Column					Empirical Scales					
	1	2	3	A	B	C	D	E	DP	GM	Psy	PD	N	PI
Row														
1	*35													
2		*53.5												
3			*45											
Col.														
A				*40										
B					*44.5									
C						*42								
D							*45							
E								*46.5						
DP									*46					
GM										*33				
Psy											*28			
PD												*51		
N													*41	
PI														*35.5

*Significant at the .05 level

disorder group scored significantly higher than the schizophrenic group on the General Maladjustment scale.

Table 8 revealed that only two of the 14 obtained U values were greater than the critical U in Table K (Siegel, 1956, p. 276). The personality disorder group scored significantly higher than the adjustment reaction on the Psychosis scale. The adjustment reaction group scored significantly higher than the personality disorders group on Column B (moral-ethical self). Therefore Hypothesis 1 could not be rejected for these two comparison groups.

Table 9 revealed that seven of the 14 obtained U values were greater than the critical U in Table K (Siegel, 1956, p. 276). The neurotic group scored significantly higher than the personality disorders group on all the self concept measures and on the Defensive Positive and Personality Integration scales. The personality group scored significantly higher than the neurotic group on General Maladjustment, Psychosis, Personality Disorders, and Neurosis scales.

Interpretation of Scores

The findings on the Tennessee Self Concept Scale did tend to validate that psychopathology existed as observed by the mental health professionals who did the intake interview for this group of clients. The observation was supported by results on the six empirical scales that differentiated one

Table 8

Mann-Whitney U Values for Two Groups of Psychiatric Patients; the Personality Disorders Group (N=19) and the Adjustment Reactions Group (N=11)

	Row			Column					Empirical Scales					
	1	2	3	A	B	C	D	E	DP	GM	Psy	PD	N	PI
Row														
1	42.5													
2		36.5												
3			32.5											
Col.														
A				54										
B					*59.5									
C						34.5								
D							47.5							
E								47						
DP									56.5					
GM										25				
Psy											*141.5			
PD												42		
N													32	
PI														24

*Significant at the .05 level

Table 9

Mann-Whitney U Values for Two Groups of Psychiatric Patients; the Personality Disorders Group (N=19) and the Neurotic Disorders Group (N=10)

	Row			Column					Empirical Scales					
	1	2	3	A	B	C	D	E	DP	GM	Psy	PD	N	PI
Row														
1	34.5													
2	*62.5													
3		50.5												
Col.														
A			*72											
B				*58										
C					41.5									
D						*53.5								
E							43							
DP								*86						
GM									29.5					
Psy										*145				
PD											41			
N												*58		
PI													31	

*Significant at the .05 level

group of clients from all others but more by degree of score and not the specific empirical scale.

The higher the numerical score (the group mean) on the self concept scales, the higher the self concept was. On the empirical scales this depended on the descending or ascending order in plotting the results on the profile sheet. A significantly high Defensive Positive score indicated defensive distortion, whereas a significantly low Defensive Positive score meant that the person was lacking in the usual defenses for maintaining even minimal self esteem. All groups had scores within the normal range on the Defensive Positive scale. The Psychosis scale differentiates psychotic patients from other groups. The higher the score is the more psychotic the client. Only the schizophrenic group scored above the normal range on this scale. The Personality Disorder scale should differentiate those persons with personality defects in contrast to psychotic states or the various neurotic reactions. The lower the numerical score, the higher is the degree of pathology on the Personality Disorder scale. Both the schizophrenic group and the personality group scored above the normal range on this scale. The lower the numerical score on the General Maladjustment scale, the higher is the general index of adjustment/maladjustment. All four groups showed evidence of general maladjustment. The Neurosis scale was designed to differentiate

the neurotic person from other groups. The lower the raw score, the higher was the degree of pathology. All groups but the adjustment reaction group showed evidence of pathology on the Neurosis scale. The adjustment reaction group scored only one integer within the normal range. Any score below six indicates low levels of adjustment on the Personality Integration scale. The schizophrenic and personality disorder group scored below five on this scale. The maximum score that was obtainable was a 25. No group scored above 10.

The most extreme scores on the empirical scales of all the groups were evidenced by the schizophrenics. The next most deviant scores were those obtained by the personality disorder group. The neurotic group was the next most deviant group and only slightly above the group of adjustment reactions who showed the least deviant scores of all the groups. Clearly the schizophrenic group showed evidence of psychosis while all other groups scored within the normal range on this scale.

The self concept scales indicated a similar phenomenon. The adjustment reaction group scored within the normal range. The neurotic group scored slightly below the range. The personality disorder group showed a more deviant profile with their greatest area of difficulty on the score measuring Behavior (Row 3) and Identity (Row 1). The schizophrenic group evidenced generally low self concepts across all measures as

did the personality disorders. However, their greatest problem area included those measured by the Behavior (Row 3) and Family Self (Col. D) scales. It did appear, then, that the more disturbed a group of individuals appeared to be, the lower their overall self concepts.

The Kendall rank correlation coefficient (tau) was computed to determine if a statistically significant relationship existed between the self concept measures and the empirical scales of the Tennessee Self Concept Scales for the four diagnostic groups in this study (Ferguson, 1966, pp. 220-225). An inspection of Tables 10, 11, 12 and 13 provides those results.

Table 10 revealed four of the 30 possible correlation coefficients reached the .05 level of significance for the schizophrenic group. Those that reached the level of significance were Family/General Maladjustment, Physical/Psychotic, Moral-Ethical/Personality Disorder, and Personal/Neurotic.

Table 11 revealed seven of the 30 possible correlation coefficients reached the .05 level of significance for the neurotic group. They were as follows: Moral-Ethical Self/Personality Disorders, Moral-Ethical Self/Defensive Positive, Moral-Ethical Self/Neurotic, Personal Self/Neurotic, Family Self/Neurotic, Family Self/Personality Integration, and Social Self/Neurotic.

Table 12 revealed 14 of 30 possible correlation coefficients reached the level of significance for the personality

Table 10

Kendall Rank Correlations Coefficients for the Group of Psychiatric Patients Diagnosed Schizophrenia

(N=5)

Self Concepts	Empirical Scales					
	DP	GM	Psy	PD	N	PI
Physical	0.3333	-0.6325	*1.0000	0.2108	-0.2108	-0.3333
Moral-Ethical	0.5278	0.0000	0.4000	*0.8000	0.4000	0.3162
Personal	0.3162	0.6000	0.2000	0.6000	*0.8000	0.3162
Family	0.1111	*1.0000	0.6325	0.2108	0.6325	0.3333
Social	0.1054	0.6000	-0.4000	0.4000	*0.8000	0.5270

*Significant at the .05 level

Table 11

Kendall Rank Correlation Coefficients for the Group of Psychiatric Patients Diagnosed Neurotic

(N=10)

Self Concepts	Empirical Scales					
	DP	GM	Psy	PD	N	PI
Physical	0.0000	0.0909	-0.3061	-0.0909	0.3820	0.1609
Moral-Ethical	*0.5000	0.2727	0.3532	**0.7273	*0.5618	0.2989
Personal	0.3182	0.2273	-0.3532	0.2727	*0.5169	0.3908
Family	0.1358	0.2247	0.2095	0.4045	*0.6000	**0.7957
Social	0.2273	0.3182	-0.2119	0.4091	*0.5169	0.3449

*Significant at the .05 level
**Significant at the .01 level

Table 12

Kendall Rank Correlation Coefficients for the Group of Psychiatric Patients Diagnosed Personality Disorders

(N=19)

Self Concepts	Empirical Scales					
	DP	GM	Psy	PD	N	PI
Physical	0.1321	*0.3842	-0.2744	0.0604	0.1976	**0.5019
Moral-Ethical	*0.4392	0.2109	0.0783	**0.6090	0.2426	0.2177
Personal	**0.6209	0.2849	-0.0545	**0.5526	**0.5060	0.2690
Family	**0.5119	*0.4170	-0.2598	**0.4671	**0.6113	-0.0187
Social	**0.5868	0.3222	-0.2249	*0.3494	**0.5911	-0.1569

*Significant at the .05 level
**Significant at the .01 level

disorders group. They were Moral-Ethical/Defensive Positive, Personal/Defensive Positive, Family/Defensive Positive, Social/Defensive Positive, Physical/General Maladjustment, Family/General Maladjustment, Moral-Ethical/Personality Disorder, Personal/Personality Disorder, Family/Personality Disorder, Social/Personality Disorder, Personal/Neurotic, Family/Neurotic, Social/Neurotic, Physical/Personality Integration.

Table 13 revealed 22 of 30 possible correlation coefficients reached the level of significance for the adjustment reaction group. They were Physical/Defensive Positive, Moral-Ethical/Defensive Positive, Personal/Defensive Positive, Social/Defensive Positive, Physical/General Maladjustment, Moral-Ethical/General Maladjustment, Personal/General Maladjustment, Family/General Maladjustment, Social/General Maladjustment, Physical/Psychotic, Moral-Ethical/Psychotic, Social/Psychotic, Physical/Personality Disorder, Moral-Ethical/Personality Disorder, Personal/Personality Disorder, Family/Personality Disorder, Physical/Neurotic, Moral-Ethical/Neurotic, Personal/Neurotic, Family/Neurotic, Social/Neurotic, Family/Personality Integration.

Because there did appear to be a strong correlation between self concept measures and empirical scales as measured by the Tennessee Self Concept Scale, Hypothesis 2 which stated that no statistically significant relationship existed, was

Table 13

Kendall Rank Correlation Coefficients for the Group of Psychiatric Patients Diagnosed Adjustment Reaction

(N=11)

Self Concepts	Empirical Scales					
	DP	GM	Psy	PD	N	PI
Physical	*0.5556	**0.7664	**-0.6416	**0.7664	**0.7156	0.2096
Moral-Ethical	*0.5926	**0.7664	*-0.5284	**0.8038	*0.6055	0.4002
Personal	**0.6729	*0.5849	-0.4191	*0.5094	**0.8335	0.3270
Family	0.2936	*0.5371	-0.3366	*0.5742	**0.7091	*0.4343
Social	*0.4074	**0.6916	*-0.4152	0.3178	**0.6422	0.1715

*Significant at the .05 level
**Significant at the .01 level

rejected. Of the 120 possible statistically significant relationships, 47 did reach the level of significance at the .05 level. Twenty-one of these 47 correlation coefficients reached the level of significance at the .01 level.

Summary

This chapter presented an analysis of all the collected data for the initial 50 subjects in this study. The demographic data was categorized and the responses to the problem checklist regrouped into a frequency table. Tables were presented which included a presentation of the group raw score means, the Mann-Whitney U values, and Kendall rank correlation coefficients. The results depicted by these values was presented. A summary review statement of the study begins Chapter IV followed by the findings that emerged. A discussion of the conclusions that were derived from the analysis of these findings is then concluded with recommendations for further study.

CHAPTER IV

Summary

Before proceeding through the final conclusions of this study which led to specific recommendations, a brief summary of the preceding chapters is in order. A survey of the literature revealed that before a person reaches the age of the fully mature adult, many developmental tasks need to reach completion which usually occurs by around 25 years of age. This study was concerned with the period in this process that occurred between the end of the adolescent stage of development and the beginning of the fully mature adult, roughly between the ages of 18 and 25 years of age. More specifically, this study was concerned with the problems of growth and change within the self concept of the individual during this transition stage. Wylie proposed that an internal organization takes place within the generic self concept that is influenced by that person's experiences. When experiences are positive the ideal self concept is enhanced. When less than adequate experiences take place, the actual self concept is minimized and falls far short of the ideal self concept. When a pathology ensues following this organization,

most self theorists agreed that some degree of incongruence has occurred between the ideal self concept and the actual self concept.

The problem studied was expressed in the questions: Is there a relationship between particular aspects of self concept measures and particular indicators of pathology as measured by the Tennessee Self Concept Scale for a group of psychiatric clients 18 to 25 years of age? Do clients 18 to 25 years of age who sought psychiatric intervention at the Central Oklahoma Community Health Center characteristically possess low self concept? Did the subjects in this study show evidence of a psychological pathology? Did the measures obtained on the Tennessee Self Concept Scale's empirical scales tend to support the diagnosis given by the mental health professionals who interviewed these clients?

Out of these questions posed, two emerging hypotheses evolved which were stated in the form of specific null hypothesis for statistical analysis:

> Hypothesis I: There is no statistically significant difference in behavior performance, self concepts, and empirical variables on the Tennessee Self Concept Scale among the various diagnostic groups: schizophrenics, neurotic disorders, adjustment reactions, and personality disorders, respectively.

Hypothesis II: There is no statistically significant relationship between the self concept measures and empirical scales as measured by the Tennessee Self Concept Scale for each of the diagnostic categories: schizophrenic, neurotic disorders, adjustment reactions, and personality disorders, respectively.

The four groups which comprised the study included five schizophrenics, ten clients with diagnoses of a neurotic disorder, eleven adjustment reactions, and nineteen diagnosed as personality disorders. These final 45 subjects were all first admission clients at a state supported community mental health center located in an urban setting with a large, nearby state university. The two instruments used to collect data included an unstandardized problem check list and the Tennessee Self Concept Scale.

The method used for analysis of the data included computation of the correlation coefficients, Kendall Tau to test hypothesis I. The non-parametric Mann-Whitney U test was used as a test of difference to examine hypothesis II. A frequency distribution of the problem check list was converted to percentages for analysis of the chief presently problems for these clients.

Findings

Within the scope and limitations of the study, the following findings were obtained.

1. An inverse relationship did exist between several aspects of self concept measures and several indicators of pathology as measured by the Tennessee Self Concept Scale for the four groups of psychiatric clients investigated in this study. Following the computation of the Kendall rank correlation coefficient (tau) for 120 possibilities, 47 were found to reach the level of significance at the .05 level. Twenty-one of these 47 correlation coefficients reached the level of significance at the .01 level. For the schizophrenic group (N=5) four of 30 possible correlation coefficients reached the level of significance at the .05 level. The neurotic group (N=10) had seven of 30 significant correlation coefficients at the .05 level. Of the 30 possible relationships for the personality disorder group (N=19), 14 reached the level of significance. Twenty-two of 30 possible correlation coefficients reached the .05

level of significance for the adjustment reaction group. A survey of Figure 2 graphically illustrates that the poorer the self concepts for each of the four groups, the higher was the degree of pathology.

2. First admission clients, 18 through 25 years of age who sought psychiatric intervention at the Central Oklahoma Community Mental Health Center during July, 1977 through October, 1977 did characteristically possess low self concepts as measured by the Tennessee Self Concept Scale.
3. All clients between 18 and 25 years of age who sought psychiatric intervention and stayed for the full intake process at the Central Oklahoma Community Mental Health Center between July, 1977 and October, 1977, did show evidence of a psychological pathology as measured by the Tennessee Self Concept Scale and as perceived by the mental health professionals at the center.
4. The measures obtained on the Tennessee Self Concept Scale's empirical scales did show evidence of pathology for all the clients

in this investigation but did not discriminate between diagnostic categories as given by mental health professionals at the Central Oklahoma Community Mental Health Center.

Conclusions and Discussion

Evidence in this study confirmed that the actual self concept as measured by the Tennessee Self Concept Scale did fall far short of what the ideal self was expected to be. That incongruence existed was supported by the fact that several measures of pathology were in evidence.

Evidence existed that confirmed 69 percent of the clients, who appeared for admission to the Central Oklahoma Community Mental Health Center between the ages of 18 and 25 years from July, 1977 through October, 1977, felt blue and moody and lacked self confidence. Lack of ability or circumstances necessary to conclude the tasks engendered during this particular phase of development may have contributed to the widespread prevalence of these complaints across these clients. Which of the tasks left uncompleted for this developmental age may be only one or may be several. A thorough analysis of this was not determined by this study.

That clients in this study had shown up for admission as a psychiatric patient at the Center indicated an admission

of failure at satisfactory adjustment to the problems usually encountered in everyday living. This admission could have accounted for the preponderance of low self concept scores.

This study did subject to statistical analysis two hypotheses which grew out of questions posed for this study. The first question was concerned with whether a relationship between particular aspects of self concept measures and particular indicators of pathology existed for a group of psychiatric clients 18 to 25 years of age as measured by the Tennessee Self Concept Scale. This was affirmed for all groups. Less evidence existed for the schizophrenic group than did the other three groups. This does not mean that less pathology was evident. Quite the reverse was true. The possibility existed that N for this group (5) was simply too small to generalize. Due to an overlap of numerous items in the construction of the column scores and the empirical scores of the Tennessee Self Concept Scale, spuriously high measurements could possibly account for the high correlation coefficients that were obtained.

All of the four groups investigated in this study did characteristically exhibit low self concepts as measured by the Tennessee Self Concept Scale. The schizophrenic group, the neurotic group, and the personality disorder group all scored below the average range on the eight measures of self concept. The adjustment reaction group scored just barely within the

normal range on six of the eight scales and below on two of the scales. The greatest area of difficulty for all the groups were on Row 1 which describes the client's basic identity, Row 3 which measures the individual's perception of the way he functions, and Column D which reflects the client's feelings of adequacy, worth, and value as a family member.

Of the final 45 subjects tested in this study, all showed some evidence of a psychological pathology. Although not in the same degree or within the same empirical scale, several areas of pathology were measured. All subjects but the schizophrenics scored just barely within the average range on the psychosis scale. The adjustment reaction group showed less evidence of pathology but did measure outside the normal range on the General Maladjustment and Neurotic scale as did all the groups.

Did the data obtained by the administration of the Tennessee Self Concept Scale tend to support the diagnosis given by the Mental Health professionals at the Central Oklahoma Community Mental Health Center? In general, the Tennessee Self Concept Scale did appear to be valid in diagnosing pathology for the 18 to 25 year old psychiatric client. However, in specific discrimination between diagnostic categories, evidence refuted this. The conclusion reached was that clinical judgment is better. A prevalent practice has been observed among mental health professionals that whenever possible a

less severe, i. e. adjustment reaction as opposed to schizophrenia, diagnosis be given to the much younger psychiatric client. This seemed to have been the prevailing practice with this particular population.

The theoretical position posed by this study indicated that certain developmental tasks are engendered by the 18 to 25 year old emerging adult (Farnsworth, 1966; Blos, 1967; Rappoport, 1972). When these tasks are completed the developing self concept is enhanced and a greater chance at developing into the ideal self concept emerges. When disruption of the developmental tasks occurs, the actual or real self concept does not reach the level of the ideal self concept. This study corroborates the position taken by Jersild (1963) and Wylie (1968) that this creates dissonance within the individual and from this dissonance pathology emerges. Which of the developmental tasks left uncompleted was beyond the scope of this study and could only be assumed to have existed. However, evidence supported that low self concept--the actual self concept--did exist for this population and that ideal self concepts would be necessary for decreased dissonance to emerge thus leading to a much lower degree of pathology.

Recommendations

The results of the study suggest several possibilities for further research:

1. Additional studies should be conducted in other types of psychiatric settings to provide additional information as to the degree to which the findings could be generalized to other groups of psychopathologically disturbed emerging adults.

2. Replication studies should be conducted with another kind of sample, i. e. delinquents, to see if similar differences and relationships exist.

3. Studies should examine the sex variable as well as private versus public institutional clients in more detail.

4. Studies should utilize other self concept instruments which might possibly be more sensitive indicators of differences in self concept and pathological measures.

5. Studies should be done at various stages of hospitalization of the psychopathologically disturbed client to see if changes are evident in the self concept and in what direction.

6. Grouping of this population was based upon already given psychiatric diagnosis. To confirm that less severe diagnosis is given to the younger client, a panel of judges could judge blindly the individual profiles of each client given self concept tests with subsequent diagnostic labeling following perusal of the profiles.

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APPENDIX A

PROBLEM CHECK LIST

NAME:_____ DATE:_____

Here is a list of problems which many people have---problems relating to health, work, family, temperament, and so on. Please read through the list and check those statements that represent your problems.

( ) Poor living conditions.
( ) Lacking self-confidence.
( ) Not being really smart enough.
( ) Being physically unattractive.
( ) Needing a philosophy of life.
( ) Feeling I am too different.
( ) People finding fault with me.
( ) Feeling no one cares for me.
( ) Feeling life is not worthwhile.
( ) Trying to forget an unpleasant experience.

( ) Daydreaming
( ) Poor appetite.
( ) Confused in my religious beliefs.
( ) Stomach trouble.
( ) Needing a job.
( ) Too much interfering by relatives.
( ) Wishing I had a different family.
( ) Needing information about sex.
( ) Not knowing how to look for a job.
( ) Finding sex hard to control.

( ) Getting into debt.
( ) Having a poor memory.
( ) Lacking ambition.
( ) Being led too easily by others.
( ) Feeling ill at ease with other people.
( ) Not knowing my vocational abilities.
( ) Constantly worrying.
( ) Too emotional.
( ) Too nervous or high strung.
( ) Feeling inferior.

( ) Worrying how I impress people.
( ) Not getting along well with people.
( ) Not really having any friends.
( ) Having to live with relatives.
( ) Too much quarreling at home.
( ) Having difficulty in making decisions.
( ) Feeling I am a failure.
( ) Thinking too much about sex.
( ) Working too hard.
( ) Finding my work too boring.

( ) Afraid of Marriage.
( ) Having trouble with my speech.
( ) Needing legal advice.
( ) Not having enough social life.

( ) Speaking or acting without thinking.
( ) Being stubborn.
( ) Having trouble understanding what I read.

( ) Being too jealous.
( ) Being disliked by someone.
( ) Being left out of things.
( ) Being treated unfairly.
( ) Not being understood by my family.

( ) Feeling forgotten by my family.
( ) Having an unhappy home life.
( ) Disappointed in a love affair.
( ) Headaches.
( ) Troubled by lack of religious faith in others.

( ) Muscular aches and pains.
( ) No steady income.
( ) Getting into arguments or fights.
( ) Disliking certain persons.
( ) Feeling blue and moody.

( ) Unhappy too much of the time.
( ) Sometimes afraid of going insane.
( ) Bothered by thoughts running through my head.

( ) Bothered by thoughts of suicide.
( ) Sometimes feeling forced to do things.
( ) Having a guilty conscience.
( ) Giving into temptation.
( ) Needing advice about marriage.

( ) Having unusual sex desires.
( ) Sexual desires unsatisfied.
( ) Hearing voices.
( ) Strange experiences.
( ) In trouble with the law.

( ) Drinking too much.
( ) Life may be in danger.
( ) Others trying to control my thoughts.
( ) Shouldn't be in the hospital.
( ) Committed unjustly.

