

SOME ASPECTS OF SELF-CONCEPT

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SOME ASPECTS OF SELF-CONCEPT

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CHAPTER I

INTRODUCTION

In recent years there has been a growing interest on the part of those persons interested in personality in self-concept and, with this interest, self-concept has become a prominent theoretical construct in psychology. The emphasis has been put on the importance of our self-regarding attitudes as a source of motivation in all behavior (4, pp. 126-127).

There is no consensus among psychologists as to what is meant by self-concept. The lack of consensus is elucidated even in the early work regarding self-concept. James (18) pointed out one of the obvious difficulties when he stated that the individual has many selves. The individual might conceive of the self that he really believes that he is, the self that he realistically aspires to be, the self that he believes is perceived by others, the self that he hopes he is now, and the self that he fears he is now, etc. The self-concept has been considered as one of these selves, some of these selves, or all of these selves. Also, the self-concept may be considered as a configuration of these and of other possible self-definitions. One investigator may choose to

investigate one of these selves, while another chooses to investigate some other aspect of one's feeling toward himself.

Several varying definitions of self-concept have been advanced. Hall and Lindzey (14, p. 468) feel that the concept of self as used in modern psychology has come to have two distinct meanings: it is defined as the person's attitudes and feelings about himself, and it is defined as a group of psychological processes which govern behavior and adjustment.

Hillgard (16, p. 347) refers to the self-concept as one's image of himself. Lundholm (14, p. 470) distinguishes between a subjective self and an objective self. Combs and Snygg (8, p. 127) define self-concept as that aspect of one's phenomenal field which is most important to the individual or that aspect which is the central frame of reference in understanding one's self and in directing behavior. Rogers (22), Allport (1), and Gordon (13) emphasize the importance of a personal frame of reference in understanding the behavior of the individual. An inclusive definition and the one presented in this paper is as follows:

Self-concept is the individual's phenomenologically unitary constellation of beliefs about and attitudes toward himself, the organization of his self-reflexive affective-cognitive structures, as reflected operationally in his description of himself (26, p. 206).

It is also suggested that the self is not a collection of mental states, but is an organization which is active as a whole (24, p. 112). It is believed that each individual strives both consciously and unconsciously to maintain a

consistent picture of himself in accordance with the person he thinks of himself as being. "The degree of personality integration that any individual possesses is in large measure due to the extent to which his various conceptions of himself in his major roles are consistent with each other" (4, p. 129). Brandt has stated that self-concept is an organized and organizing dynamic within the personality structure (5, p. 56).

The acquisition of self-concept is through learning.

Our attitudes toward ourselves begin to take definite form in early childhood through parent-child relationships, especially those relationships which have a close bearing on how a child thinks his parents value him as a person. It seems certain that self-regarding attitudes acquired from the family are the most fundamental and the most persistent throughout life. However, our self-conceptions are also greatly affected by our experiences in a multitude of groups outside the home during childhood and in subsequent years. When changes do occur in our self-attitudes, these changes are not due to certain experiences as such, but rather to the way we interpret or perceive these experiences in relation to ourselves (4, p. 130).

There is general agreement that a negative or low self-concept indicates stress and tension within an individual and, in general, maladjustment. Chase (7, p. 497) stated that a low self-concept is assumed to indicate an unsatisfactory level of adjustment. Several studies have concluded that the concept of self is significantly different in maladjusted persons and that low or negative self-concept is associated with maladjustment (4, p. 314; 7, p. 497; 19, p. 370).

The interpretation of a positive self-concept is not so general. A large body of research, as done by C. R. Rogers (22), is based on the assumption that a positive self-concept

indicates a well-adjusted individual. Emphasized is the importance of self-integration with the implicit assumption that the well integrated individual would also be integrated into his society. Rogers and Dymond (23) have recently suggested, however, that the positive self-concept may also indicate a highly defensive paranoid individual. Frenkel-Brunswik (11, p. 409) offers further support of the theory that positive self-concept, for some individuals, may be compensatory in nature. Hart (14, p. 115) has pointed out the difficulty in differentiating between true self-esteem and inflated self-esteem. Thus there is the possibility that high self-regard can compensate for underlying negative attitudes.