APPENDIX B

INDIVIDUAL TENNESSEE SELF CONCEPT SCALE PROFILES

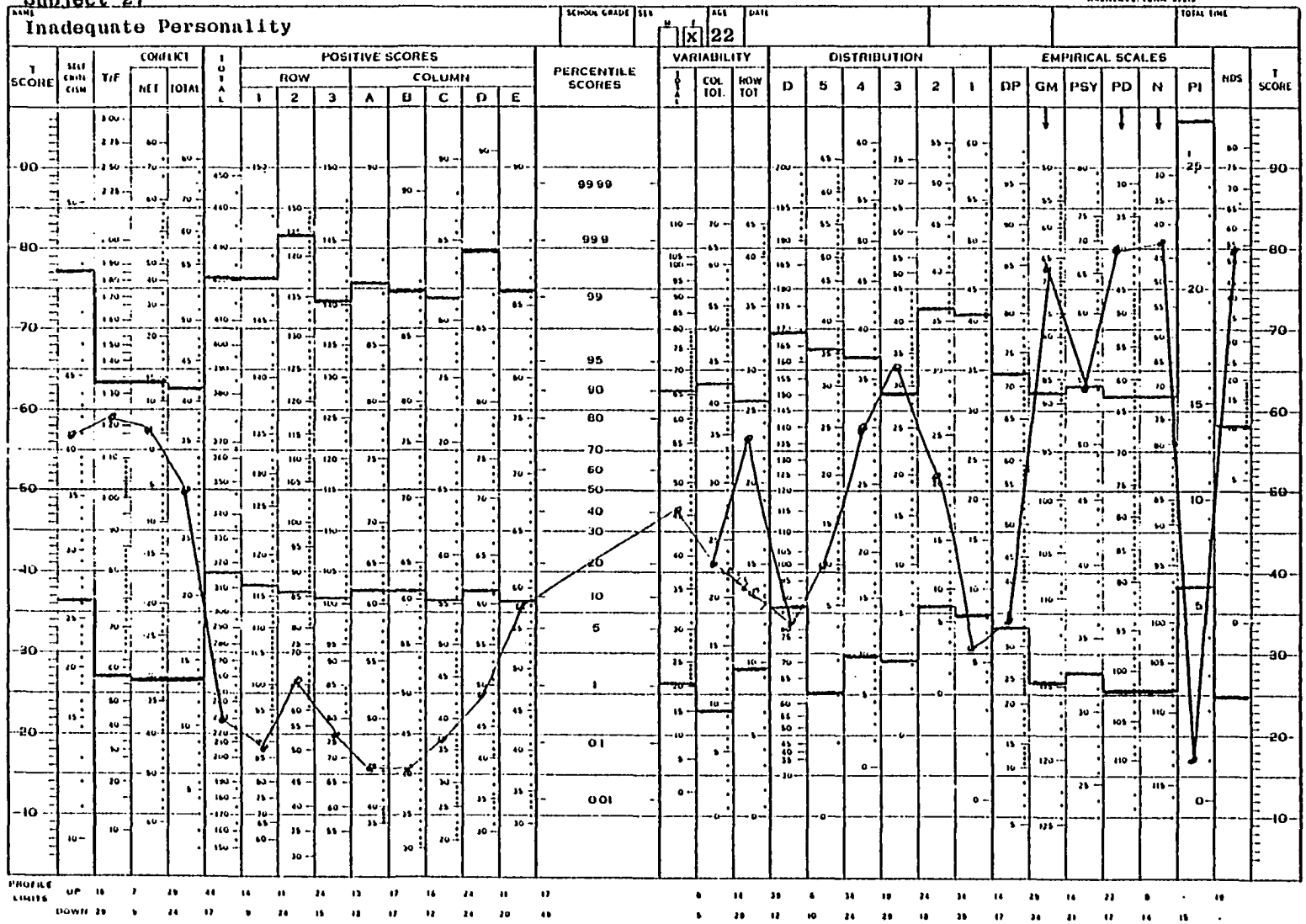
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 27

Inadequate Personality



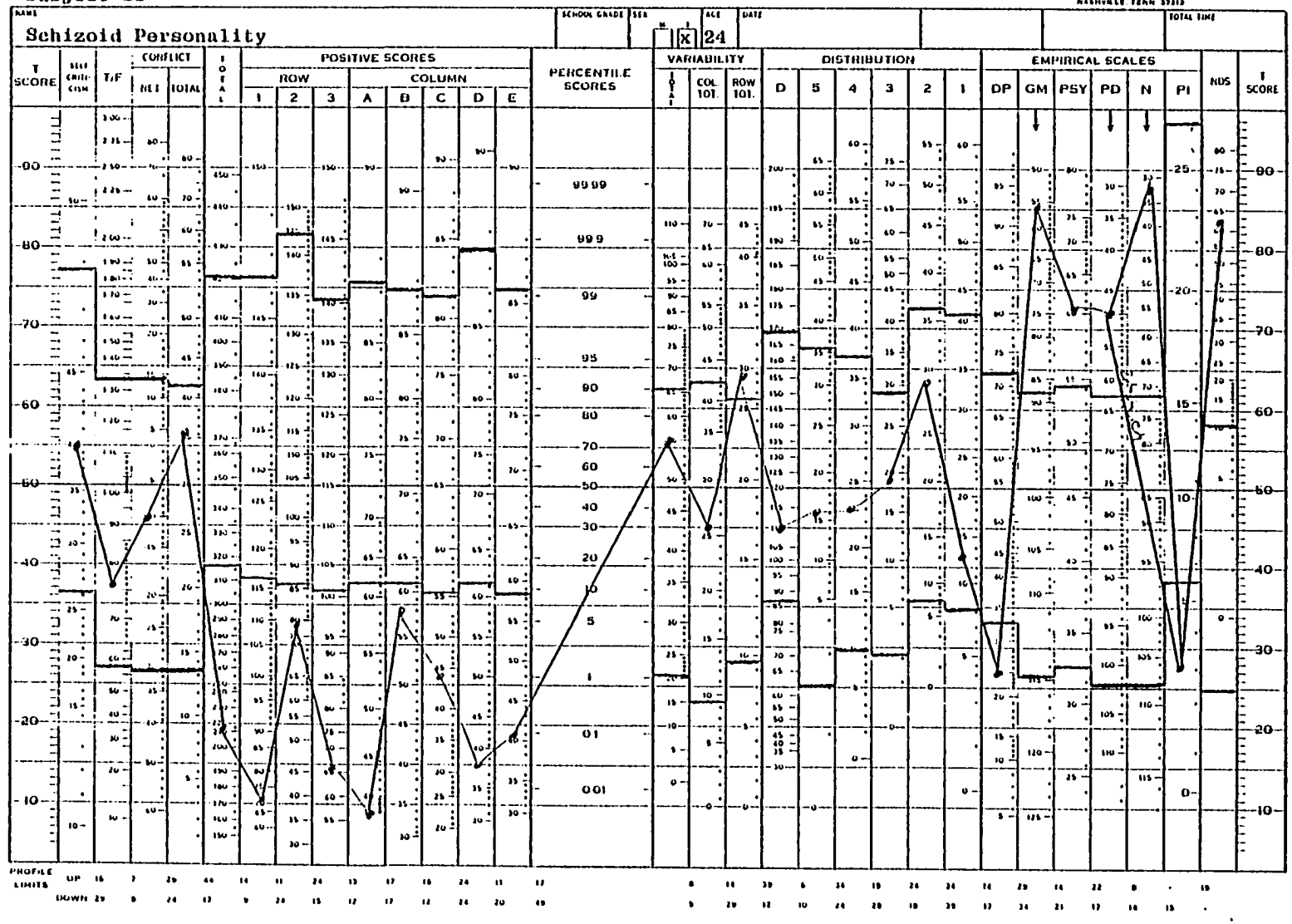
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 11

Schizoid Personality



Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 8

Obsessive-Compulsive Personality

SCHOOL GRADE | SEX M X F | AGE 25 | DATE | TOTAL TIME

T SCORE | SELF CRITICISM | T/F | CONFLICT: NET, TOTAL | TOTAL | POSITIVE SCORES: ROW 1 2 3, COLUMN A B C D E | PERCENTILE SCORES | VARIABILITY: TOTAL, COL. TOT., ROW TOT. | DISTRIBUTION: D 5 4 3 2 1 | EMPIRICAL SCALES: DP GM PSY PD N PI | NDS | T SCORE

PERCENTILE SCORES: 9999, 999, 99, 95, 90, 80, 70, 60, 50, 40, 30, 20, 10, 5, 1, .01, .001

PROFILE LIMITS: UP / DOWN

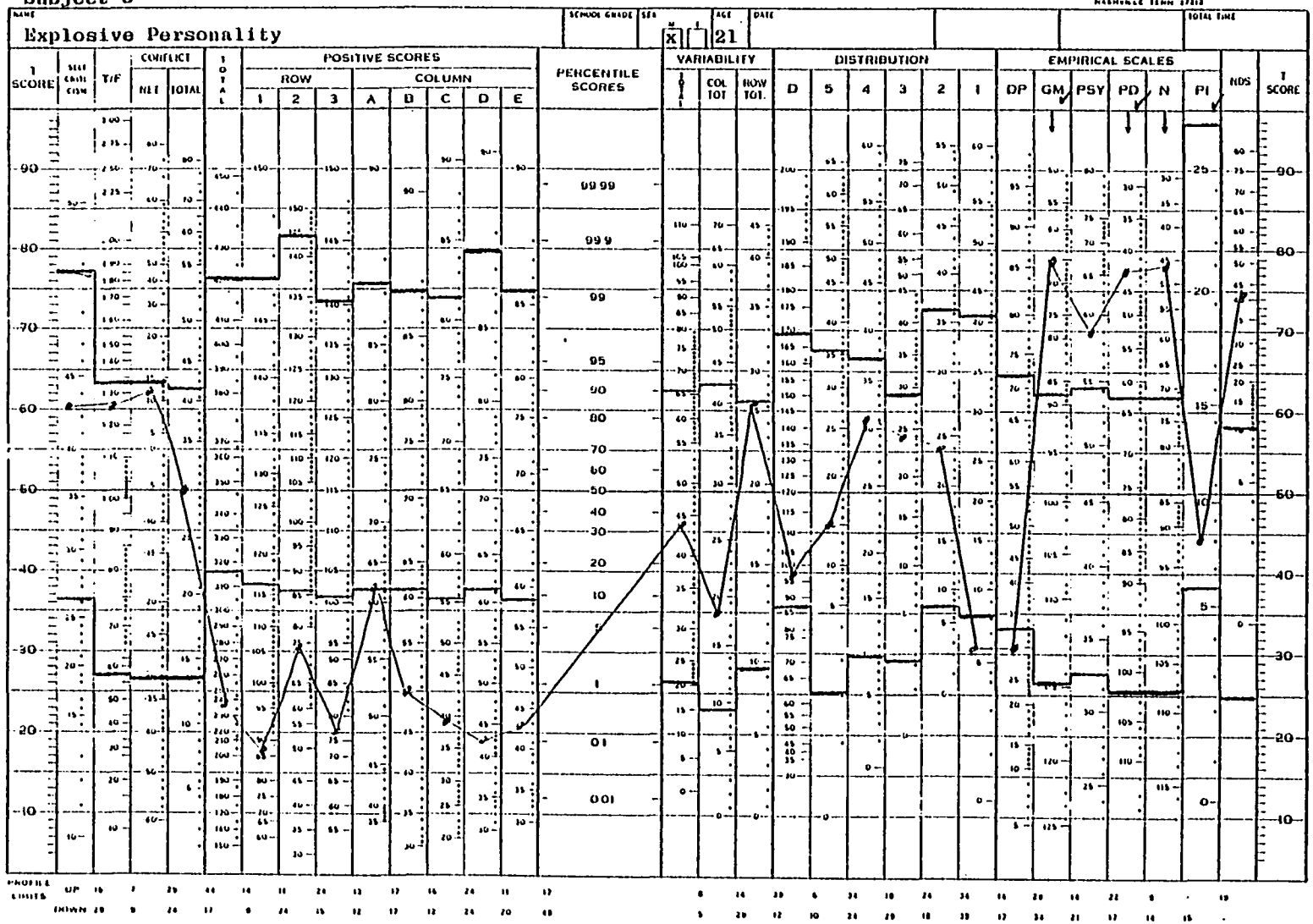
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 5

Explosive Personality



Tennessee Self Concept Scale

Subject 42

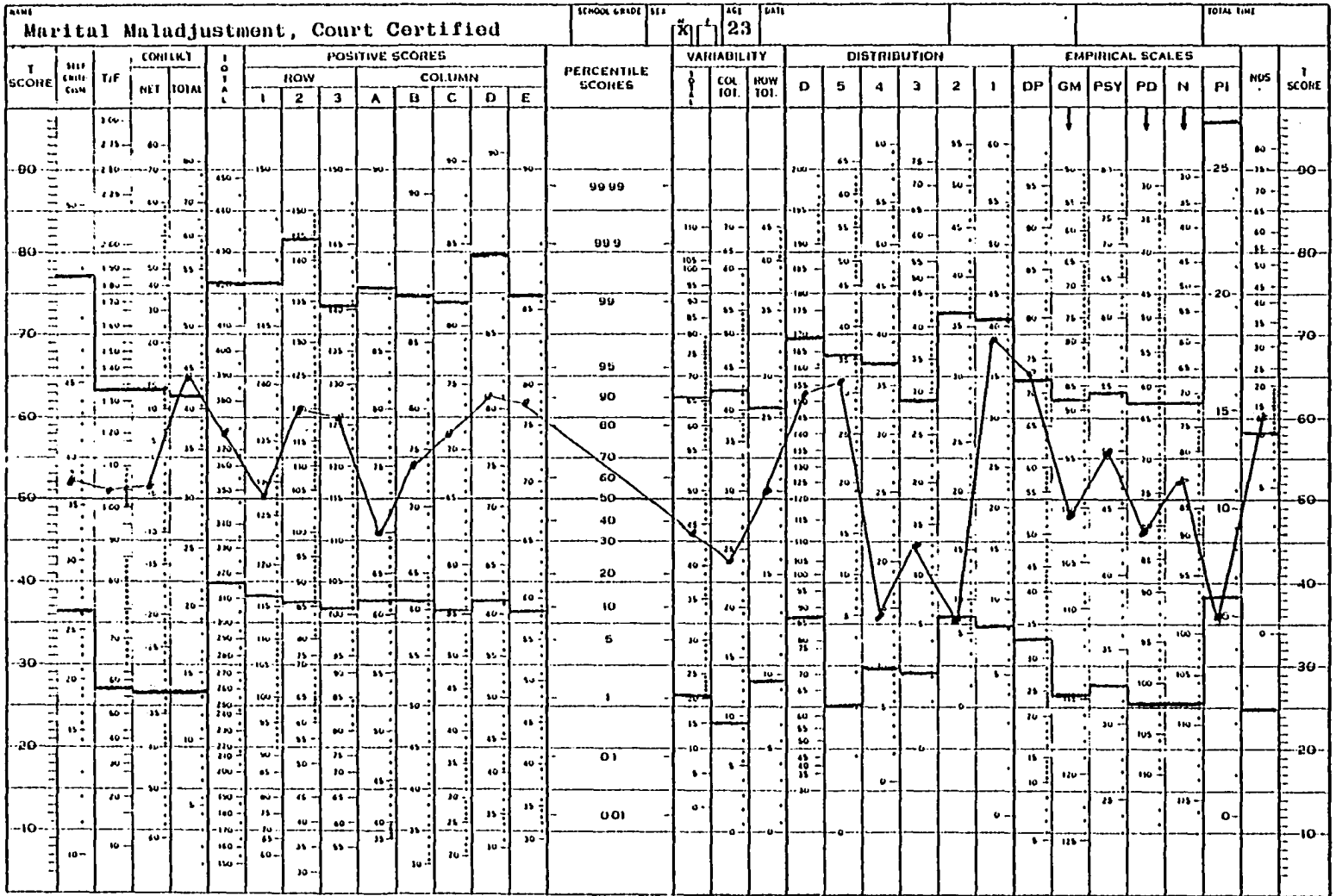
PROFILE SHEET

Clinical and Research Form

PUBLISHED BY
COUNSELOR RECORDINGS AND TESTS
BOX 6184 ACKLEN STA
NASHVILLE, TENN 37212

NAME: Marital Maladjustment, Court Certified

SCHOOL GRADE | SEX | AGE: 23 | DATE | TOTAL TIME



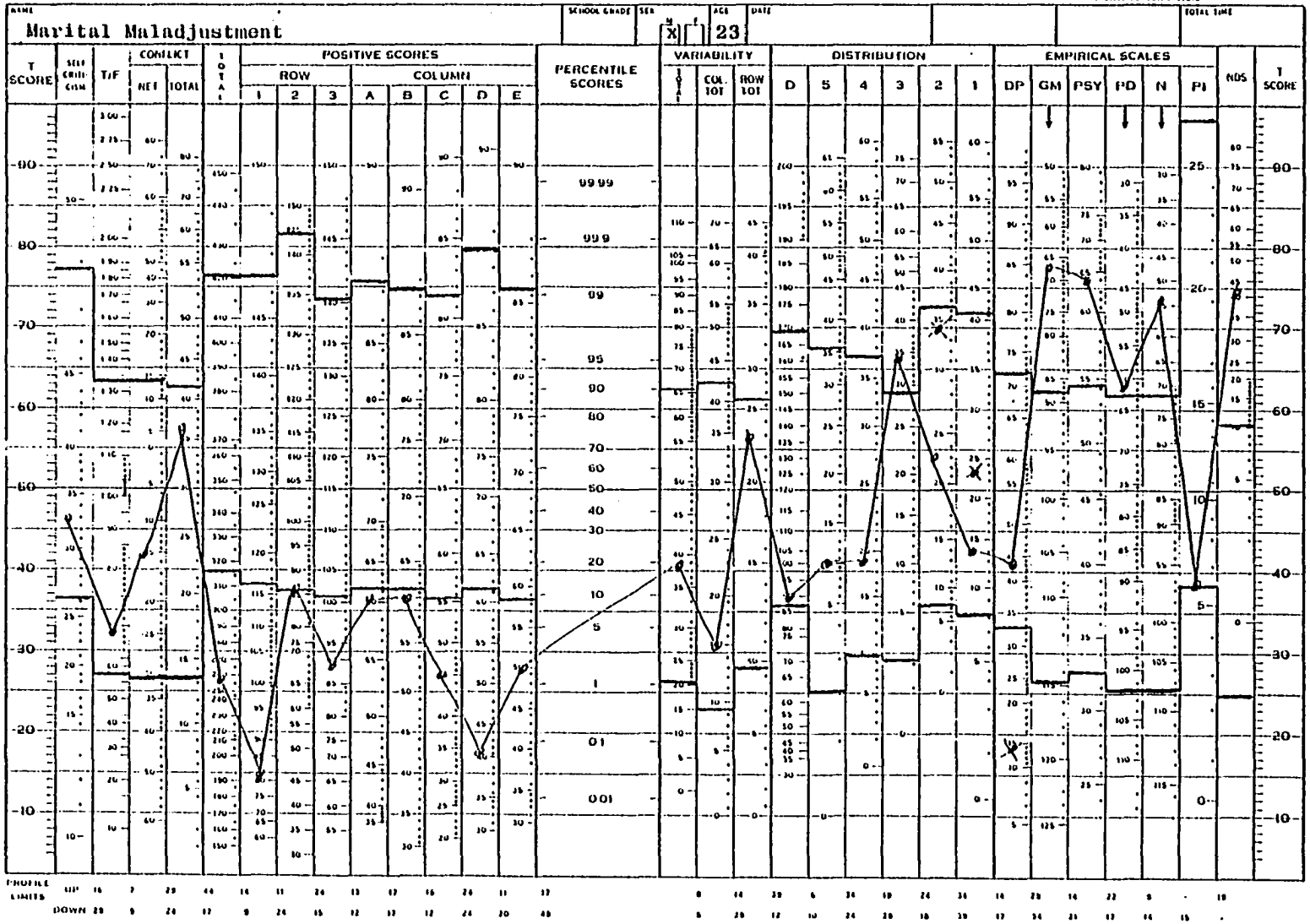
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 38

Marital Maladjustment

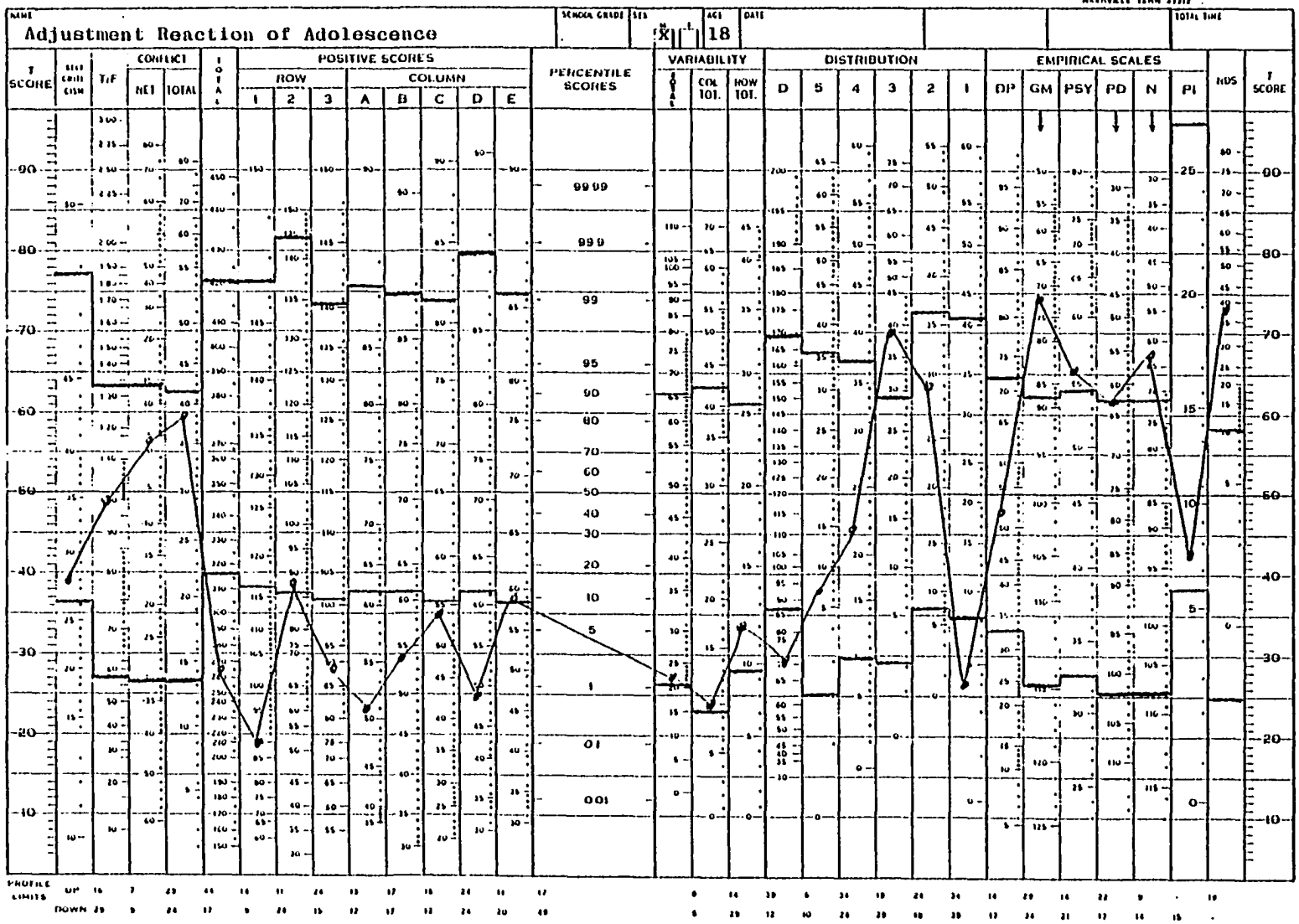


Tennessee Self Concept Scale

Subject 37

PROFILE SHEET

Clinical and Research Form

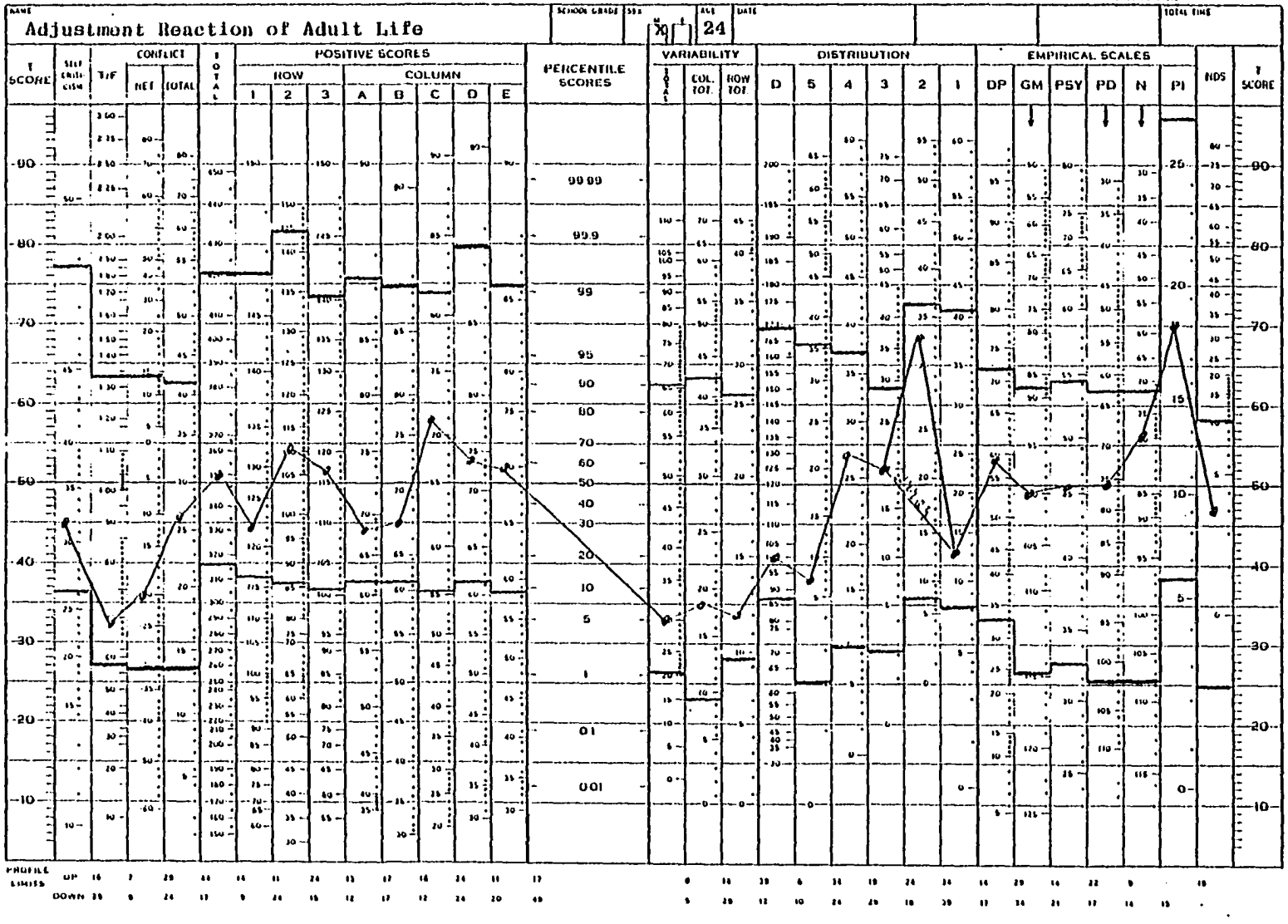


Tennessee Self Concept Scale

Subject 30

PROFILE SHEET

Clinical and Research Form

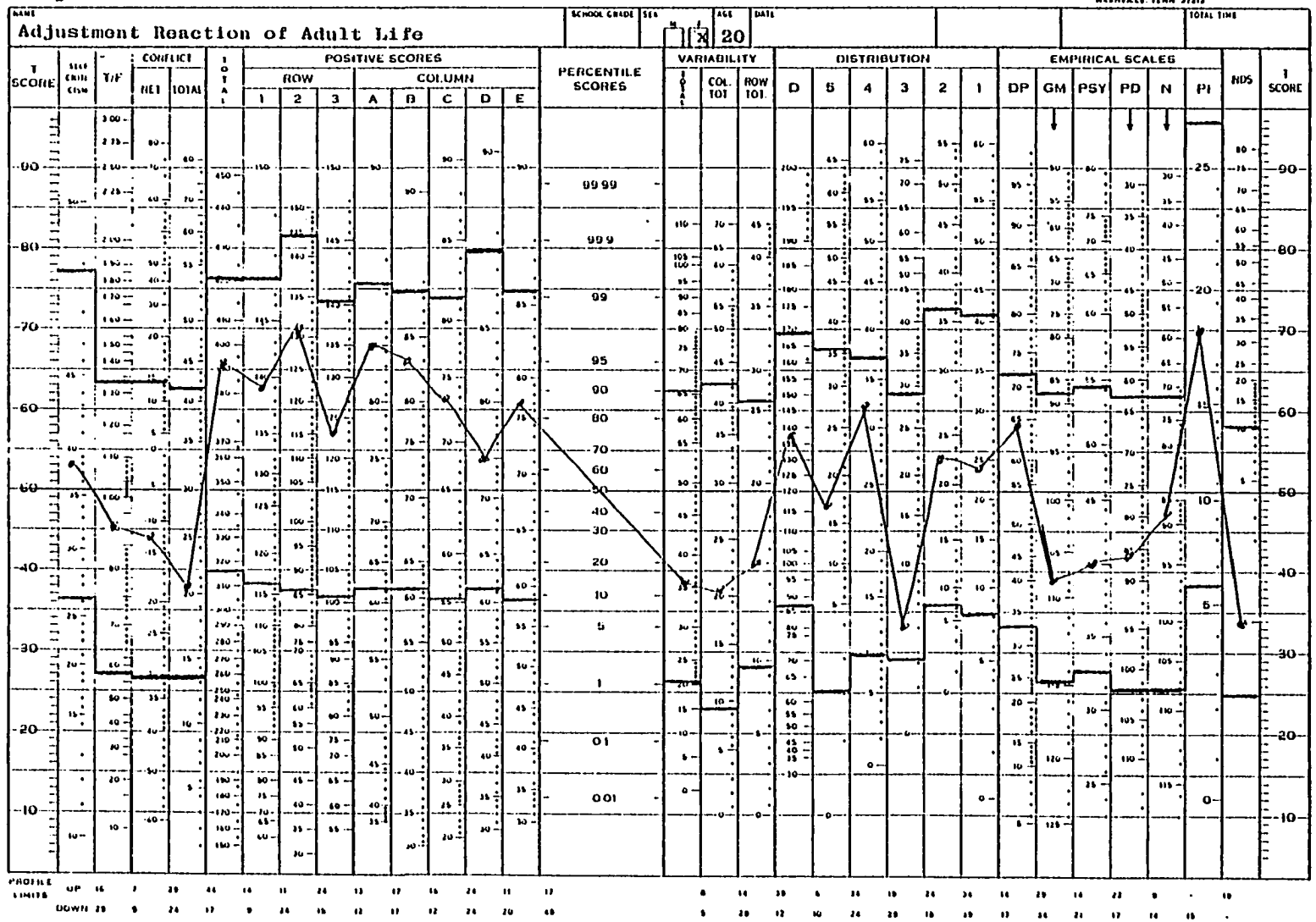


Tennessee Self Concept Scale

Subject 25

PROFILE SHEET

Clinical and Research Form

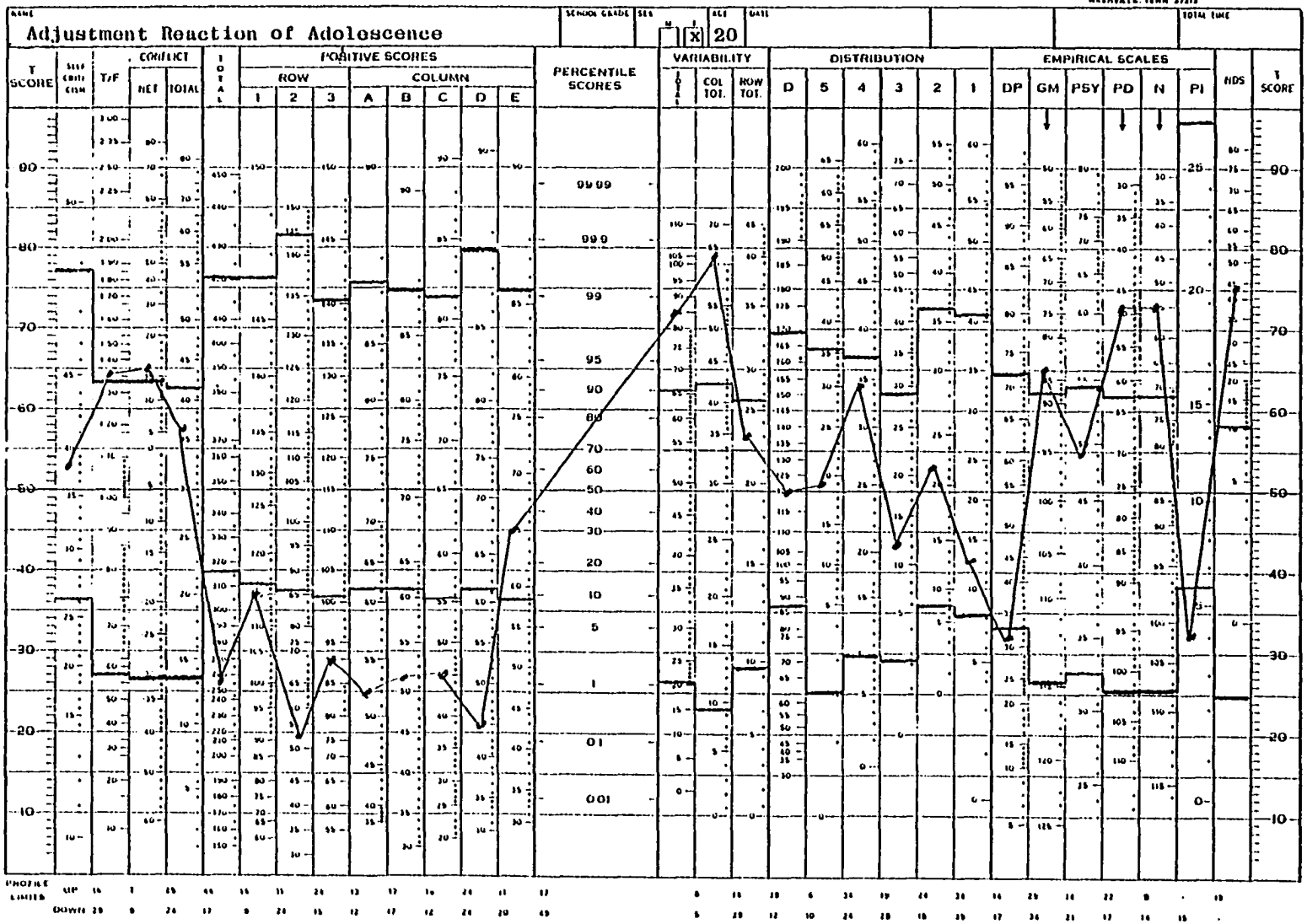


Tennessee Self Concept Scale

Subject 20

PROFILE SHEET

Clinical and Research Form



Tennessee Self Concept Scale

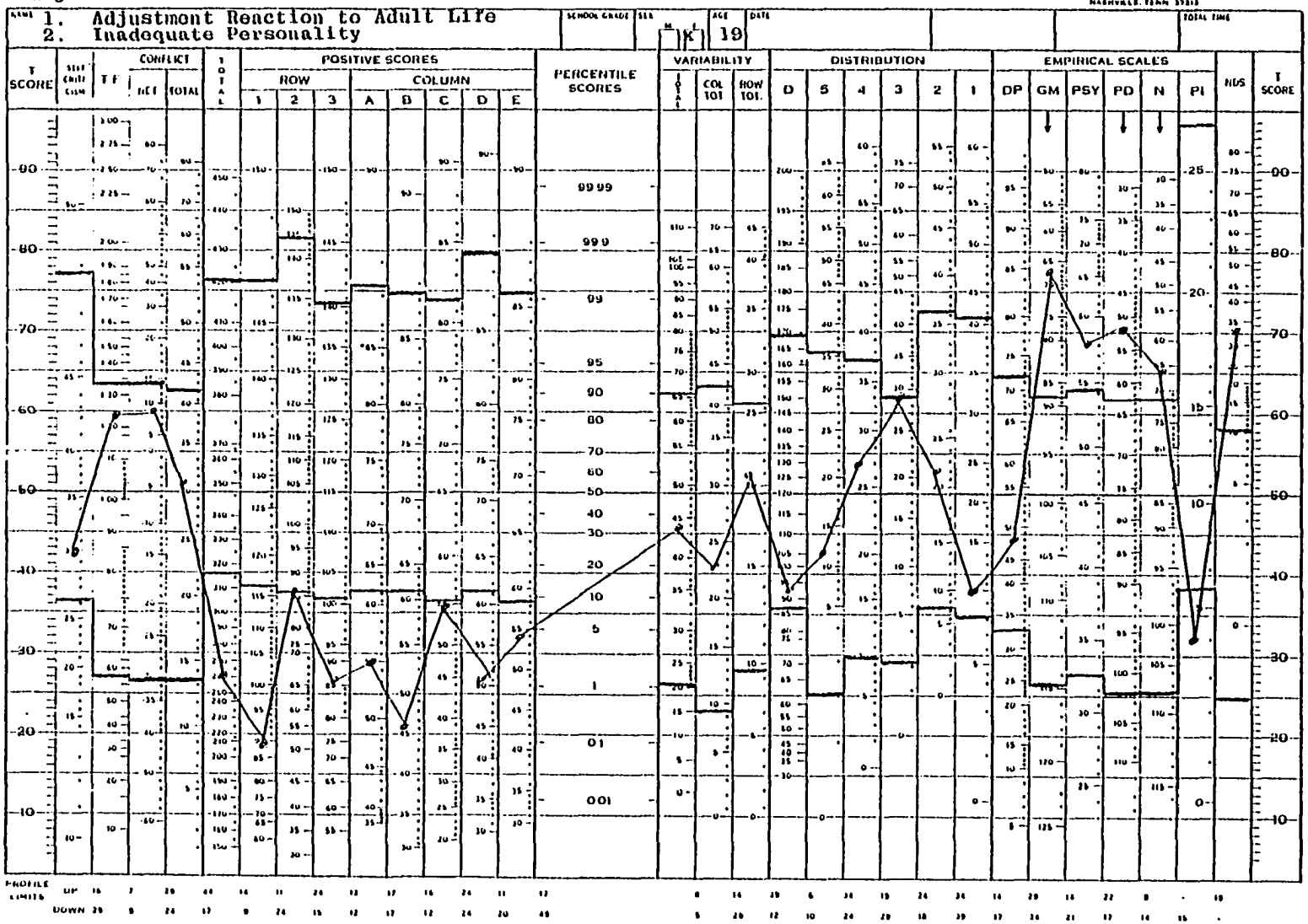
Subject 19

PROFILE SHEET

Clinical and Research Form

1. Adjustment Reaction to Adult Life
2. Inadequate Personality

AGE 19

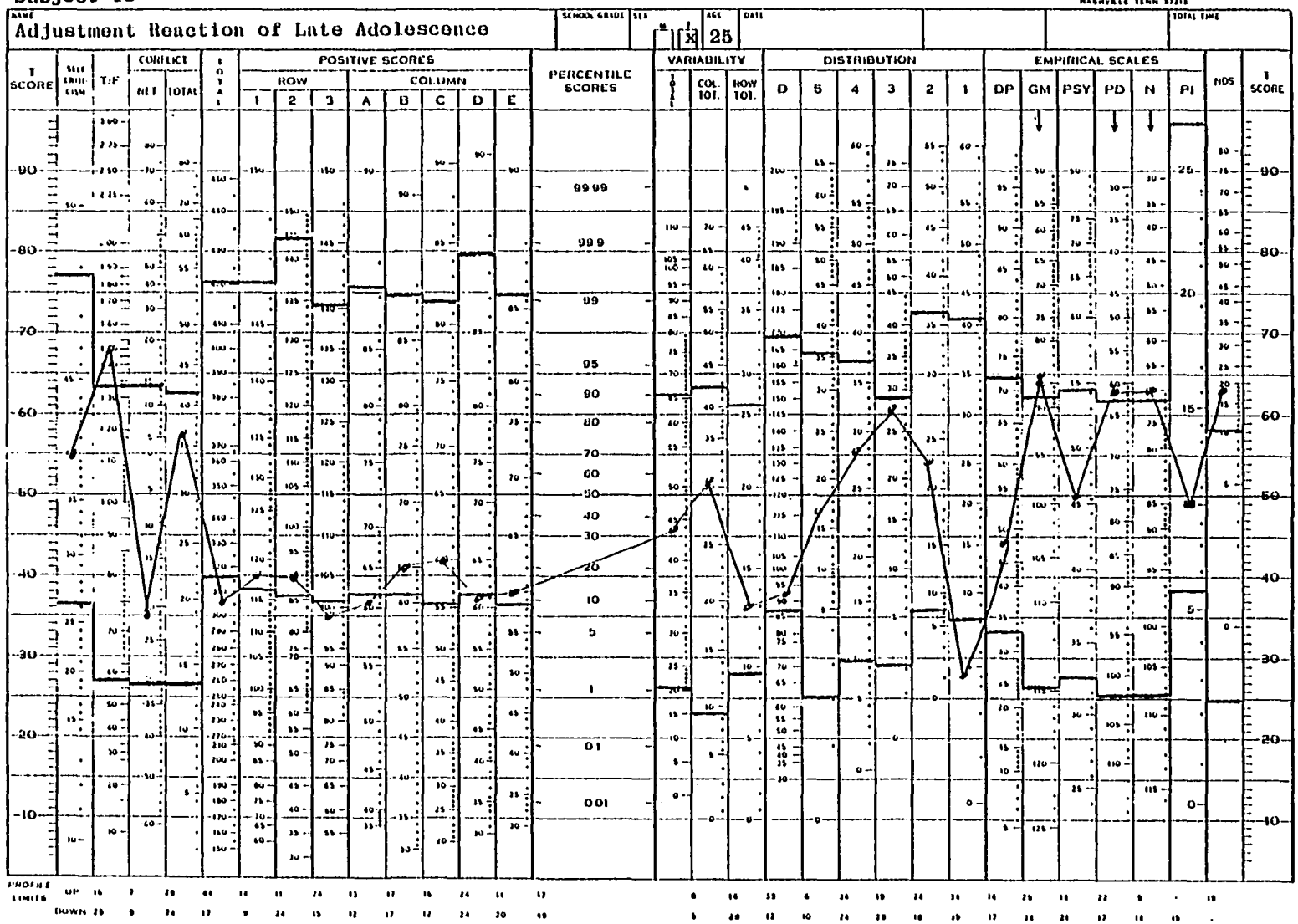


Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 18

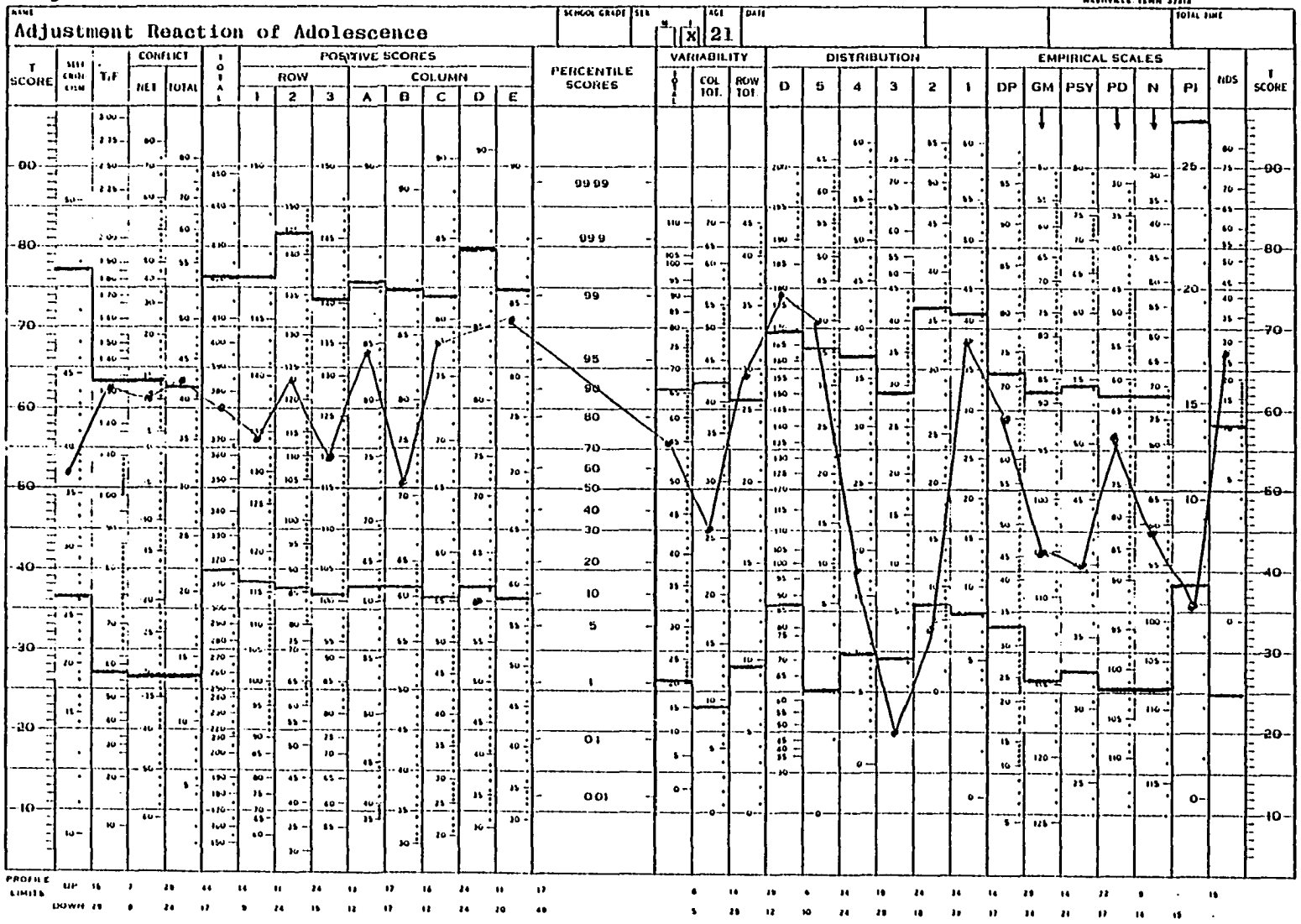


Tennessee Self Concept Scale

Subject 14

PROFILE SHEET

Clinical and Research Form

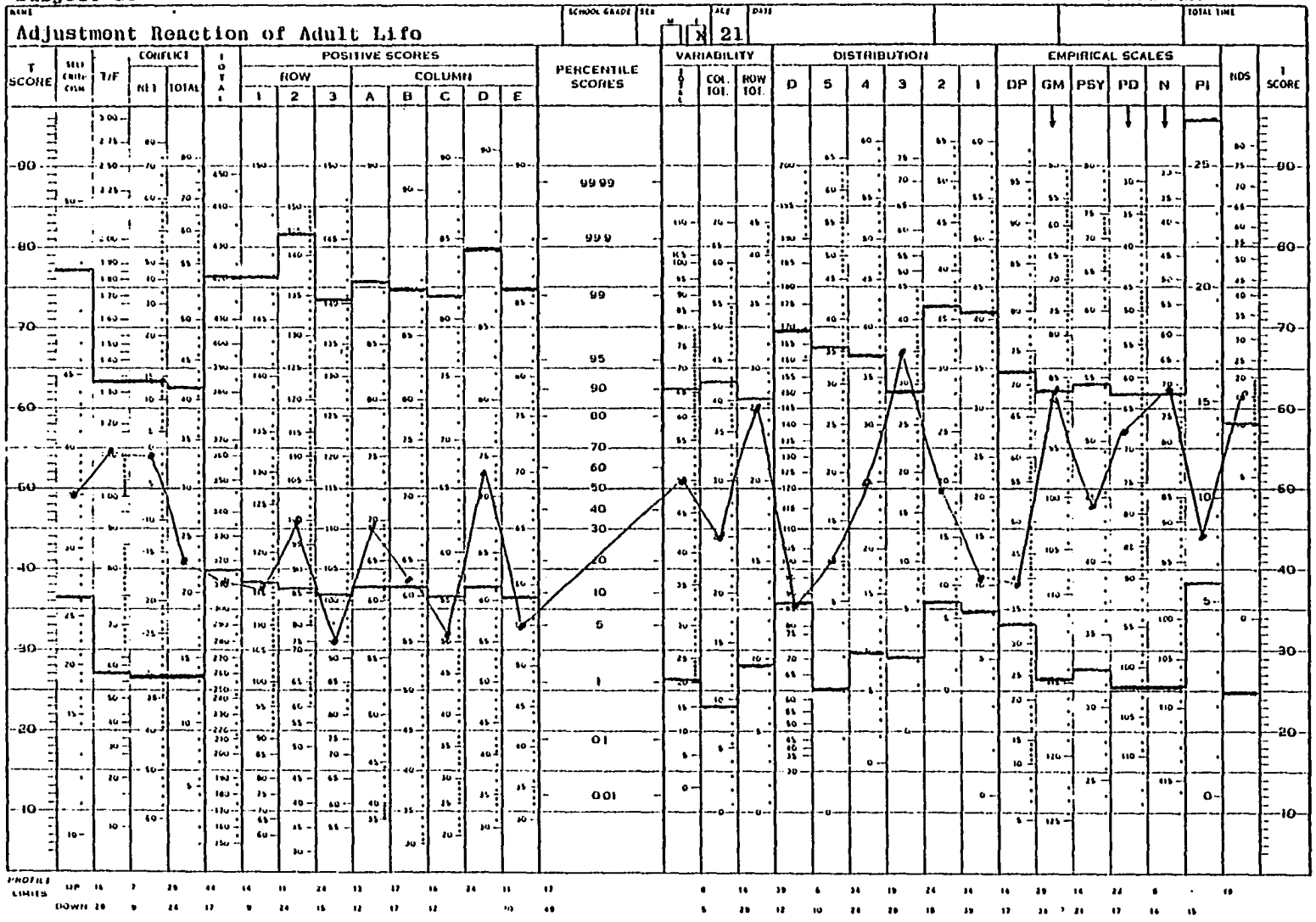


Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 10



Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 1

NAME: Adjustment Reaction of Adolescence

SCHOOL GRADE | SEX: M / F: X | AGE: 18 | DATE | TOTAL TIME

T SCORE | SELF CRITICISM | CONFLICT: T/F, NET, TOTAL | TOTAL | POSITIVE SCORES: ROW 1 2 3, COLUMN A B C D E | PERCENTILE SCORES | VARIABILITY: TOTAL, COL. TOT., ROW TOT. | DISTRIBUTION: D 5 4 3 2 1 | EMPIRICAL SCALES: DP GM PSY PD N PI | NDS | T SCORE