In regard to adjustment in terms of interpersonal relations, theoretical concepts (12, 17, 22) as well as experimental findings (2, p. 782; 21, p. 83) support the thesis that positive attitudes toward self are correlated with positive attitudes toward others.

It is generally believed that an individual's concept of himself achieves a rather high degree of organization during the course of development and comes to resist change once self-differentiation and self-definition have taken place (20, p. 227). This has generally been supported by experimental findings. Self-concept, as measured by self-concept scales, Q sort techniques, etc., show that self-concept, in general, does remain consistent--resistive to change. Correlation coefficients between test and retest administration of

self-concept scales vary from .78 to .93 for short periods of time (6, p. 605; 26, p. 209; 27, p. 1120).

Consistency or stability of self-concept has further implication. Brownfain (6, p. 603) has taken the position that stability of self-concept is a dimension of personality serviceable to the work of understanding and predicting behavior (31). He found that subjects with a stable self-concept have a higher level of self-esteem, are freer of inferiority feelings and nervousness, are better liked and considered more popular by the group, and show less evidence of compensatory behavior of a defensive kind.

Another kind of consistency can be considered--that of internal consistency. Theoretical formulations derived from clinical observation have given an important place to what might be called a multi-level conception of personality. It is believed that emotional disturbance may arise from conflict among the various levels of personality, among the various "selves." The greater the interlevel conflict, the more emotionally disturbed is the individual. Of major interest are the congruities and discrepancies among the meanings of self. Smith (27, p. 1120) has reported, however, that in a study of neurotics the discrepancy between various tests of self-concept was not related to a criterion of emotional disturbance and the degree of emotional disturbance was not predictable from any measure of self-concept. On the other hand, Taylor (26, p. 205) has indicated that an increase in the positive relationship between the self and self-ideal

(less discrepancy) may be a valid index of improvement of the mentally disturbed in therapy. Others have demonstrated that subjects with stable (less discrepancy) self-concepts are better adjusted than those with unstable self-concepts (6, p. 603).

It is believed that self-concept can be used to indicate personality changes in psychotherapy (25, p. 85). It is believed that in the course of successful therapy the self-concept becomes more positive; it becomes more congruent with the self-ideal (7, p. 497), and it becomes more self-consistent (26, p. 205). It has also been shown, however, that self-concept tends to become more positive and more consistent, and to possess a more positive relation to the self-ideal without psychotherapy when there is intensive self-introspection (26, p. 209). These differences are not as great as those occurring during the course of therapy, however.

Other ^{some} variables have been suggested as bearing some relationship to self-concept. One of these is the sex of the individual. Some results seem to indicate that women have higher self-concept scores, especially ideal-self scores, than men; but this is not a consistent finding and varies with the scale being employed to measure self-concept (19, p. 373). Age has also been suggested as having some relationship to one's self-concept (3, p. 370). One investigation into the relationship between age and self-perception found no relationship between chronological age and self-perception; it was concluded that the results were consistent

with the premise that the basic core of personality is stable throughout life (3, p. 670). The correlation coefficient between self-concept and intelligence has been found to be .32 (5, p. 59).^{SK}

The purpose of the present study is fourfold: (1) to investigate any differences in self-concept scores of a normal (adjusted) and abnormal (maladjusted) population, (2) to investigate any difference in self-concept between psychotic and nonpsychotic hospitalized patients, (3) to investigate changes in self-concept concomitant with psychotherapy, and (4) to investigate any sex differences in self-concept. The following specific hypothesis will be tested:

1. Normal, nonhospitalized subjects should have a significantly more positive self-concept than hospitalized mental patients.

2. Normal, nonhospitalized subjects should have a more consistent self-concept than hospitalized mental patients.

3. Nonpsychotic patients should have significantly more positive self-concept scores than psychotic patients.

4. Self-concept scores should become more positive during the course of psychotherapy.

5. There should be no significant difference in total self-concept scores due to sex differences.

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CHAPTER II

PROCEDURE

To test the hypotheses, the Tennessee Department of Mental Health Self-Concept Scale was administered to two populations, a normal, nonhospitalized population which consisted of college students and an abnormal, maladjusted population which consisted of hospitalized mental patients.