PERCENTILE SCORES: 9999, 999, 99, 95, 90, 80, 70, 60, 50, 40, 30, 20, 10, 5, 1, 01, 001

PROFILE LIMITS: UP 16 7 28 44 14 11 24 13 17 16 24 11 17 | 0 16 39 6 34 19 24 36 16 28 16 22 8 - 19

DOWN 25 9 24 17 9 24 15 12 17 12 24 20 49 | 5 25 12 10 24 29 18 39 17 14 21 17 14 15 -

Tennessee Self Concept Scale

PROFILE SHEET

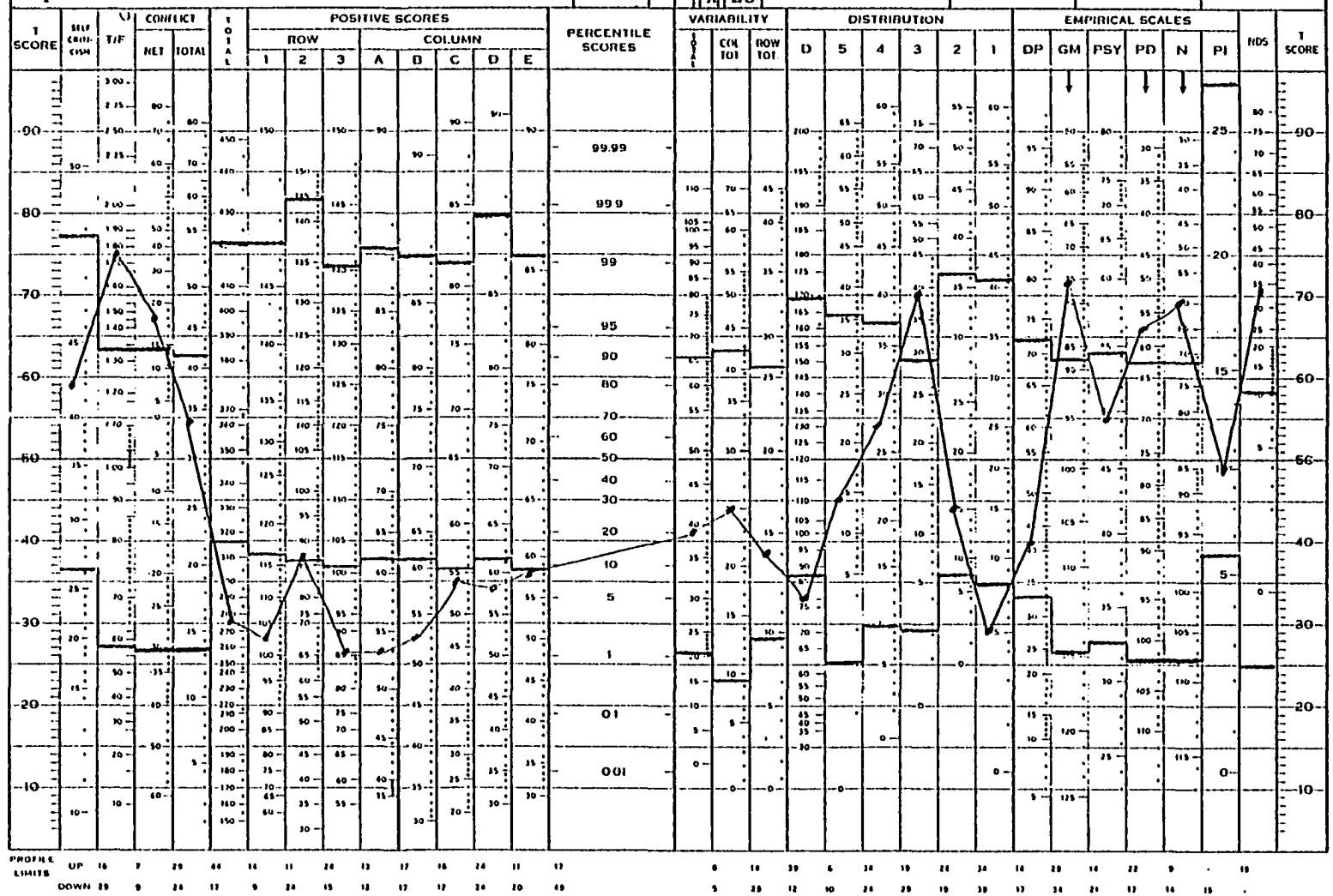
Clinical and Research Form

PUBLISHED BY
COUNSELOR RECORDINGS AND TESTS
BOX 518 C ACKLEN STA
NASHVILLE TENN 37215

Subject 22

NAME: Depressive Neurosis

SCHOOL GRADE | SEX: M [ ] F [X] | AGE: 23 | DATE | TOTAL TIME



Tennessee Self Concept Scale

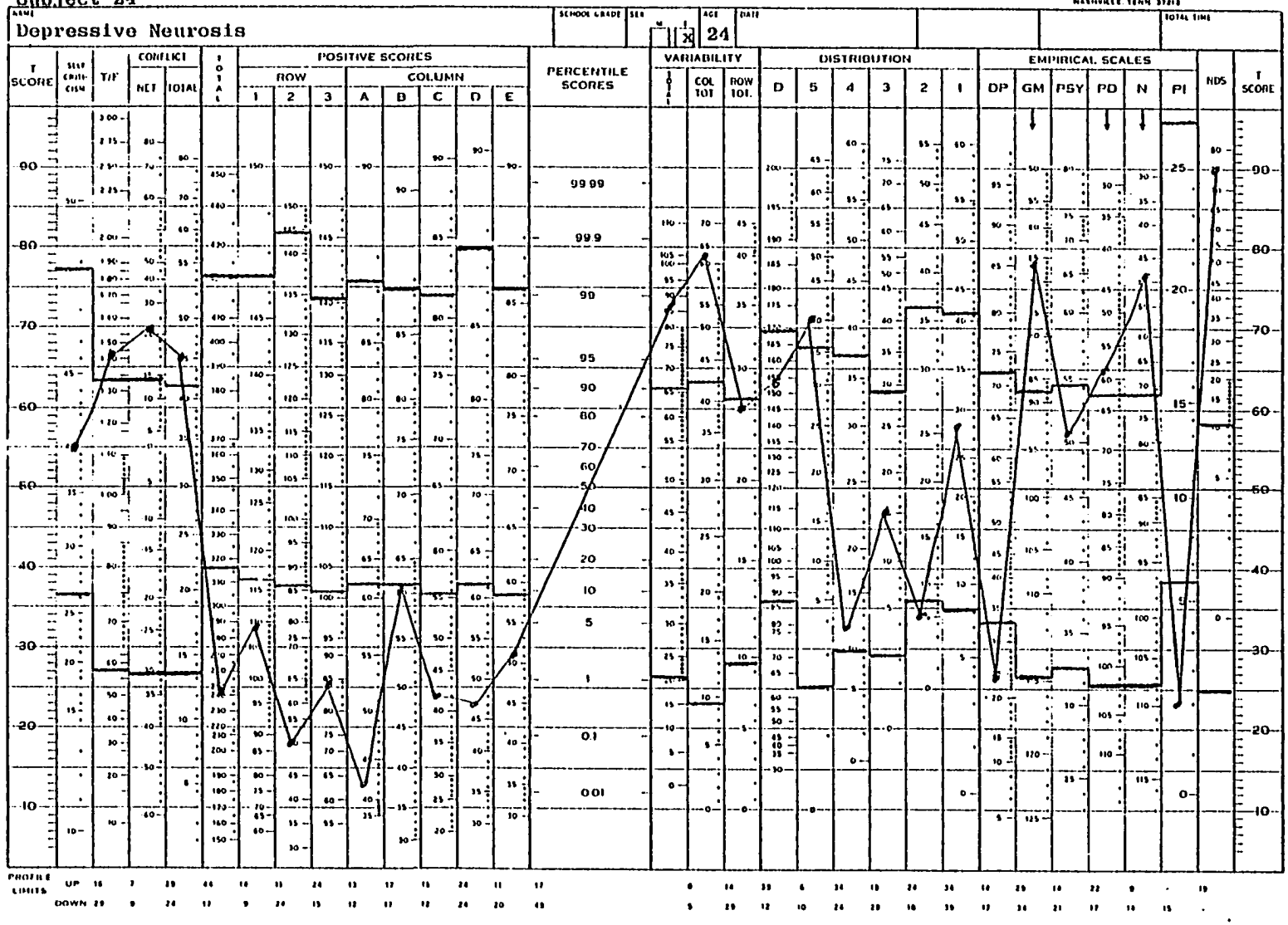
PROFILE SHEET

Clinical and Research Form

Subject 24

NAME: Depressive Neurosis

SCHOOL GRADE | SEX: M / F X | AGE: 24 | DATE | TOTAL TIME



Tennessee Self Concept Scale

Subject 26

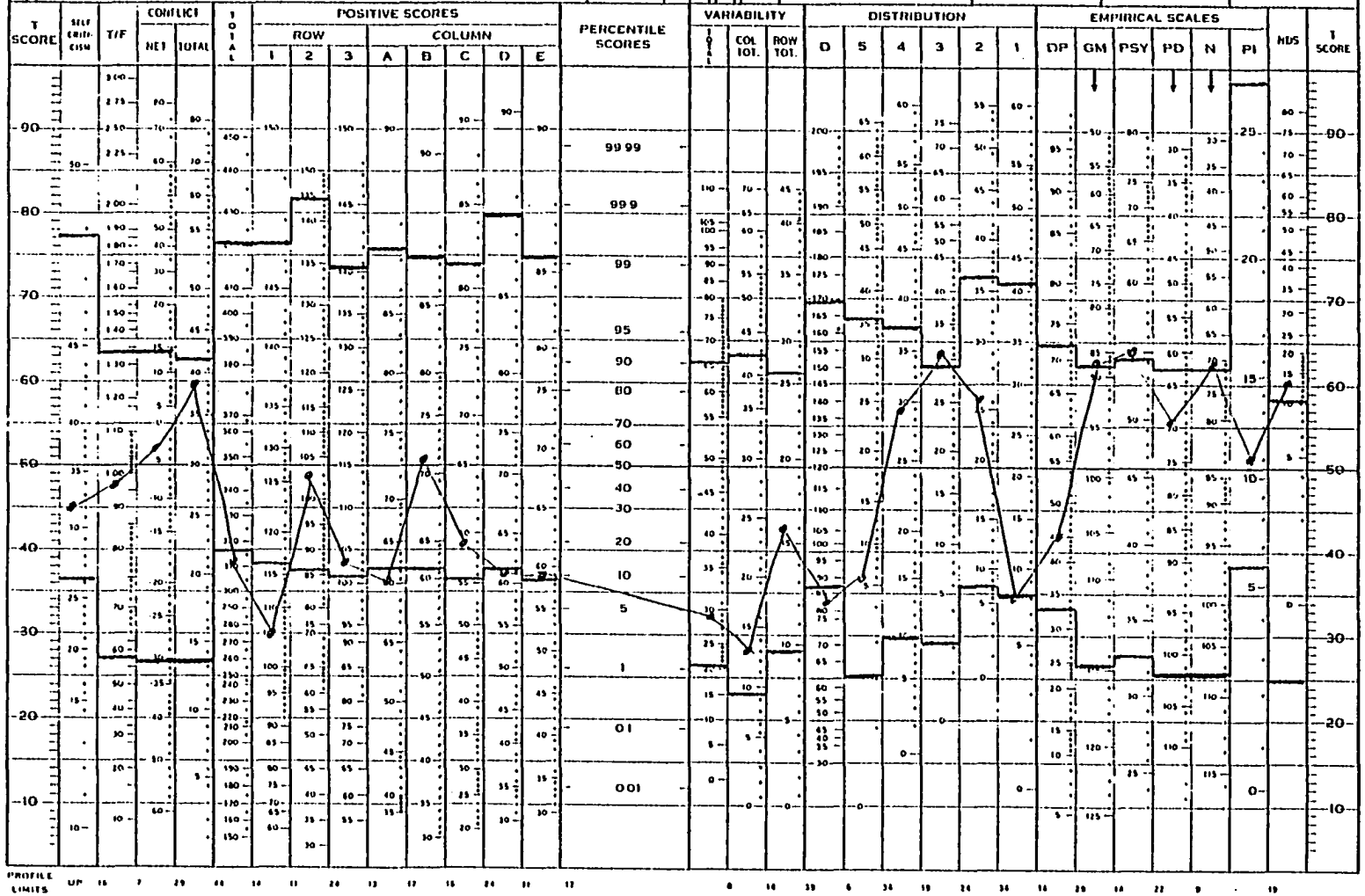
PROFILE SHEET

Clinical and Research Form

PUBLISHED BY:
COUNSELOR RECORDINGS AND TESTS
BOX 6184 ACKLEN STA
NASHVILLE, TENN 37212

NAME: Anxiety Neurosis

SCHOOL GRADE | SEX: M [X] F [ ] | AGE: 24 | DATE | TOTAL TIME



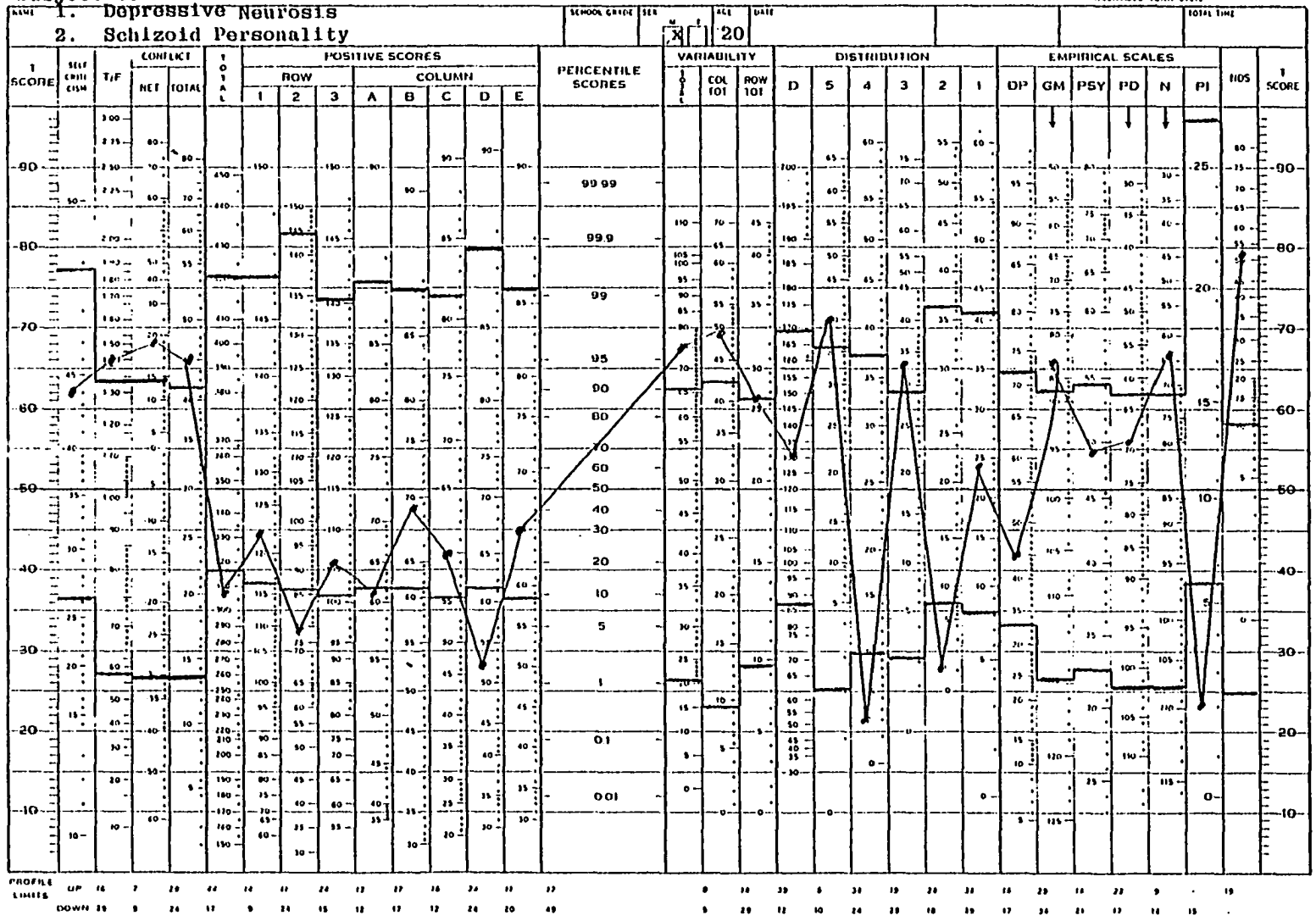
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 40

1. Depressive Neurosis
2. Schizoid Personality



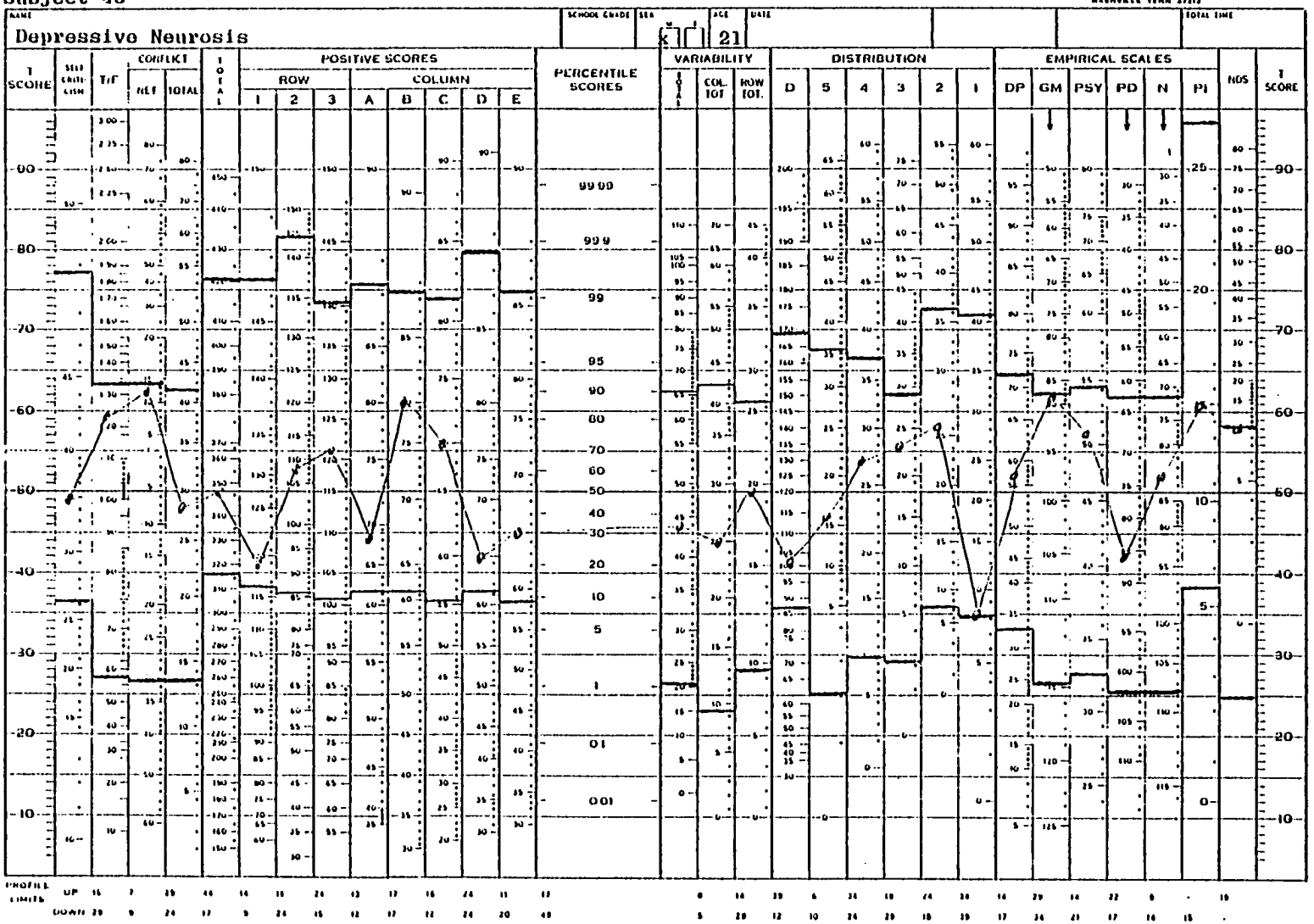
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 45

Depressive Neurosis



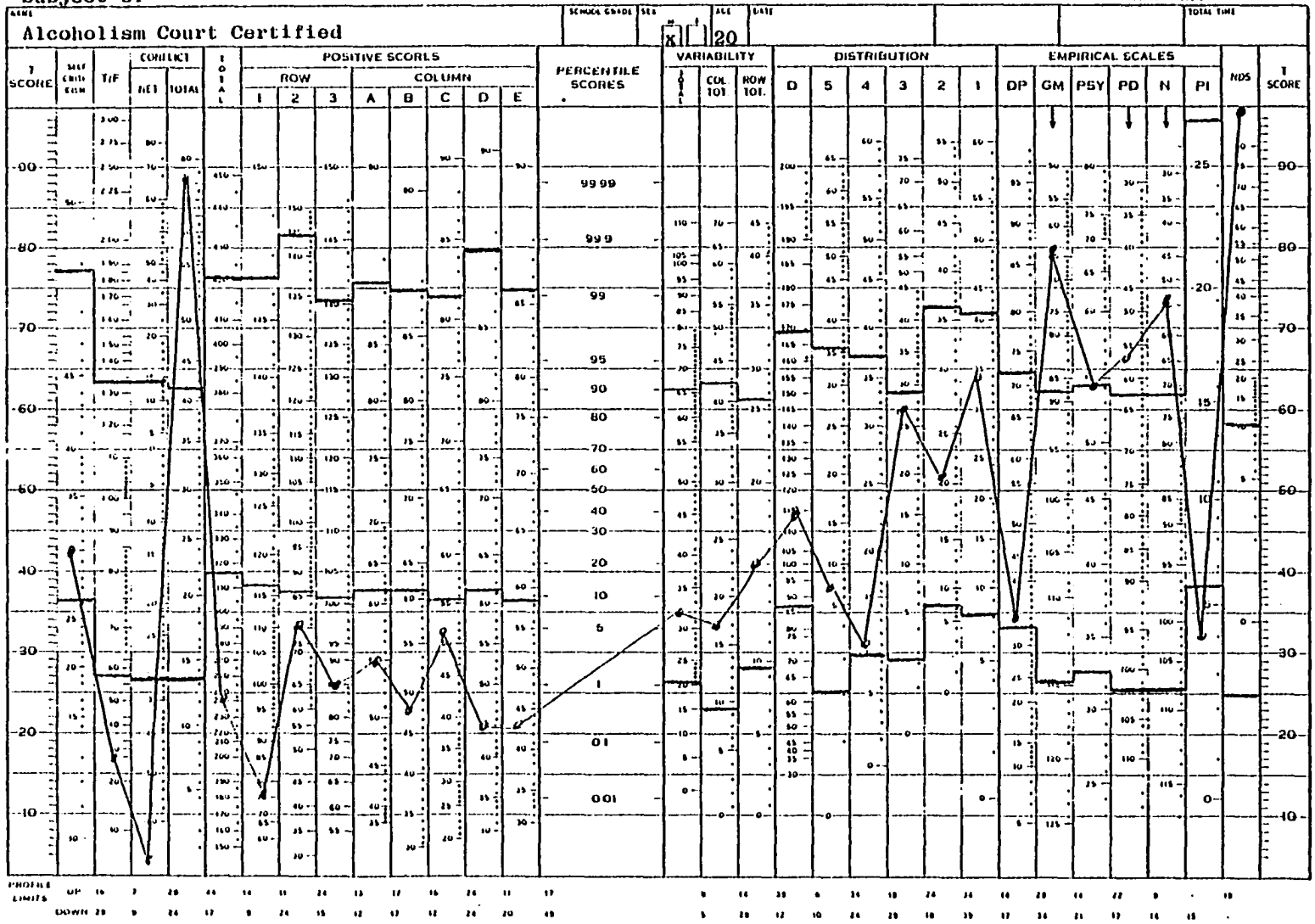
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 3T

Alcoholism Court Certified



Tennessee Self Concept Scale

Subject 18

PROFILE SHEET

Clinical and Research Form

Habitual Excessive Drinking

SCHOOL GRADE | SEX M X F | AGE 18 | DATE | TOTAL TIME

T SCORE | SELF CRITICISM | T/F | CONFLICT: NET, TOTAL | TOTAL | POSITIVE SCORES: ROW 1 2 3, COLUMN A B C D E | PERCENTILE SCORES | VARIABILITY: TOTAL, COL TOT., ROW TOT. | DISTRIBUTION: D 5 4 3 2 1 | EMPIRICAL SCALES: DP GM PSY PD N PI | NDS | T SCORE

PERCENTILE SCORES: 99.99, 99.9, 99, 95, 90, 80, 70, 60, 50, 40, 30, 20, 10, 5, 1, .01, .001

PROFILE LIMITS: UP 16 7 28 44 18 11 24 33 17 16 24 11 12 | 0 14 28 6 34 19 24 44 14 28 16 22 8 - 19

DOWN 28 0 24 17 0 25 15 12 17 12 24 20 45 | 0 28 12 10 24 28 18 38 17 34 21 17 14 15 -

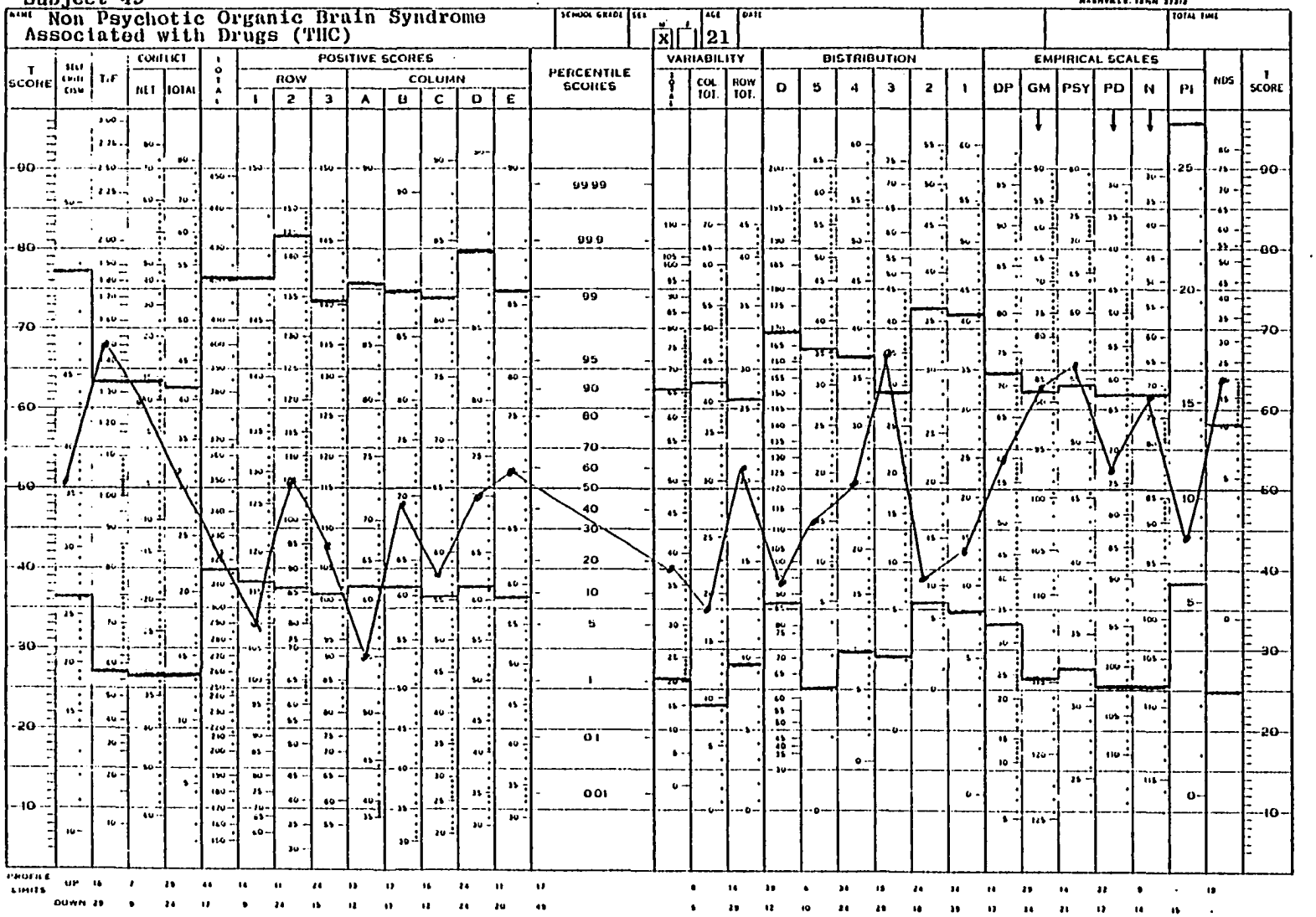
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 49

Non Psychotic Organic Brain Syndrome Associated with Drugs (THC)



Tennessee Self Concept Scale

Subject 48

PROFILE SHEET

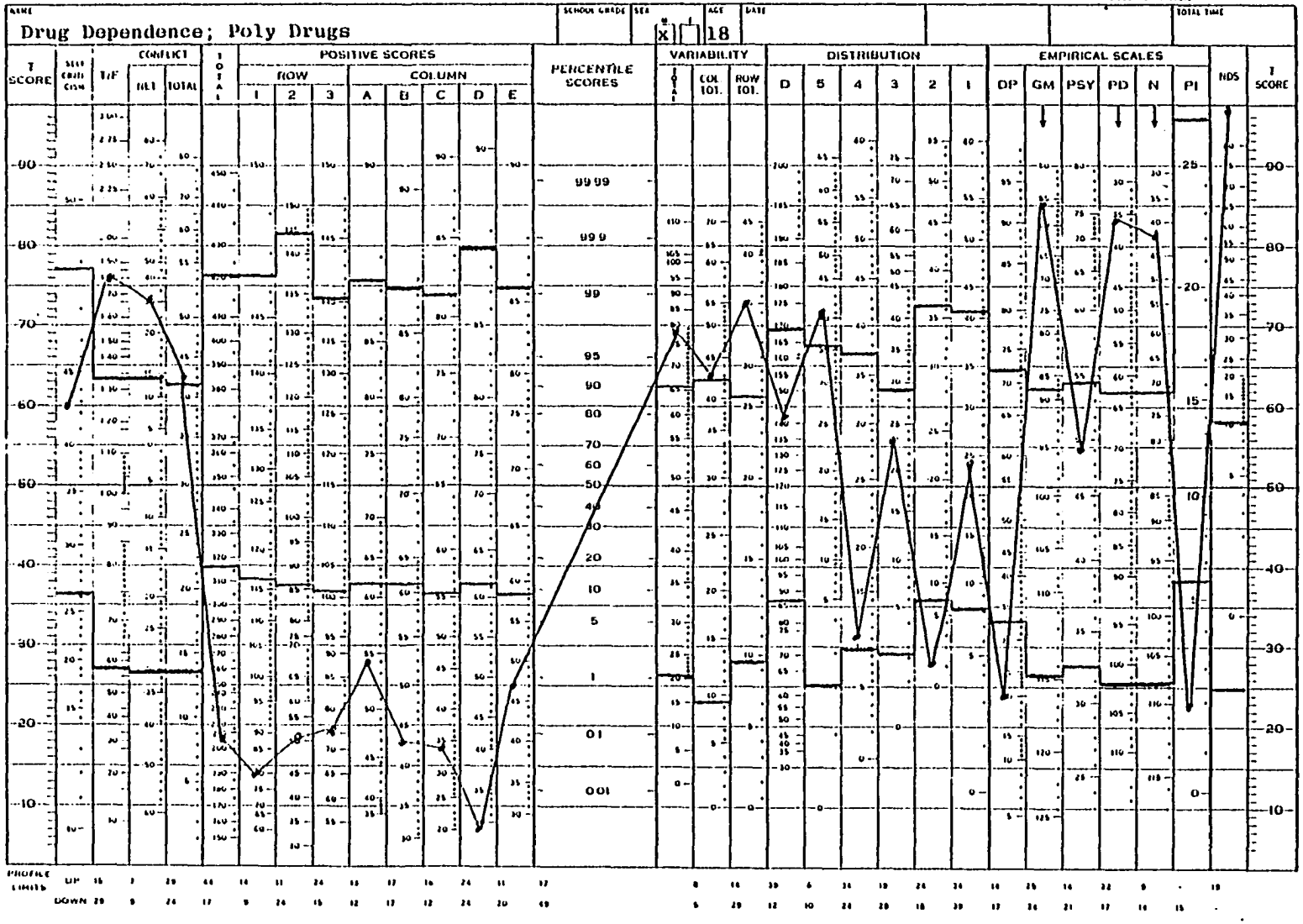
Clinical and Research Form

PUBLISHED BY:
COUNSELOR RECORDINGS AND TESTS
BOX 6184 ACKLEN STA
NASHVILLE, TENN 37212

Drug Dependence; Poly Drugs

SEX: M

AGE: 18



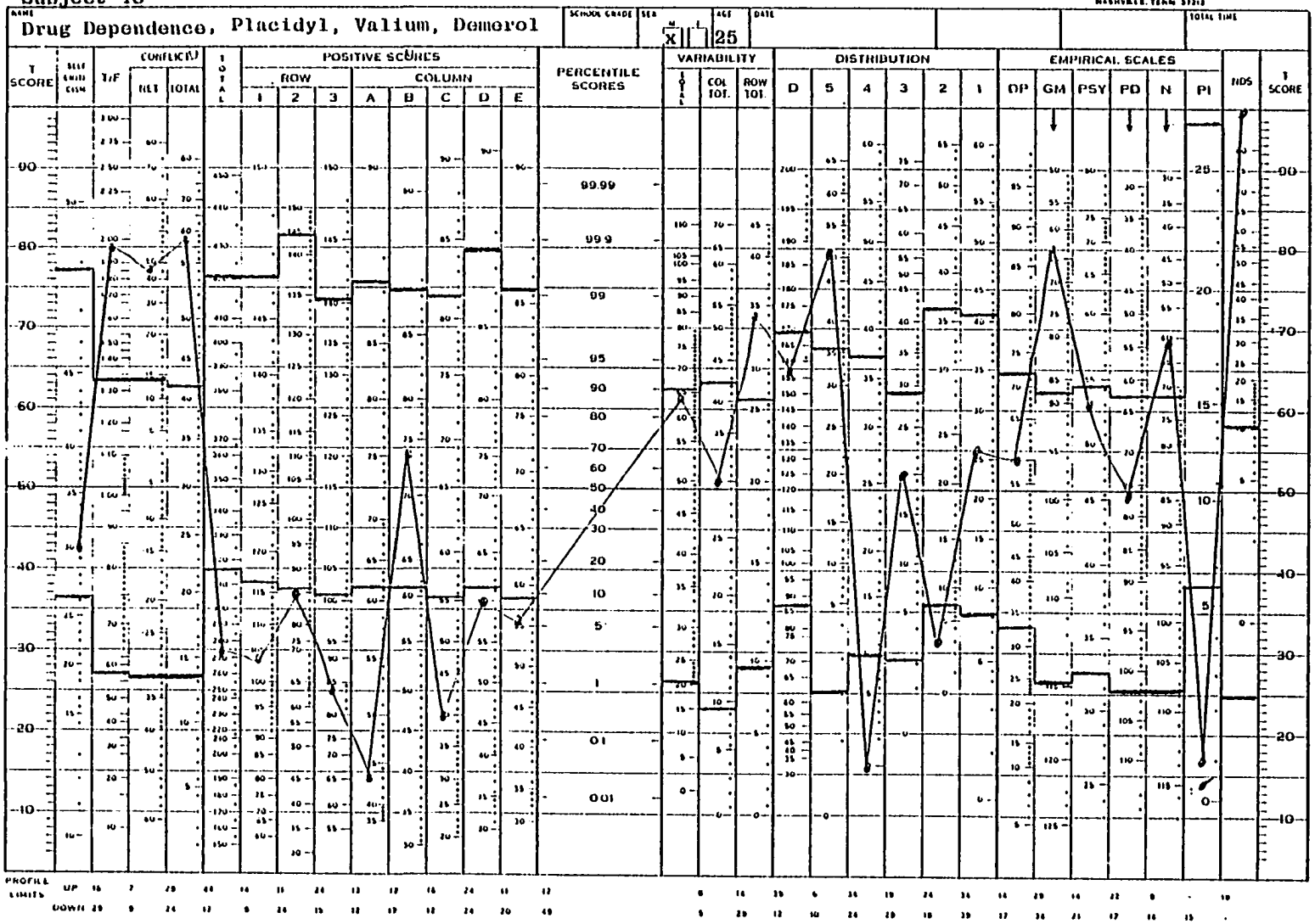
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 46

Drug Dependence, Placidyl, Valium, Demerol



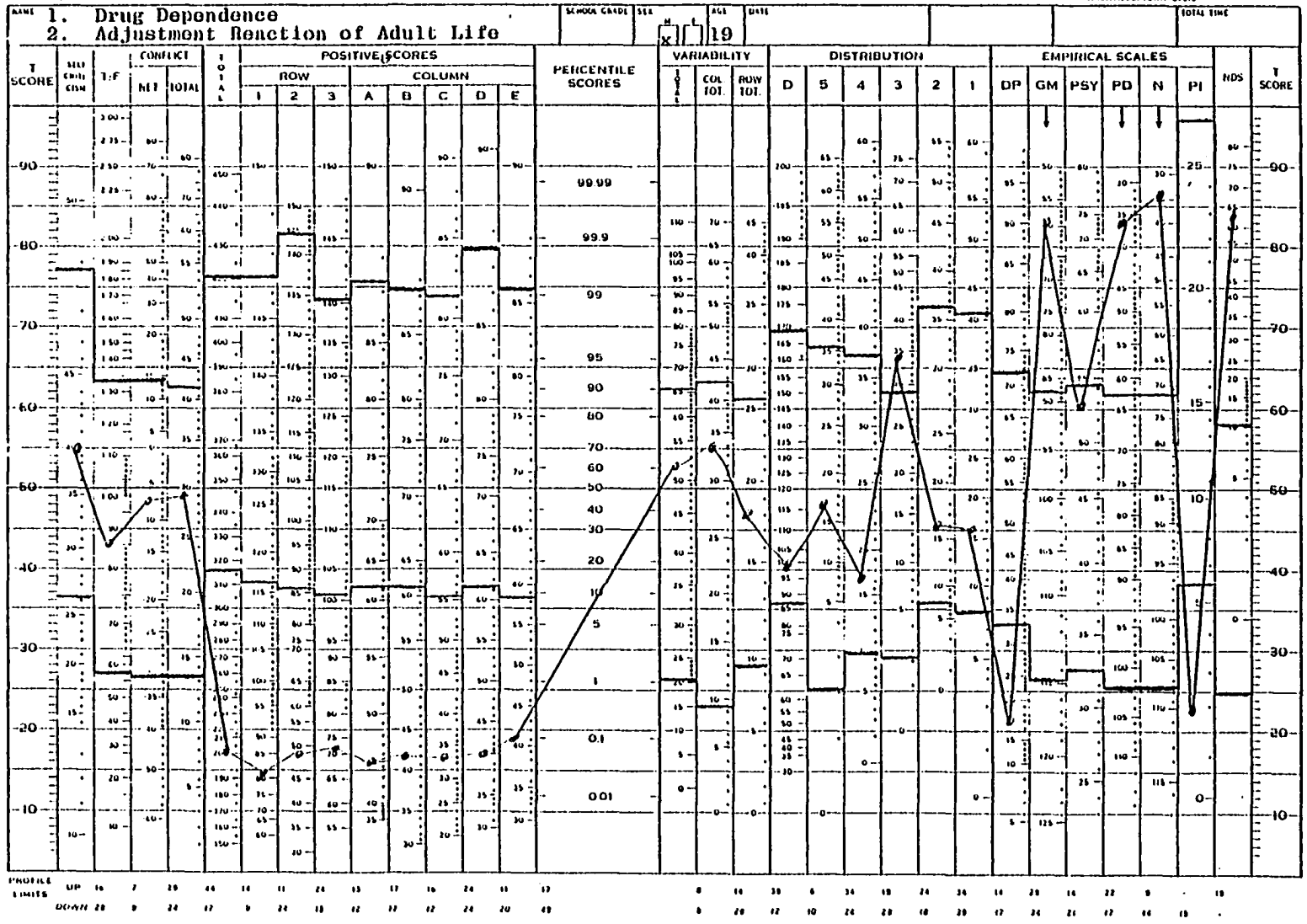
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 35

1. Drug Dependence
2. Adjustment Reaction of Adult Life



Tennessee Self Concept Scale

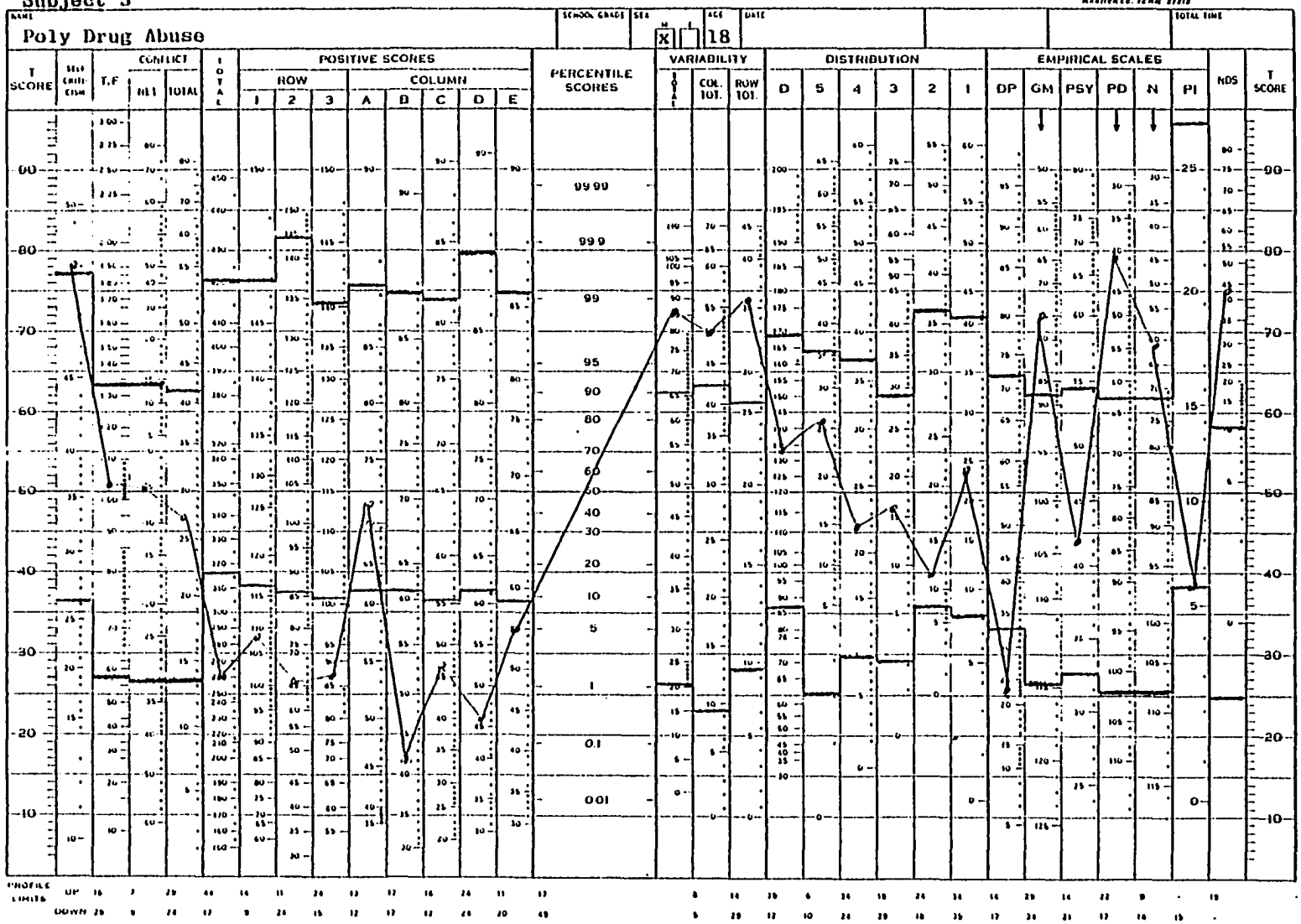
PROFILE SHEET

Clinical and Research Form

Subject 3

Poly Drug Abuse

SCHOOL GRADE | SEX M X F | AGE 18 | DATE | TOTAL TIME



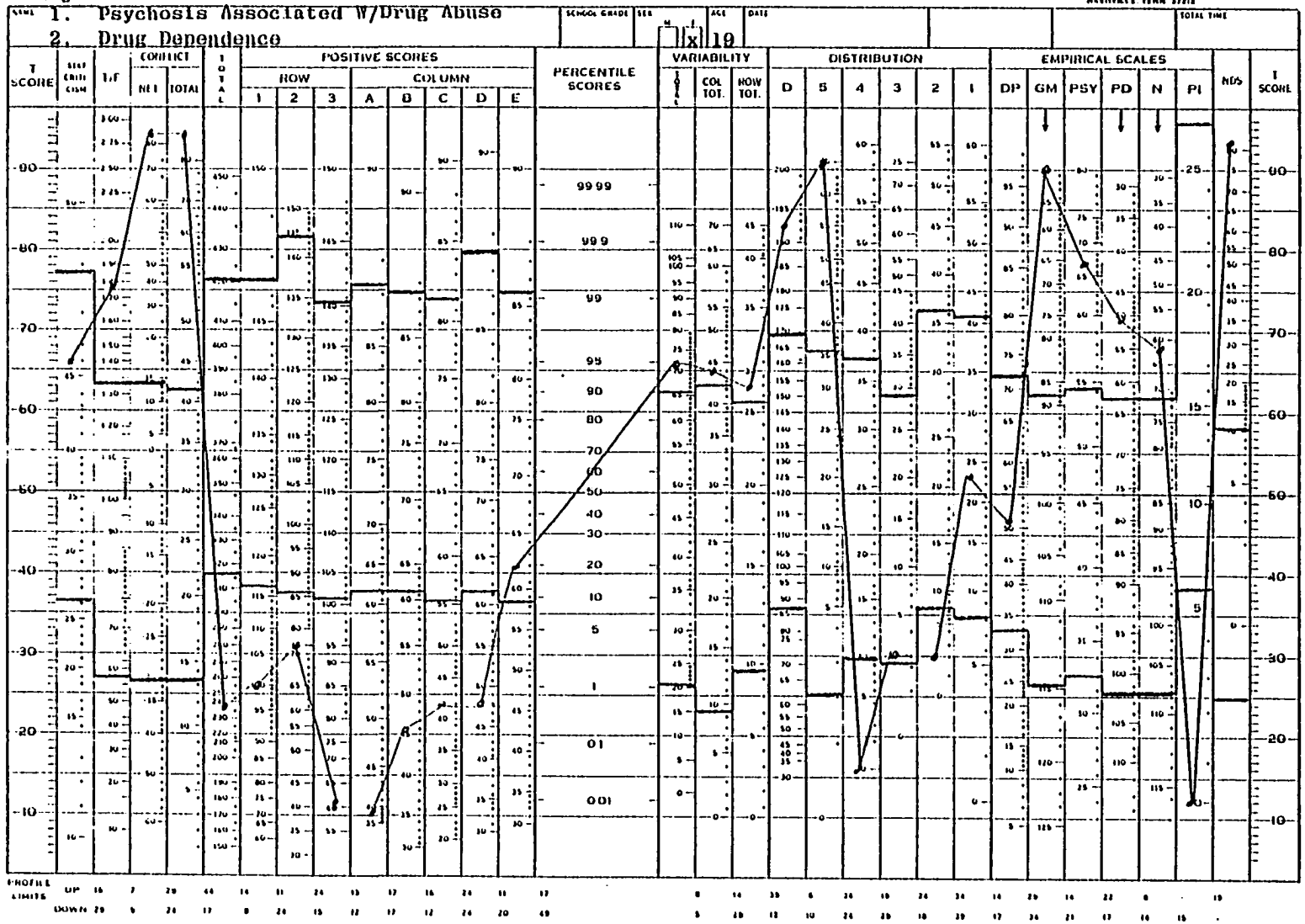
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 2

1. Psychosis Associated W/Drug Abuse
2. Drug Dependence



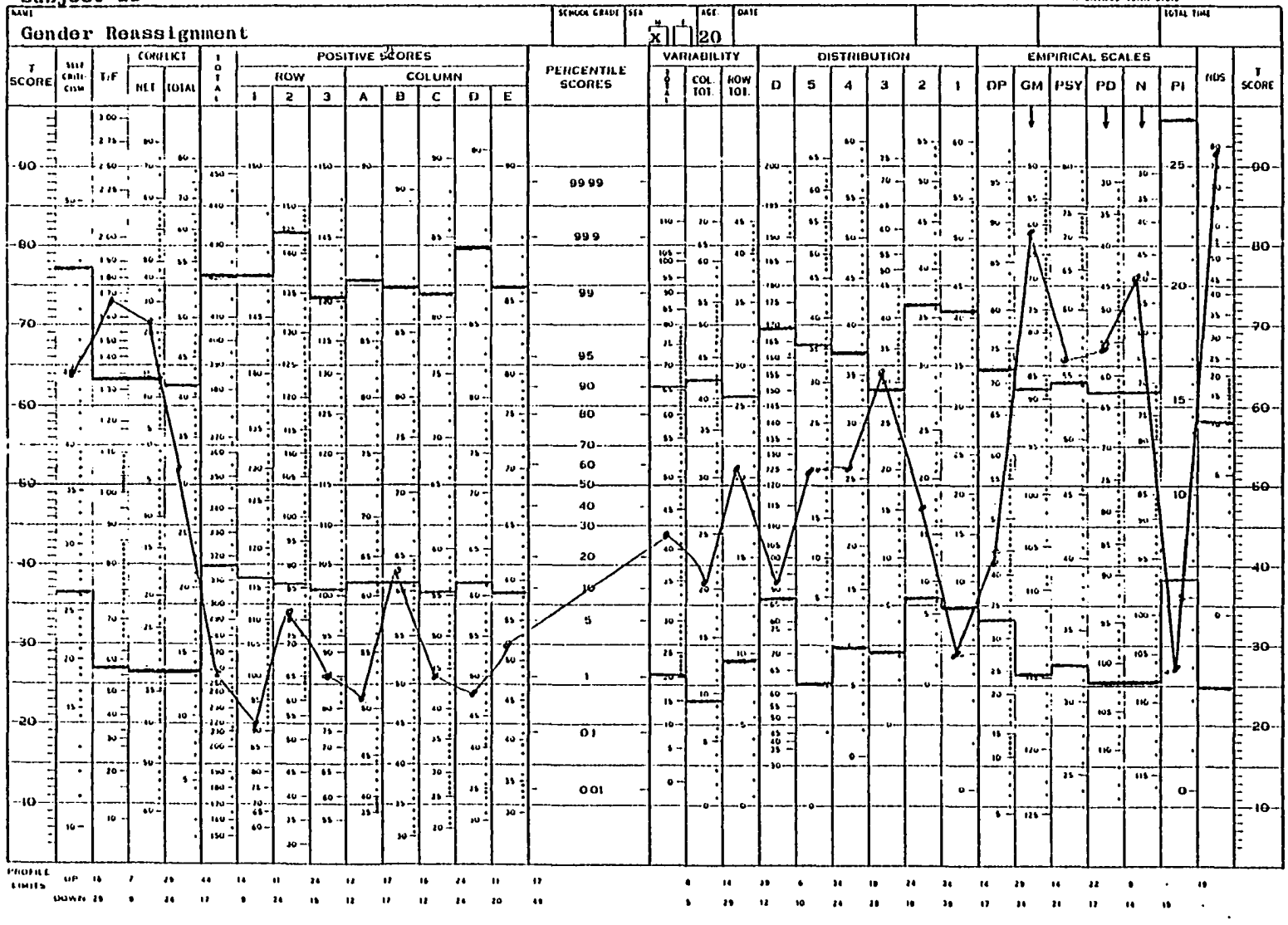
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 23