Subjects

The normal population (N-I) consisted of 143 psychology students from North Texas State College. Six college classes in psychology were administered the self-concept scale. Two classes were tested during the fall semester of 1959, two during the summer of 1960, and two during the spring of 1960. Two freshmen, two sophomore, and two senior classes were tested. The hospitalized population (H-I) consisted of 41 patients at Central Louisiana State Hospital. Subjects were selected from two wards of the white female receiving unit and one ward of the white male receiving unit. Thirty-one females and 10 males were tested. Subjects were selected by presence on the ward at a certain time when the testing took place. Those subjects who were illiterate or extremely confused were dismissed. Three subjects who started responding to the

scale did not finish because they were either too upset or became uncooperative because of paranoid delusions.

Description of Instrument

The instrument used to measure self-concept in the present study was The Tennessee Department of Mental Health Self-Concept Scale. The scale was developed by the following steps: a large pool of self-descriptive statements were obtained from other personality and self-concept scales, from recorded therapy protocols, and from other sources, such as commonly used phrases in everyday language. The items were edited for duplication, confusion of wording, ambiguity, etc. The items were classified into a tentative schema. Qualified judges made judgments as to the proper classification of each item in the theoretical schema. The final selection of items for the scale was made by analyzing the data from the judges and selecting the items on which the judges (six out of seven) agreed as to classification.

The present scale is an attempt to arrive at a more complex arrangement than previous scales, whereby a two-dimensional profile is obtained from categories which range along two different dimensions. A total score as well as various subscales are available. One of the dimensions contains three major categories: an abstract-description category, a self-satisfaction category, and a functioning or behavioral category.

The abstract-description category contains items to elicit the individual's description of what he is--the traits and characteristics he observes as he "backs off and looks upon himself as a perceptual object." The self-satisfaction category is intended to obtain what the individual's reaction is to what he perceives. It is considered to be an index of self-acceptance. The functioning category includes those items which describe how the individual perceives his behavior. It gets at what a person does. The second dimension varies according to the frame of reference which the individual uses. The following categories were used as major frames of reference: (1) physical characteristics (appearance, state of health, and sexuality), (2) moral and ethical characteristics (value system), (3) psychological characteristics, (4) primary group membership (self as perceived in relation to one's family and close friends), (5) secondary group membership (the self as perceived in relation to other people in general). Thus there are two dimensions of categories which apply to all the statements.

A third dimension is a positive-negative continuum. The ninety items which constitute the scale contain forty-five positive and forty-five negative statements. Statements were judged positive or negative by the judges on the criteria of whether it is psychologically desirable or undesirable to perceive oneself in light of the statement.

Determining the accuracy of the self-concept is an important aspect, and the present scale uses ten items from the L-scale of the MMPI for this purpose.

Collection of Data

Each subject was given a copy of the scale which contains 100 items. The college students were given an answer sheet, and they made their responses on the answer sheet. The hospitalized subjects did not make their responses on an answer sheet, but responded to the statement directly on the scale itself. This was done in order to simplify the procedure for the hospitalized patients. The following instructions appeared at the beginning of the scale and were read to the hospitalized population:

Instructions: These statements are to help you describe yourself as you see yourself. Please respond to them as if you were describing yourself to yourself. Do not omit any item! Read each statement carefully; then select one of the following responses; and next record the number that represents that particular answer in the blank space at the beginning of that statement.

Responses	Com- pletely true	Mostly true	Partly true and partly false	Mostly false	Com- pletely false
Number	5	4	3	2	1

Remember you are not trying to describe yourself as others see you, but only as you see yourself.

Further explanation was given individually if the individual indicated that he did not understand what to do. Space was provided at the top of the scale for each subject to write his name, age, sex, race, and education.

Scoring

Only those subjects who responded to all of the items were included in the analysis of the data. Scales were scored according to the score sheet. An example of the score sheet appears in the Appendix.