Gender Reassignment



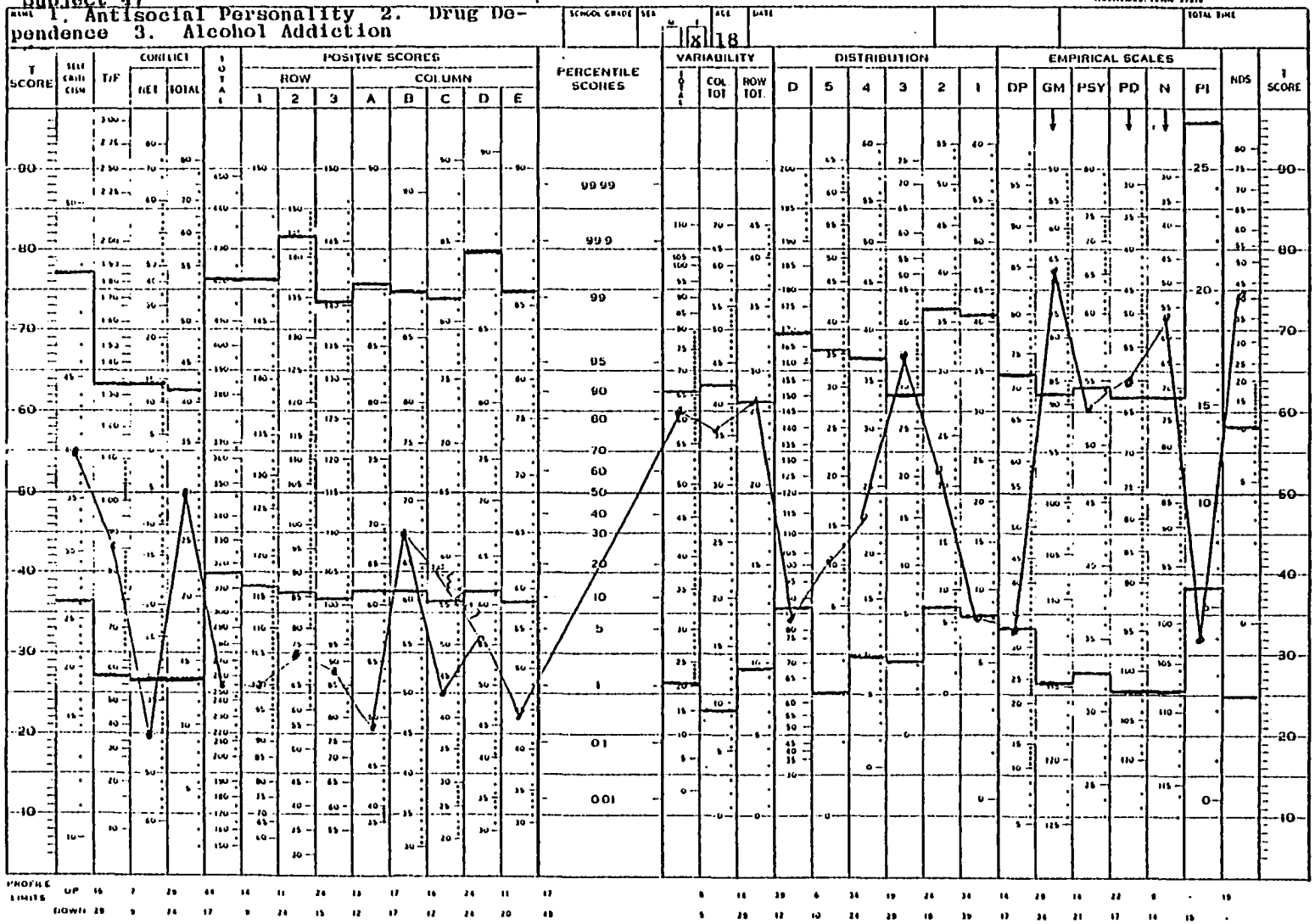
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 47

1. Antisocial Personality 2. Drug Dependence 3. Alcohol Addiction



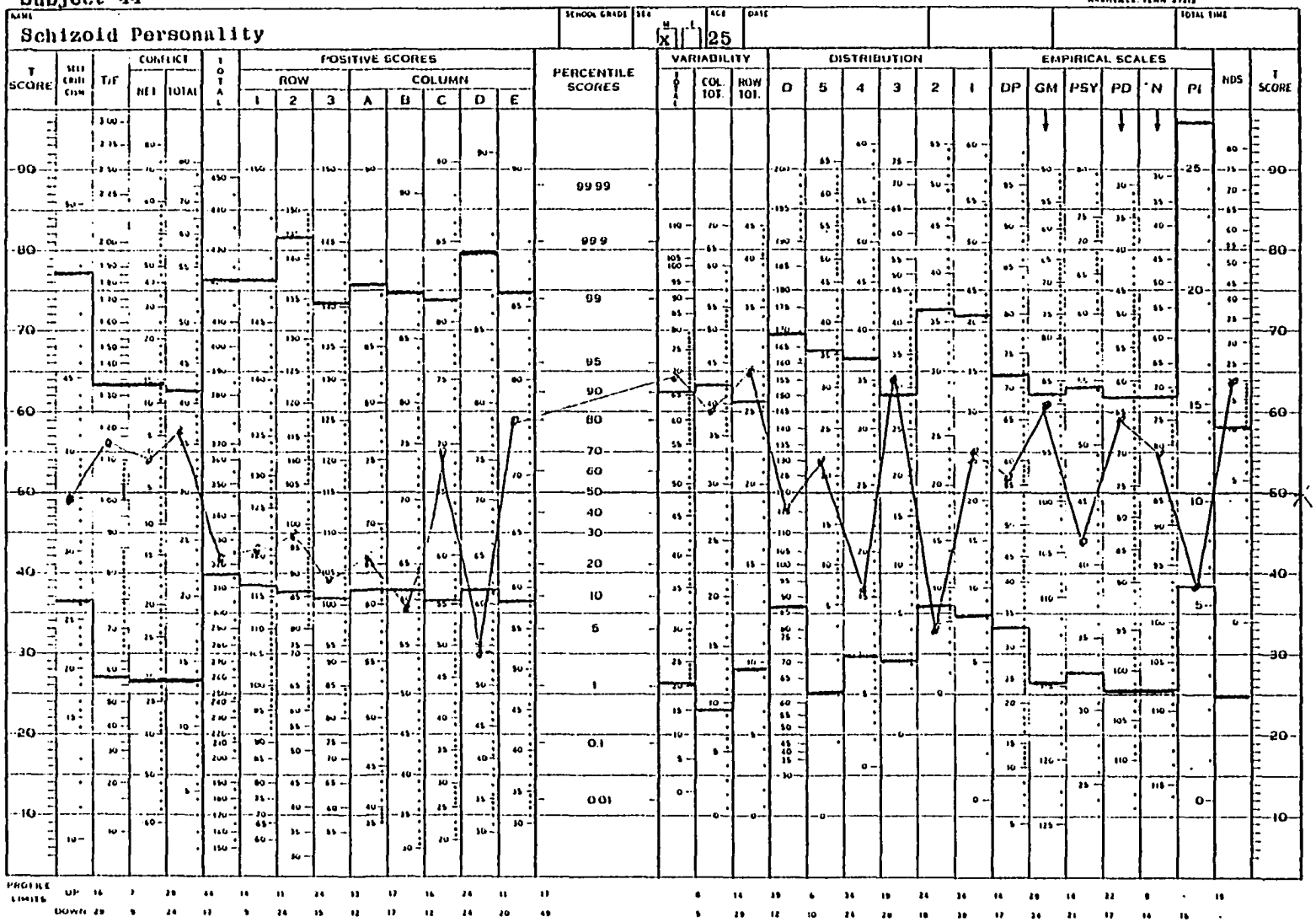
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 44

Schizoid Personality



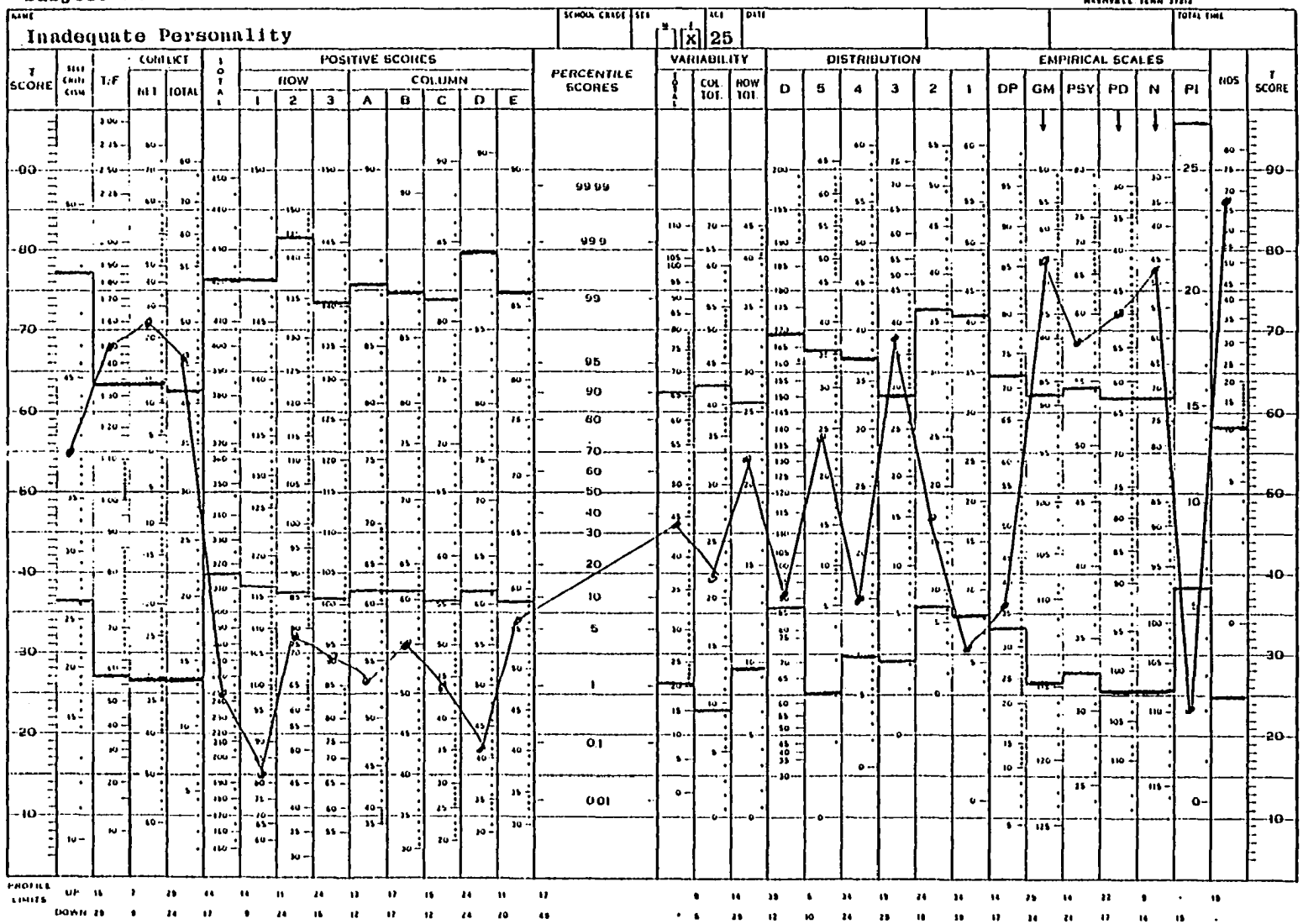
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 34

Inadequate Personality



Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 33

Explosive Personality

SCHOOL GRADE	SEX M X F	AGE 21	DATE	TOTAL TIME

T SCORE | SELF CRITICISM | T/F | CONFLICT: NET, TOTAL | TOTAL | POSITIVE SCORES: ROW 1 2 3; COLUMN A B C D E | PERCENTILE SCORES: 99.99, 99.9, 99, 95, 90, 80, 70, 60, 50, 40, 30, 20, 10, 5, 1, .01, .001 | VARIABILITY: TOTAL, COL. TOT., ROW TOT. | DISTRIBUTION: D 5 4 3 2 1 | EMPIRICAL SCALES: DP GM PSY PD N PI | NDS | T SCORE

PROFILE LINES: UP 16 7 29 45 18 11 24 13 17 16 24 11 17 / DOWN 28 9 24 17 9 24 15 12 11 12 24 20 45

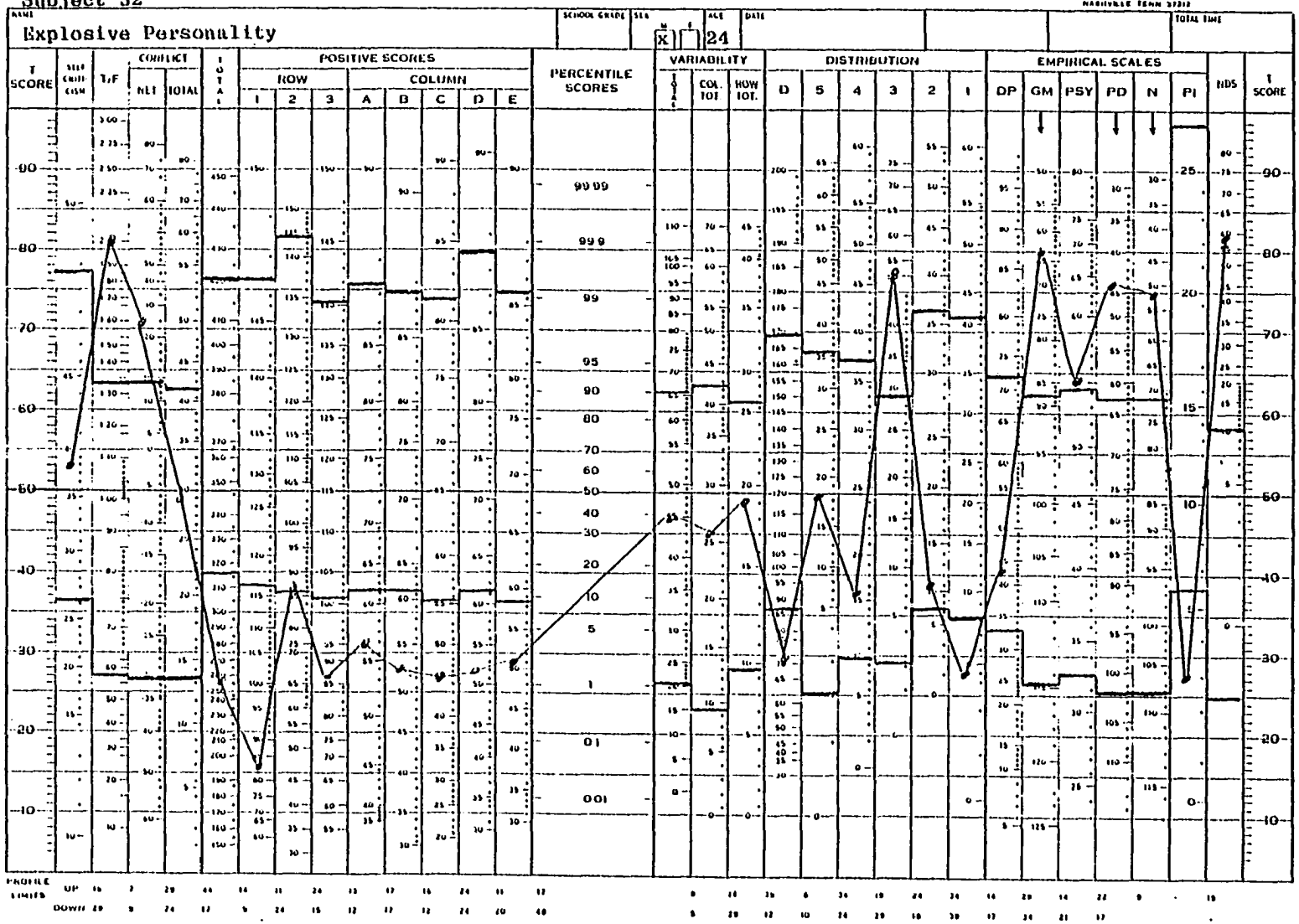
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 32

Explosive Personality



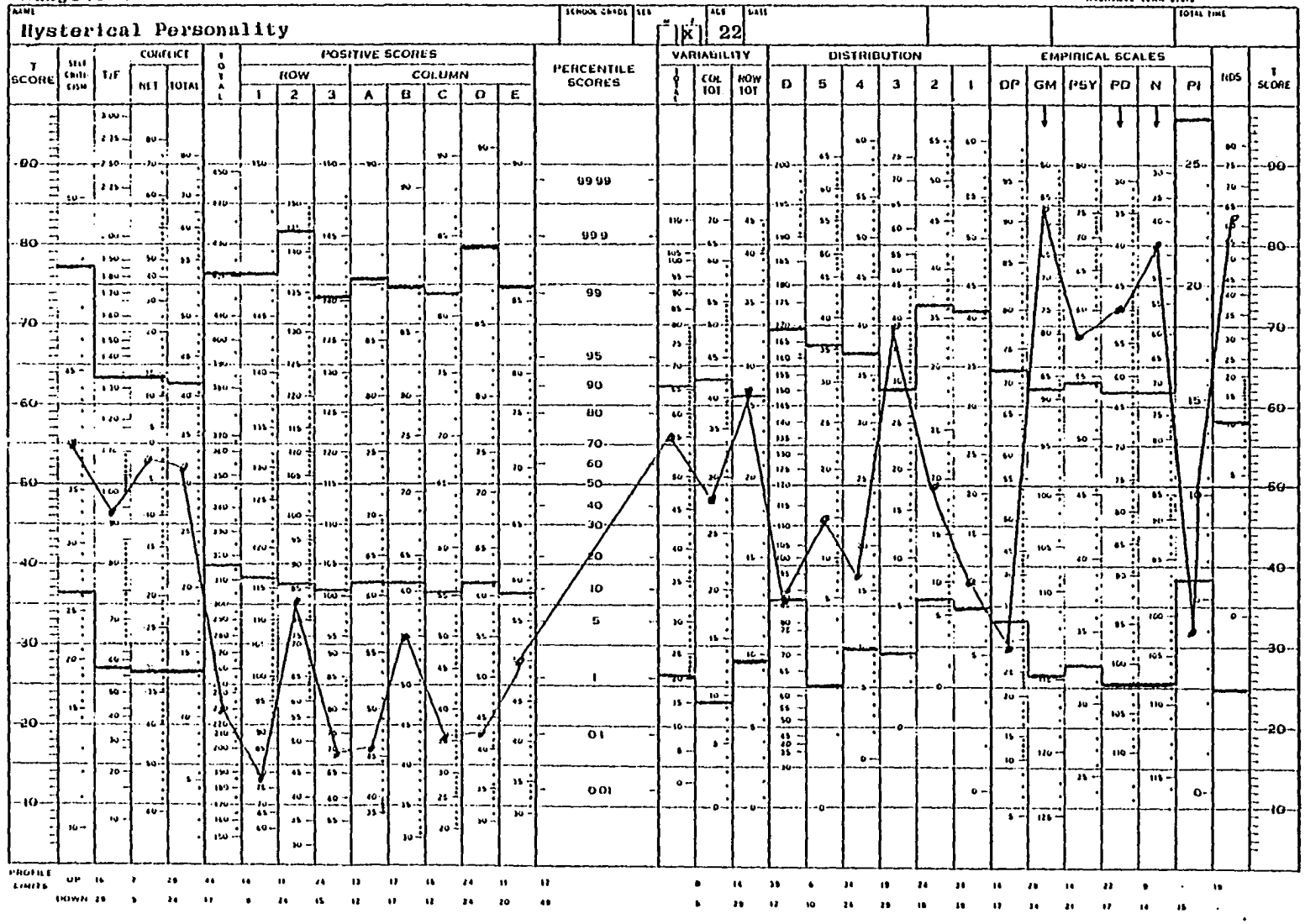
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 28

Hysterical Personality



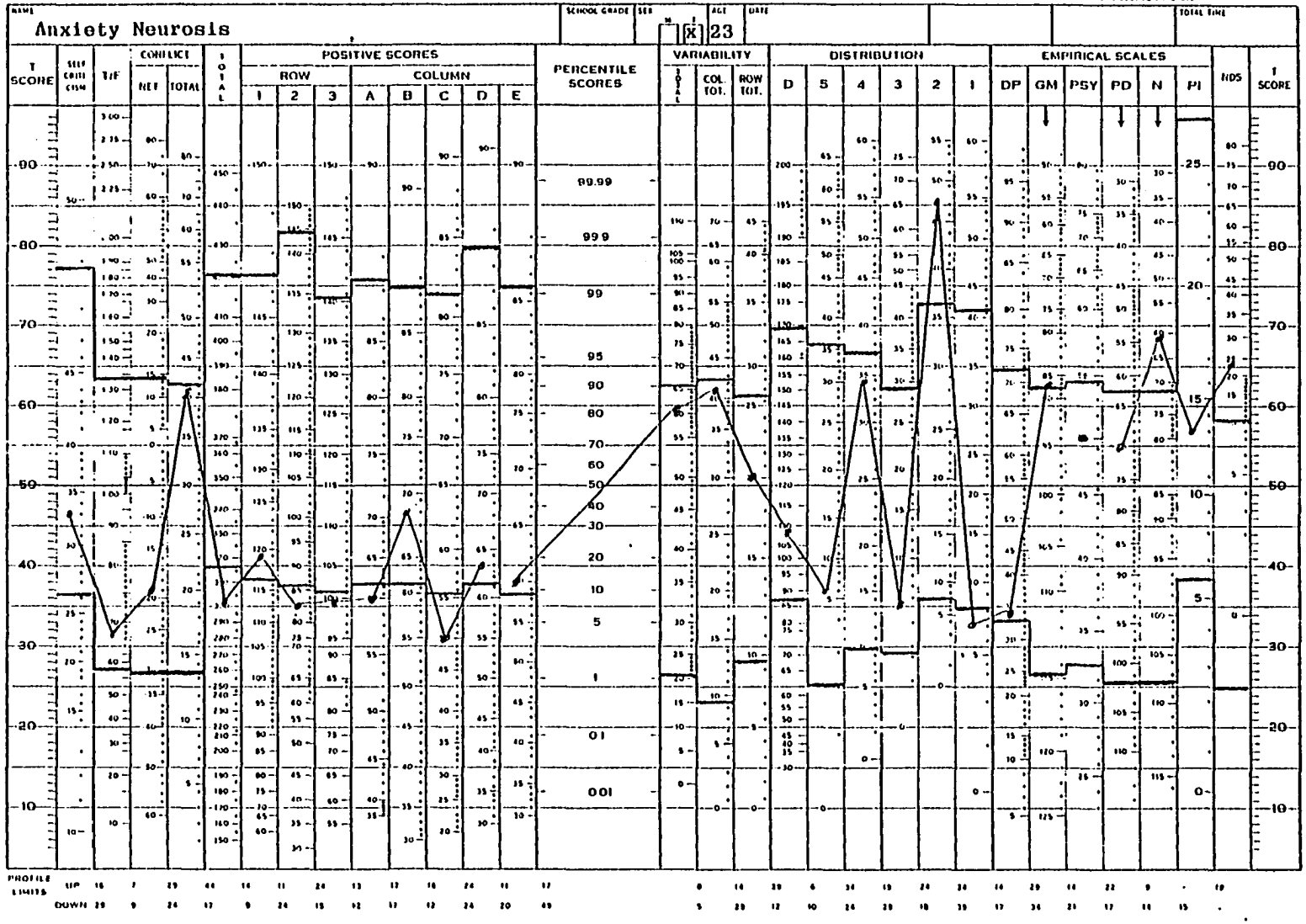
Tennessee Self Concept Scale

Subject 4

PROFILE SHEET

Clinical and Research Form

Anxiety Neurosis



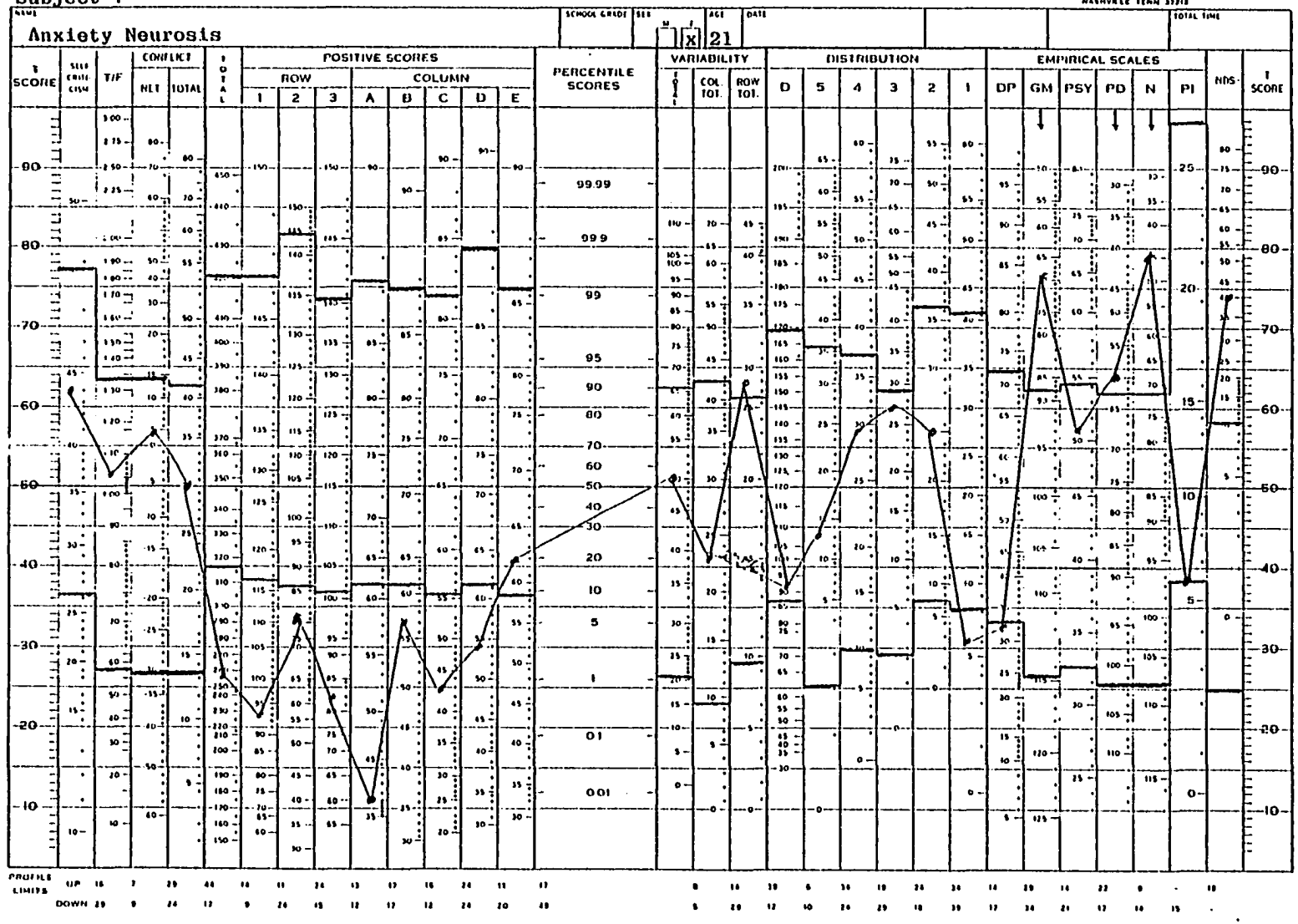
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 7