CHAPTER III

RESULTS

In order to test the first hypothesis, that normal, non-hospitalized subjects should have a significantly more positive self-concept than hospitalized mental patients, the t test of unrelated groups was employed to test the difference between the means of the N-I (normal) and H-I (hospitalized) Groups (1, p. 109). The results as given in Table I show that the H-I Group was higher in positive self-concept than N-I. This is opposite to the predicted direction. The result was significant at the .1 per cent level of confidence.

It was predicted that the normal, nonhospitalized subject would have a higher total self-concept than the hospitalized subjects. The results indicate that the hospitalized had a significantly higher total self-concept than the normal, nonhospitalized subjects. The null hypothesis, that there is no difference in the total self-concept of hospitalized and nonhospitalized subjects, can be rejected at the .1 per cent level of confidence, but the direction of the difference was opposite to that expected.

TABLE I

LEVELS OF SIGNIFICANCE OF THE DIFFERENCE BETWEEN
THE TOTAL SELF-CONCEPT SCORES OF HOSPITALIZED
AND NONHOSPITALIZED SUBJECTS

Group	N	M	SD	<u>t</u>	P
N-I	143	71.06	23.80		
H-I	41	89.93	32.41		
				3.66	.001

To test the second hypothesis, the t-test of unrelated groups was again employed (1, p. 109). The second hypothesis offered was the normal, nonhospitalized subjects should have a significantly more consistent self-concept than hospitalized mentally ill subjects. The results of the t test are summarized in Table II. Table II reveals that the hypothesis was confirmed; normal subjects were, indeed, more consistent in their self-concept, as measured by the consistency score on the TDMH Self-Concept Scale, than the hospitalized patients. The difference between the means was significant at beyond the .1 per cent level of significance. This suggests that the consistency of personality may have important implication on the adjustment level of an individual.

TABLE II

LEVELS OF SIGNIFICANCE OF THE DIFFERENCE BETWEEN
THE CONSISTENCY SCORES OF HOSPITALIZED
AND NONHOSPITALIZED SUBJECTS

Group	N	M	SD	<u>t</u>	P
N-I	143	43.14	13.45		
H-I	41	49.01	16.58	8.24	Beyond .001

The third hypothesis offered was that nonpsychotic patients should have a significantly more positive self-concept score than psychotic patients. Again, the t-test was employed to test the difference between the means. One group consisted of seventeen psychotic patients, mostly schizophrenics. The nonpsychotic subjects consisted of patients at the hospital who were not psychotic. Three were psychoneurotic, three had been diagnosed as chronic brain syndrome, and one had a personality trait disorder. The results are summarized in Table III.

TABLE III

LEVELS OF SIGNIFICANCE OF THE DIFFERENCE BETWEEN THE SELF-
CONCEPT SCORES OF PSYCHOTIC AND NONPSYCHOTIC SUBJECTS

Group	N	M	SD	<u>t</u>	P
Psychotic	17	90.6	30.4		
Nonpsychotic	7	104.8	32.5	.297	ns

As can be seen in Table III, the hypothesis that there is a difference in the self-concept between psychotic hospitalized patients and nonhospitalized psychotic patients is not confirmed. From the present result it must be concluded that there is no difference between the self-concept of the psychotic and nonpsychotic mental patient.

The fourth hypothesis offered was that self-concept scores should become more positive during the course of psychotherapy. A group of five women who were to be in group psychotherapy were tested at the first meeting. The group met for one and a half hours twice a week. The second testing took place five weeks after the initial meeting. Self-concept scores are summarized in Table IV. Due to the small number of cases in the present study, it seems unfair to test the hypothesis by the use of mean differences, but the t-test summarization for the difference between means of the total positive self-concept scores, the consistency scores, and the L-scores appear in Tables V, VI, and VII, respectively.