Anxiety Neurosis



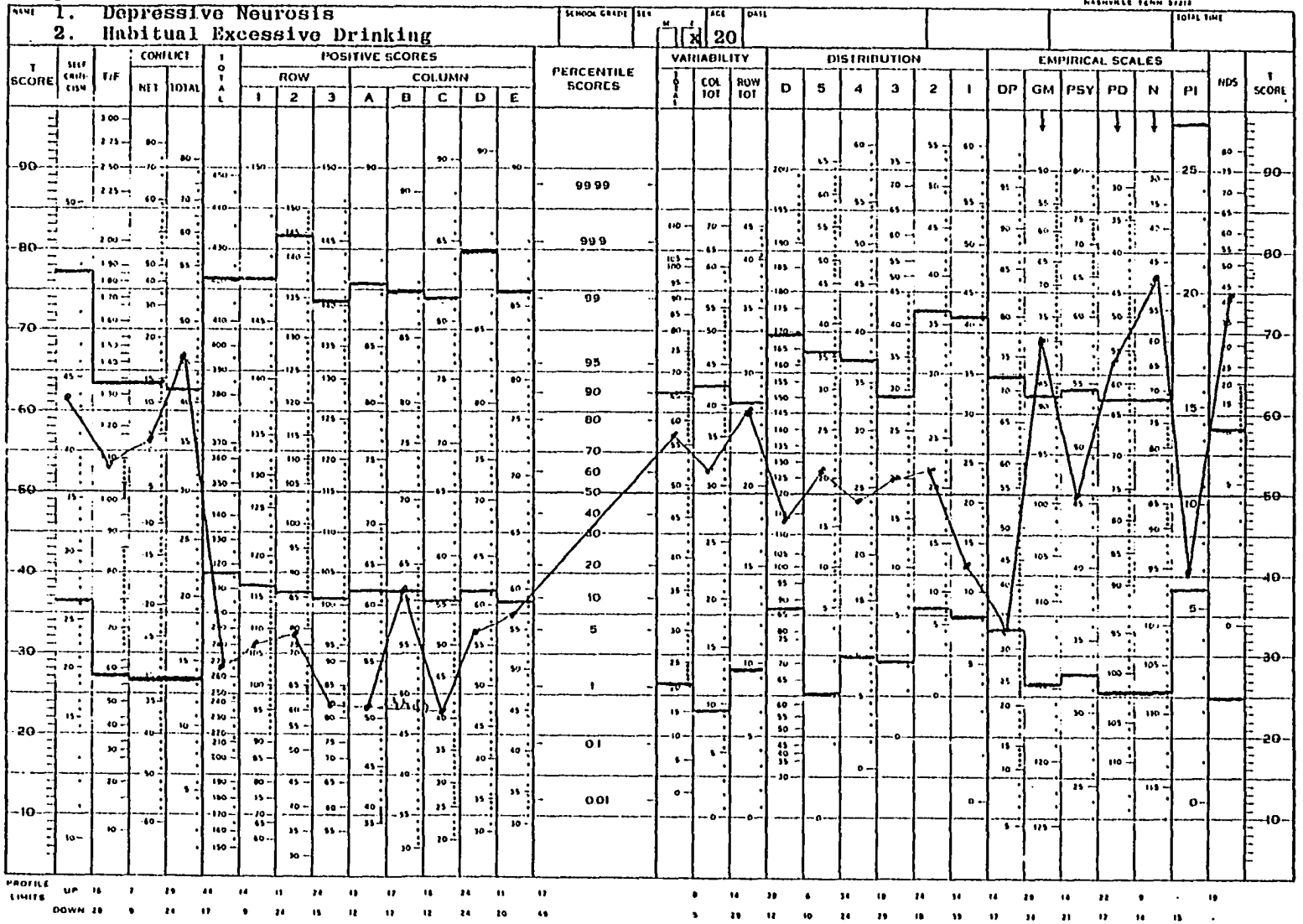
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 16

1. Depressive Neurosis
2. Habitual Excessive Drinking



Tennessee Self Concept Scale

Subject 17

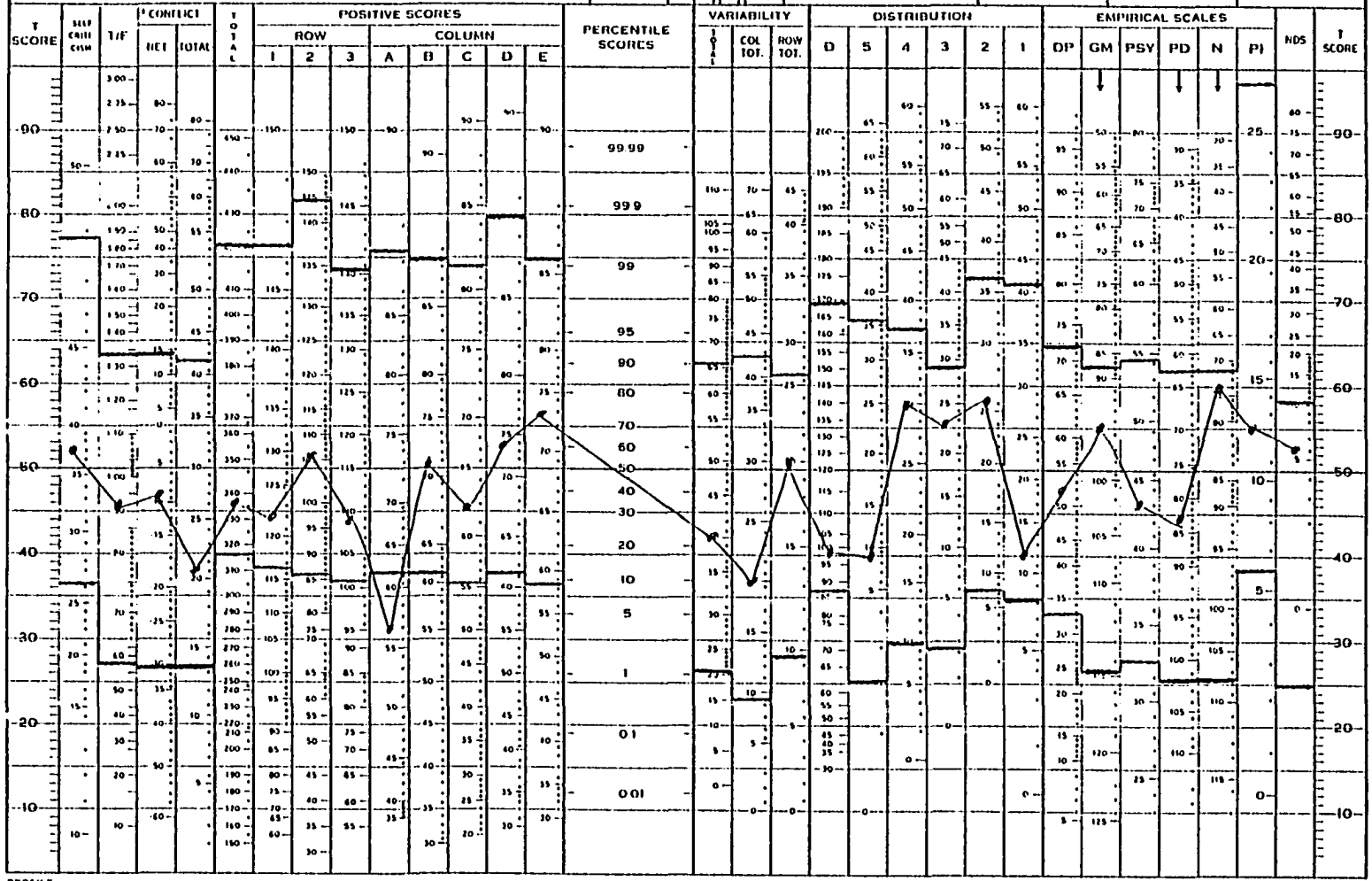
PROFILE SHEET

Clinical and Research Form

PUBLISHED BY
COUNSELOR RECORDINGS AND TESTS
BOX 6184 ACKLEN STA
NASHVILLE, TENN. 37212

NAME: Anxiety Neurosis

SCHOOL GRADE | SEX: M [X] F | AGE: 24 | DATE | TOTAL TIME



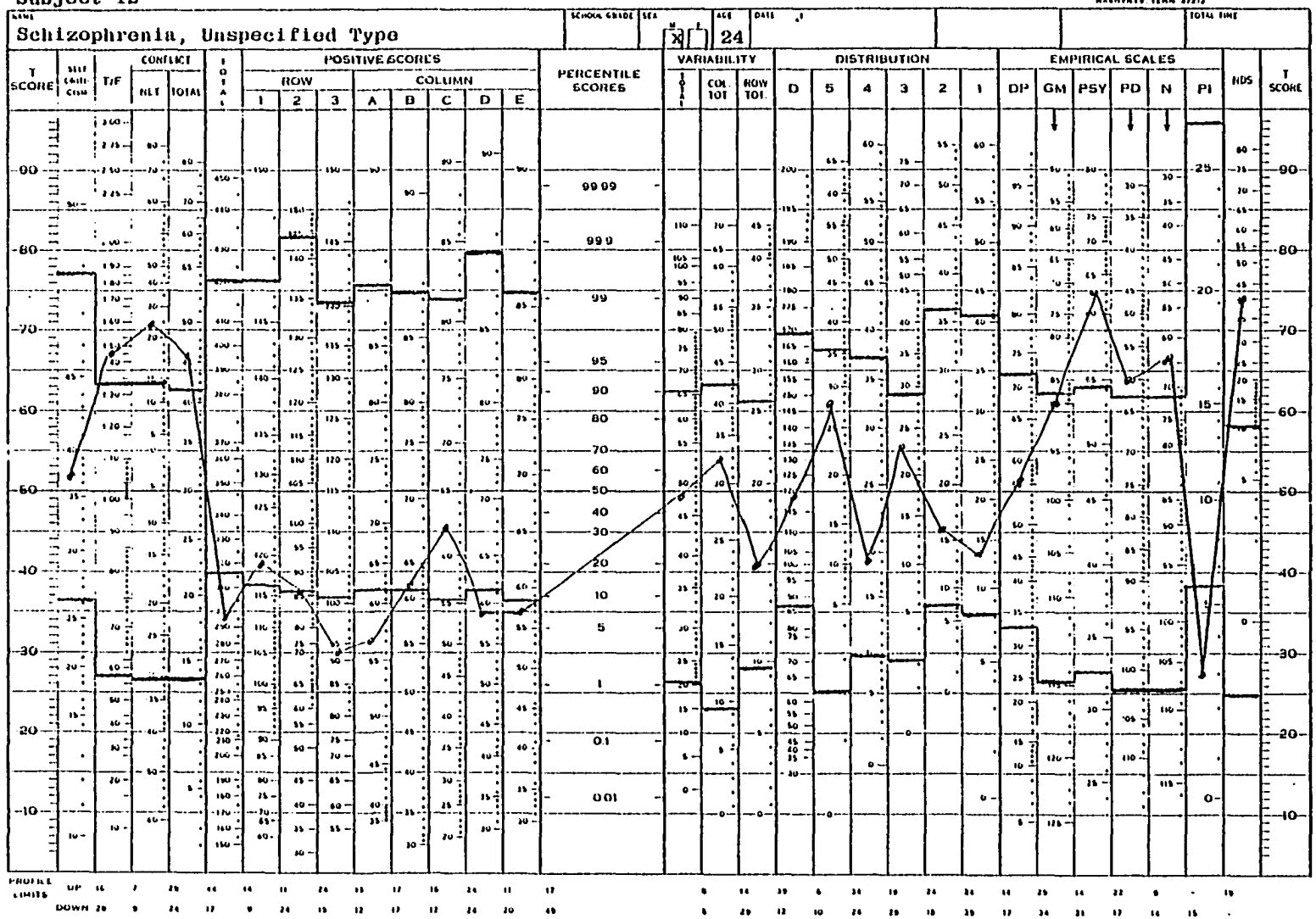
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 12

Schizophrenia, Unspecified Type

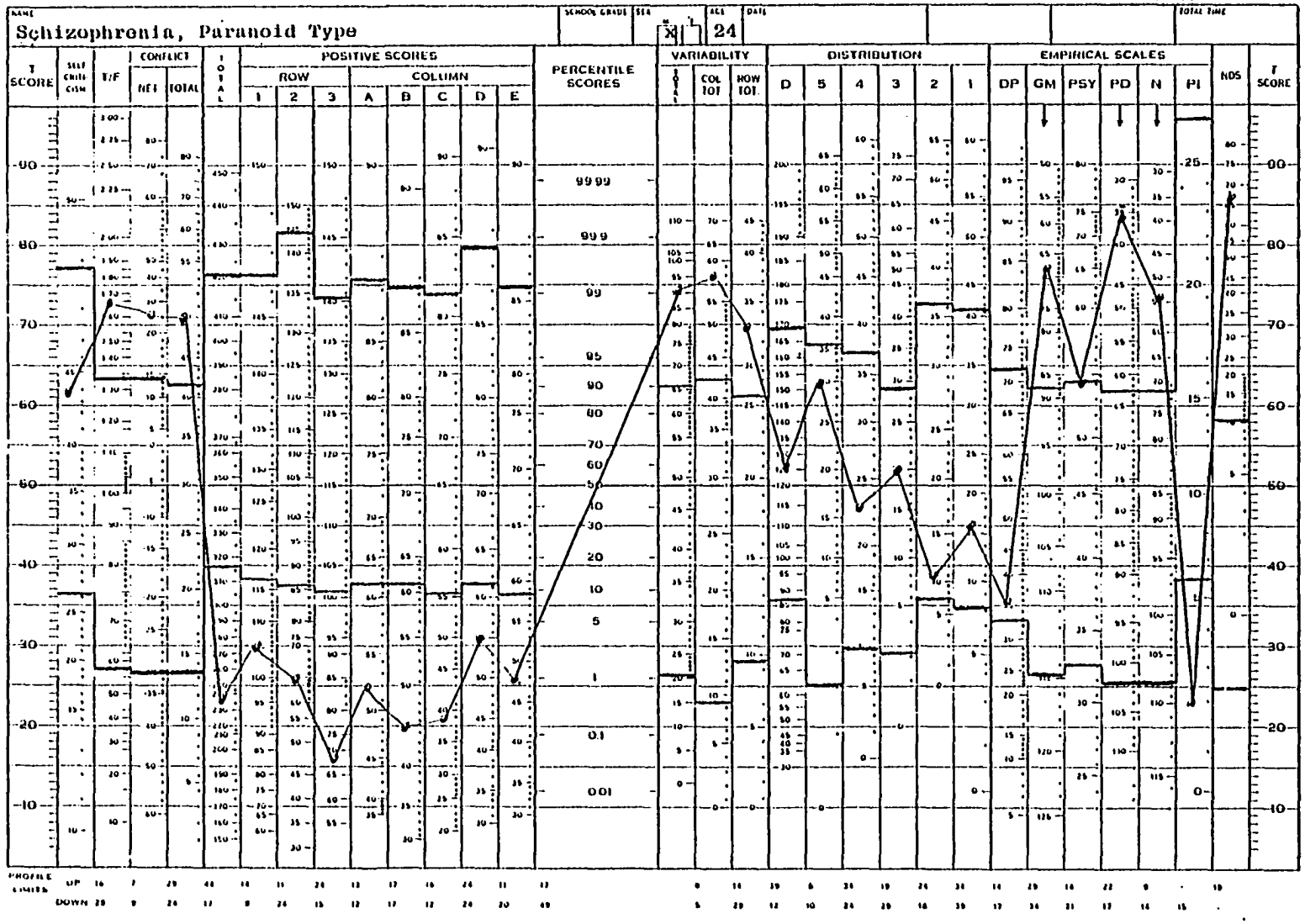


Tennessee Self Concept Scale

Subject 20

PROFILE SHEET

Clinical and Research Form



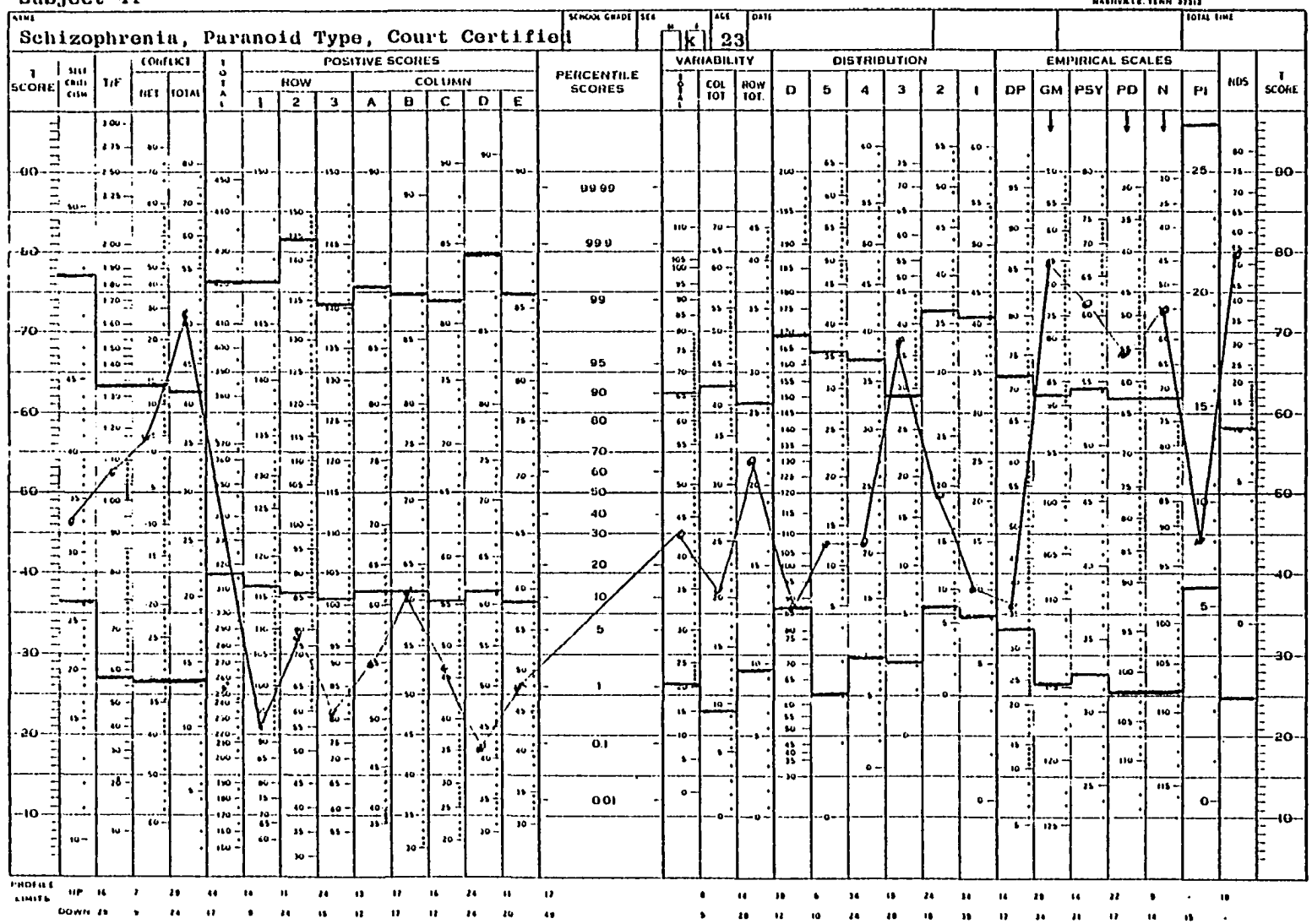
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 41

Schizophrenia, Paranoid Type, Court Certified



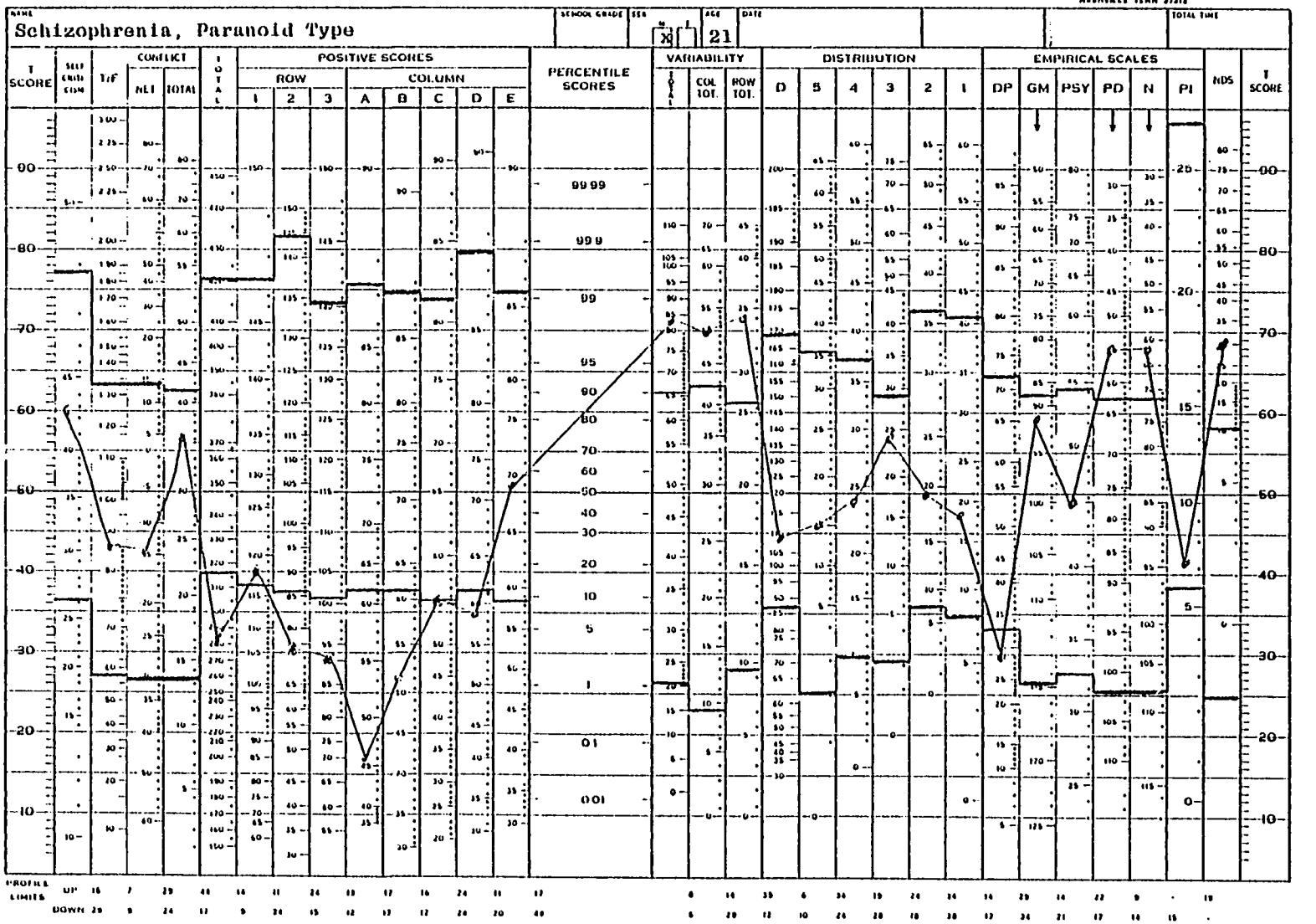
Tennessee Self Concept Scale

Subject 48

PROFILE SHEET

Clinical and Research Form

Schizophrenia, Paranoid Type



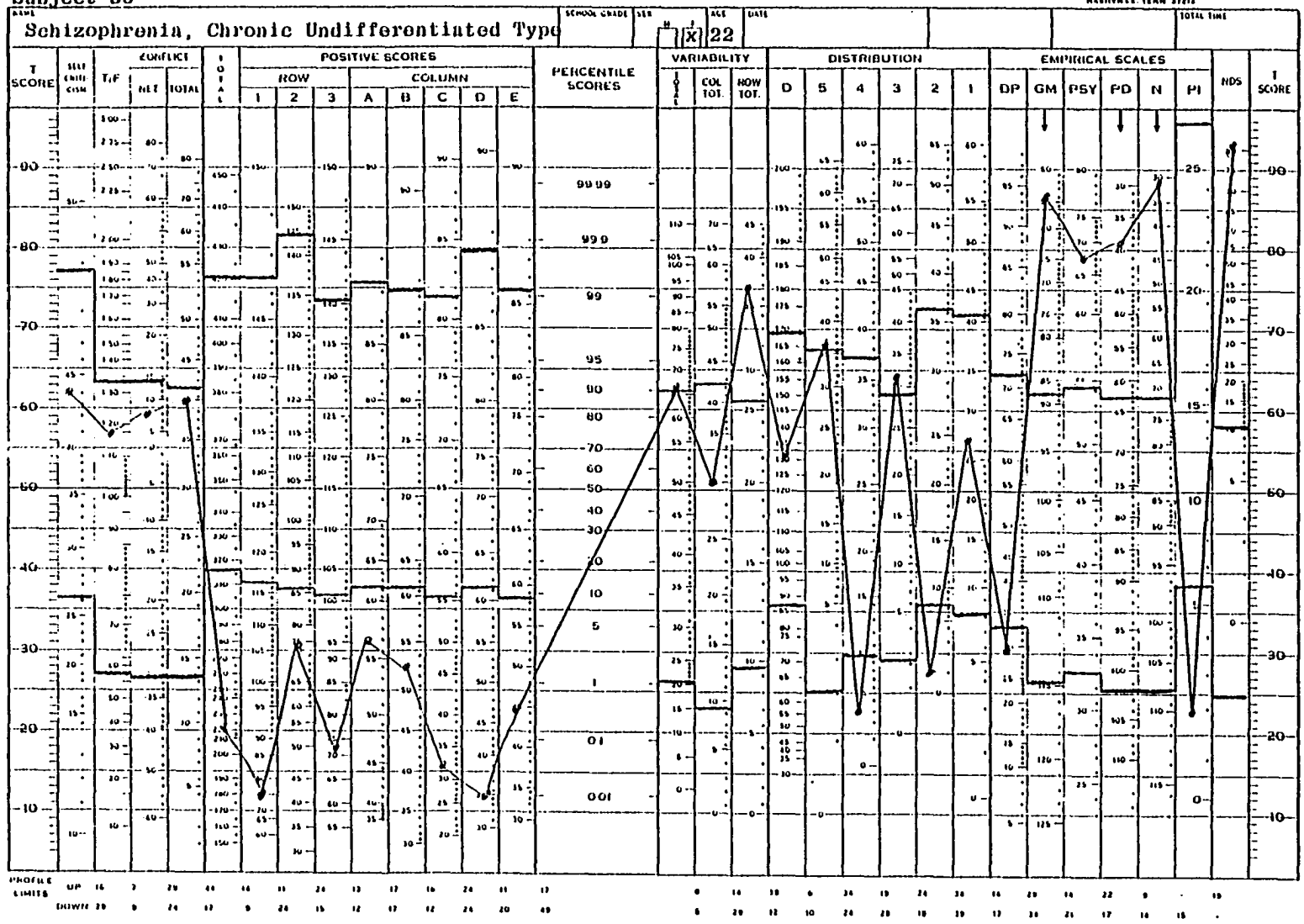
Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 50

Schizophrenia, Chronic Undifferentiated Type

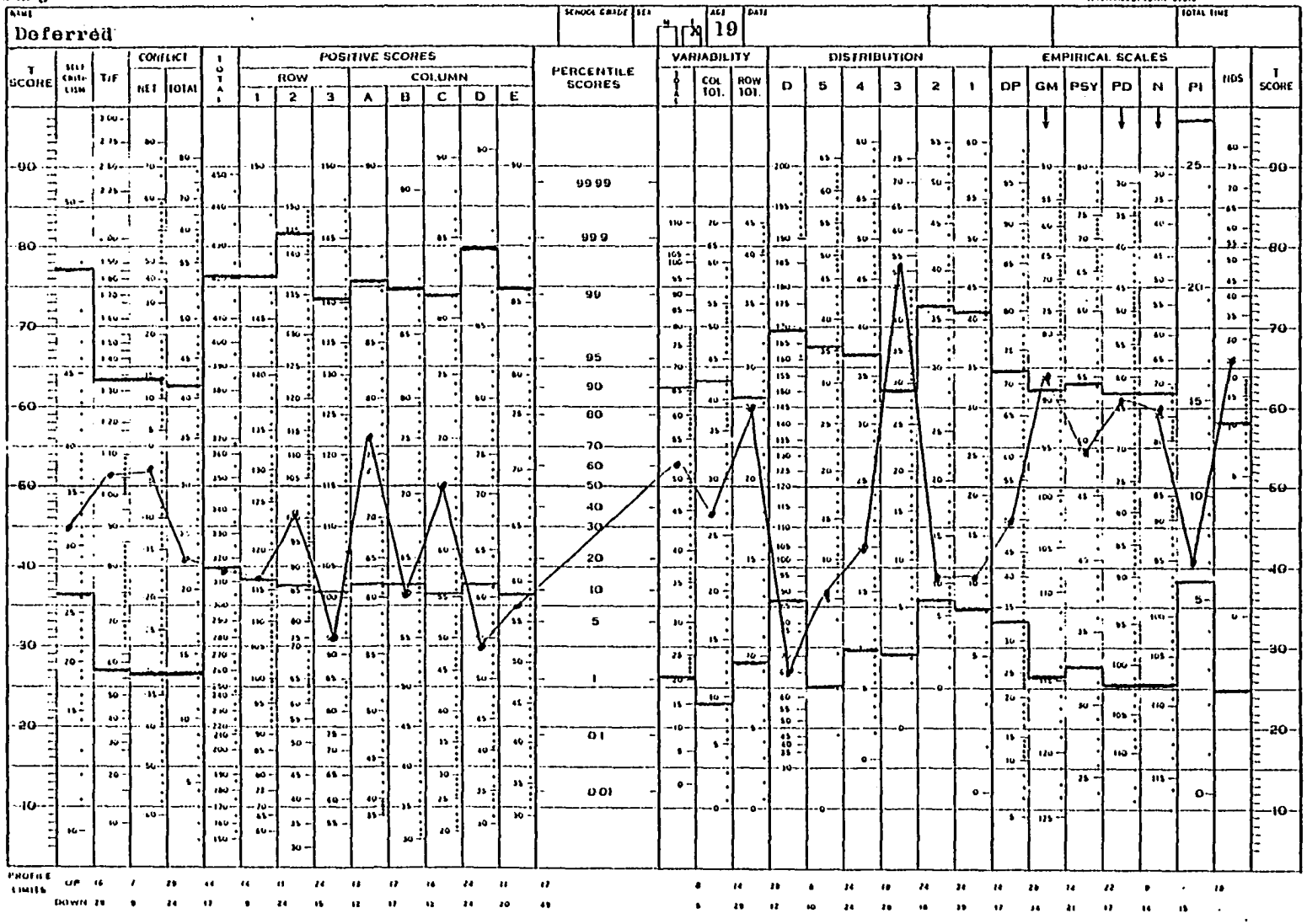


Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 9



Tennessee Self Concept Scale

Subject 39

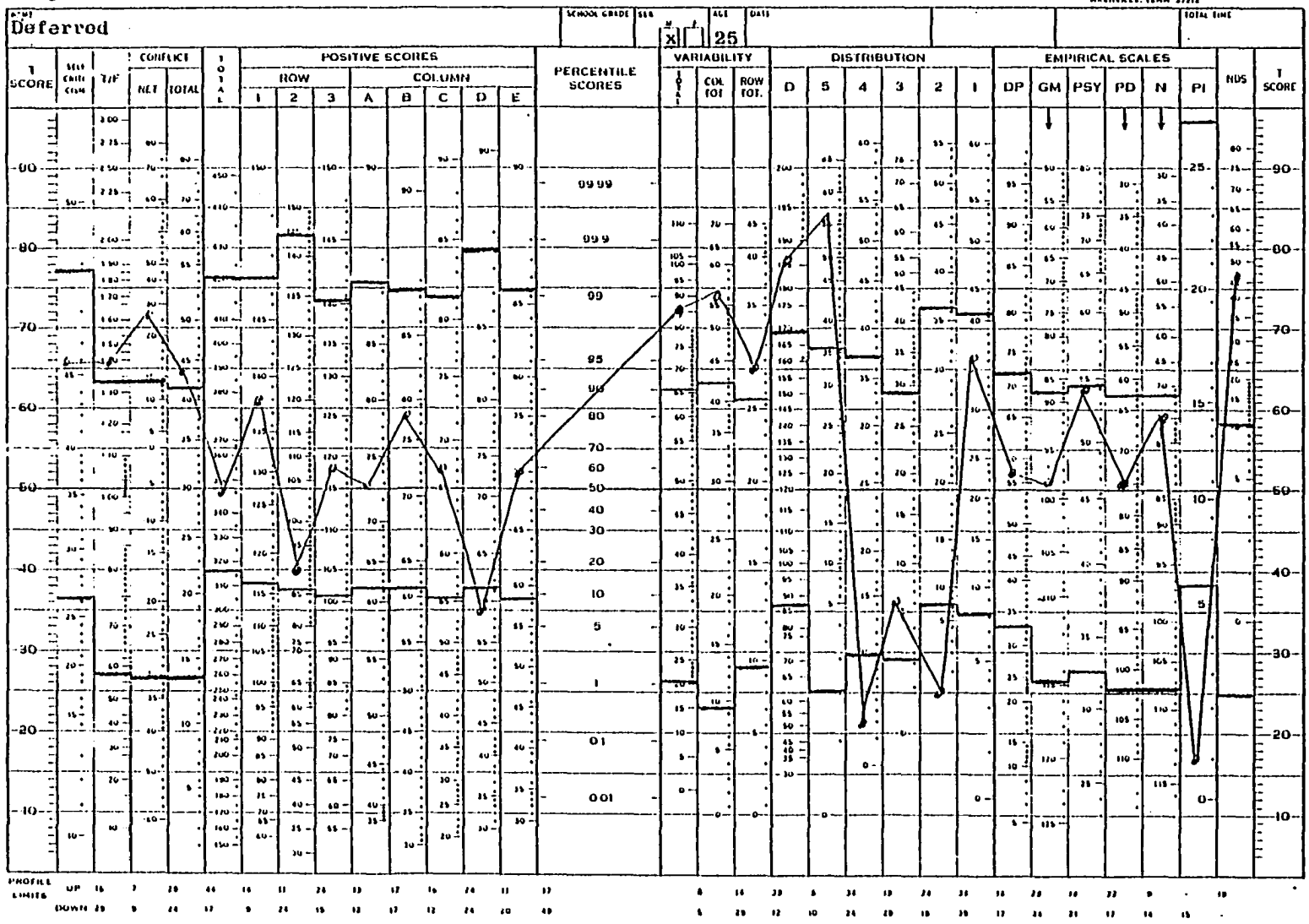
PROFILE SHEET

Clinical and Research Form

PUBLISHED BY
COUNSELOR RECORDINGS AND TESTS
BOX 6184 ACKLEN STA
NASHVILLE, TENN 37212

Name: Deferred

SCHOOL GRADE | SEX: M [X] F [ ] | AGE: 25 | DATE | TOTAL TIME

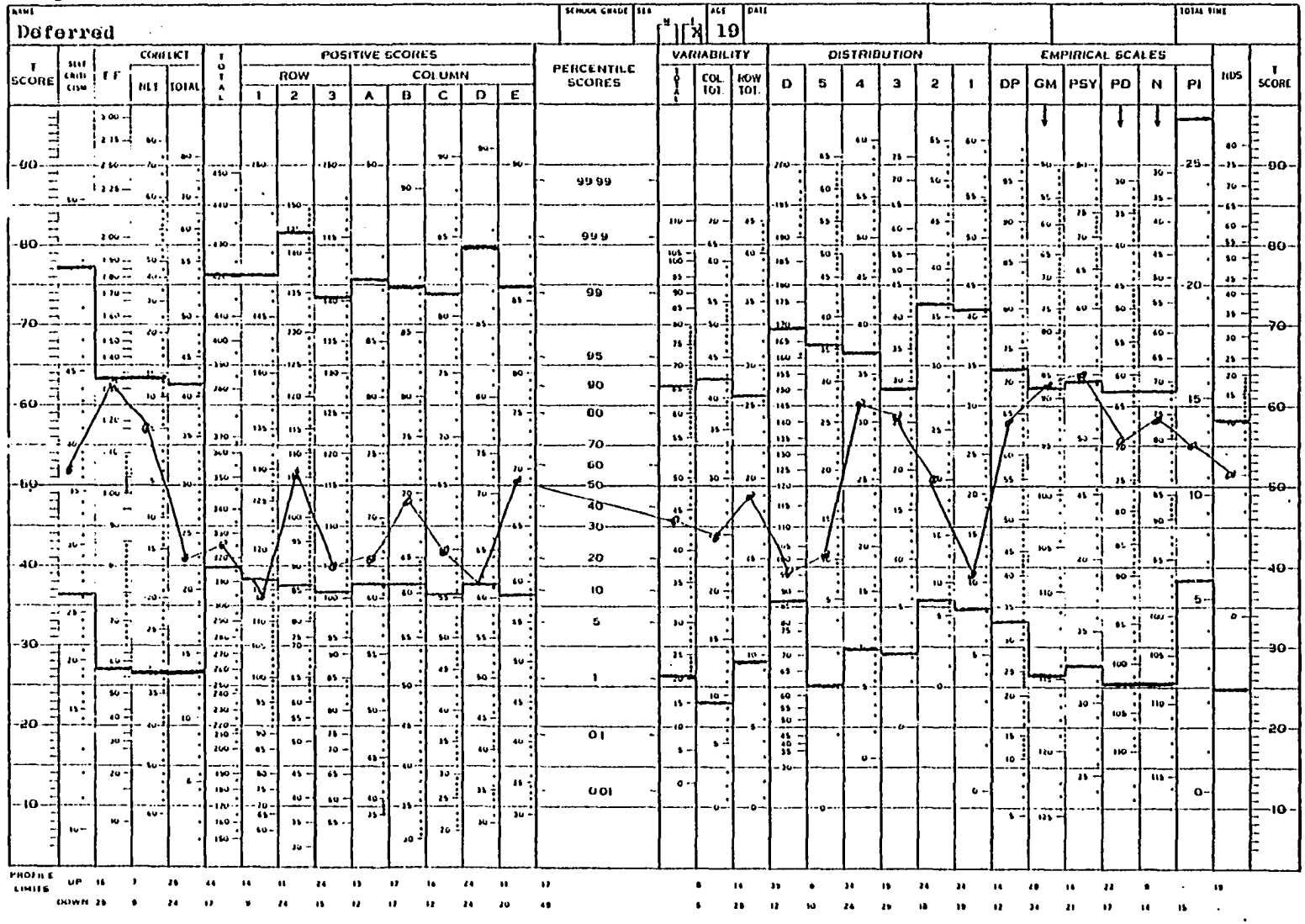


Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 36

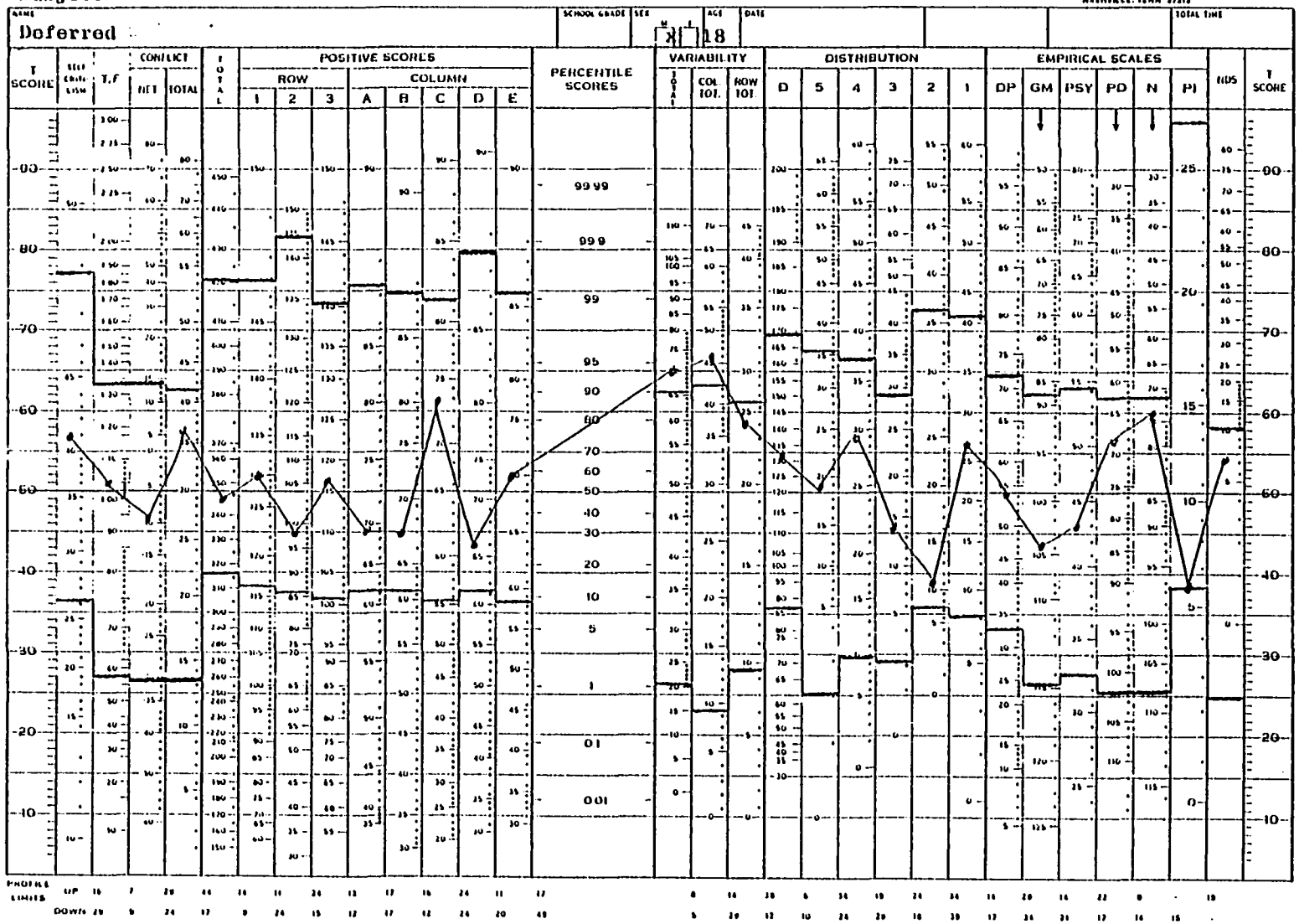


Tennessee Self Concept Scale

Subject 18

PROFILE SHEET

Clinical and Research Form



Tennessee Self Concept Scale

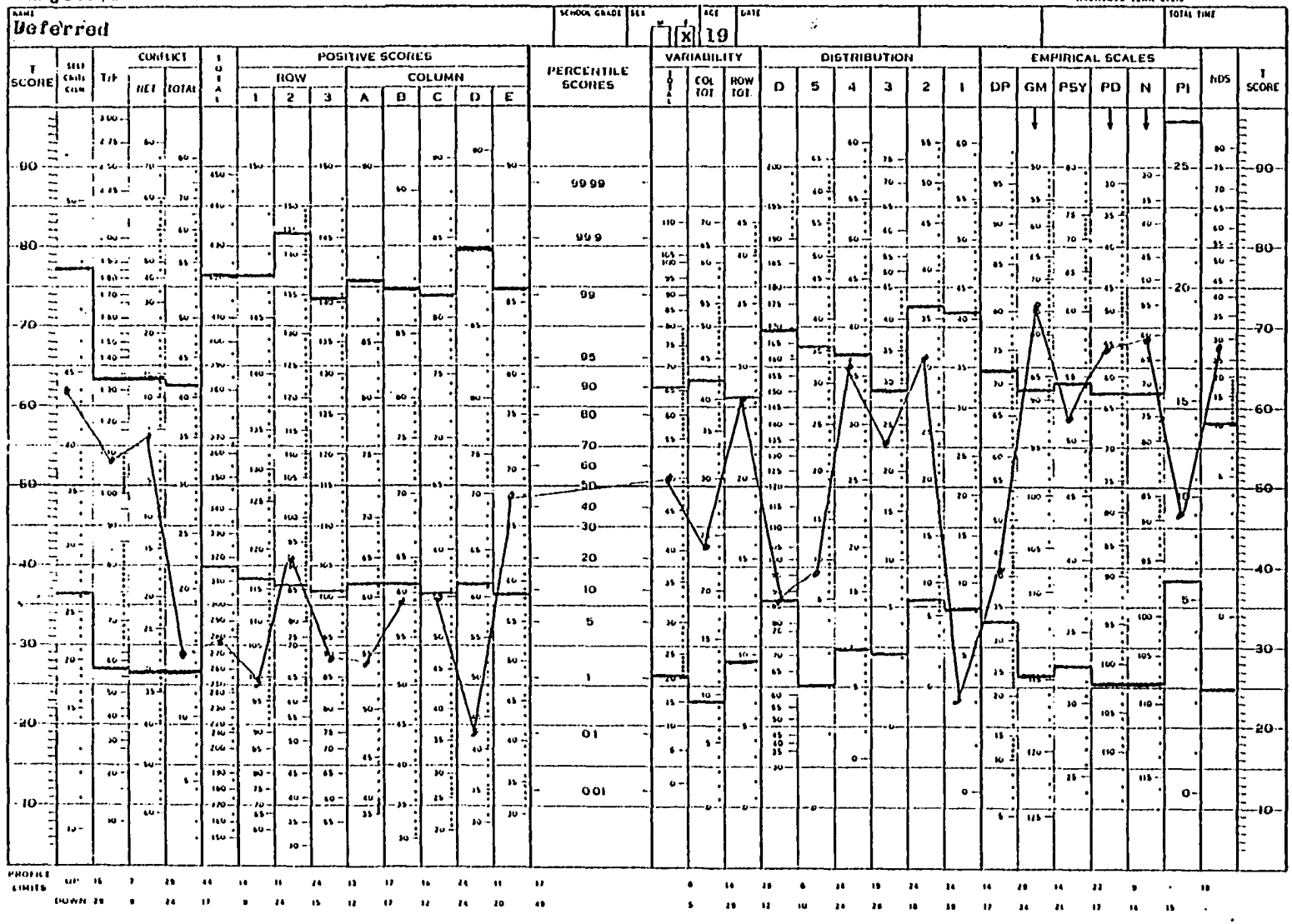
PROFILE SHEET

Clinical and Research Form

Subject 61

Deferred

SCHOOL GRADE | SEX M [X] F | AGE 19 | DATE | TOTAL TIME



Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form

Subject 21