Since such a few cases were available for the testing of this hypothesis, it is felt that more information concerning each individual in the study should be provided. A brief description of each individual in the study was taken from each patient's hospital record. The descriptions are as follows:

Individual number one, Mary, is a young, white female, twenty years of age. She is single, has a high school education and has been employed as a waitress. Present attack of mental illness began about one year ago and she has

threatened her parents and her sister. She has been excited and depressed at times, and she thinks that her family is against her. She is not having hallucinations at the present time, but she has imagined that she sees people. She thinks that both of her parents are crazy. She is at present becoming violent, beginning about six weeks prior to entering the hospital. She laughs to herself, drinks when she can get it, and sleeps poorly. She was formerly at the hospital for a period of thirty-five days during the winter of 1958. Her diagnosis is Schizophrenic reaction, chronic undifferentiated type.

The second individual, Alice, is a white female who is thirty-three years of age. She has a high school education and has been married for twelve years. Her present attack of mental illness began only a few days ago and she is depressed and has recently had a hysterectomy. At the time of admission she was in good contact with her surroundings, but was extremely agitated and depressed. She cried when spoken to and showed no animation or interest. For some time her symptoms were not severe enough for hospitalization and during this time the patient stated that she was depressed, had no energy, could not sleep, had no appetite, suffered from gastrointestinal symptoms, and experienced tremulousness. Her husband stated that she had always been high strung and a perfectionist. She throws temper tantrums. Her diagnosis is psychoneurotic reaction, depressive reaction.

Individual number three, Betty, had been seeing private psychiatrists for two years prior to her admission to the hospital. On admission she was in good contact with her surroundings, but she was quite restless and agitated, and freely told that she was seeing the face of her grandfather and hearing his voice. She is superficial, laughs a great deal, and exhibited rather bizarre behavior. She told of an unhappy childhood and a father who showed little affection toward her and her mother; however, she was close to her grandfather. She was married to a man who was unfaithful to her and stole from every employer he had. When she found that he was a thief and unfaithful, she became nervous, depressed, and apprehensive. Her diagnosis is schizophrenic reaction, schizoaffective type.

The fourth individual, Joanne, is a thirty-one year old female with a high school education. Her illness had a gradual onset beginning two years ago when she began telling things which did not happen. She would become angry and throw things at her husband. She is destructive, depressed, excited, and homicidal. She has threatened her husband. She talks to herself, sees visions, and hears voices, and also thinks that her parents and husband are against her. On admission the patient was in good contact, cooperative, and well oriented; but she was quite confused about events that happened just before coming to the hospital. At the age of ten she found out from school friends that she was adopted. She felt that as a child she received little attention because

of her younger sister. Recently she feels that she is being hypnotized by strangers she sees and through letters. She has felt that her husband was going to kill her and that her whole family was against her. Her affect is sometimes euphoric. She projects many paranoid ideas toward members of her family. Her diagnosis is schizophrenic reaction, paranoid type.

The fifth individual, Sharon, is twenty-three years of age. She has gone to the eighth grade, but is illiterate. The patient, on admission, was vague and inappropriate, and did not know why she was in the hospital. At times she is mute and seclusive and then becomes very active and gay. She has a history of temper tantrums and hysterical episodes. She sometimes appears to be frightened, and, at times, will not respond to simple questions. She has inadequate affect, loose association, expansiveness, and illogical trends of thought. She has an infantile, uncritical and superficial manner of thinking and reacts to some life areas, particularly those which call for emotional adjustment to situations involving more than one other person. She has little or no ability to appreciate the feelings and motives of others. Her diagnosis is schizophrenic reaction, simple type.

TABLE IV

SUMMARY OF SELF-CONCEPT SCORES AT THE BEGINNING
AND AFTER FIVE WEEKS OF GROUP PSYCHOTHERAPY

	Total		L-score		Con- sis- ten- cy		Ab- str- act		Satis- fac- tion		Func- tion- ing	
	I	II	I	II	I	II	I	II	I	II	I	II
1. Mary	62	45	36	44	48	46	18	12	29	28	15	5
2. Alice	40	112	26	33	57	36	25	44	0	32	15	36
3. Betty	23	52	33	36	57	48	11	28	-1	10	13	14
4. Joanne	17	101	33	22	72	62	22	40	-17	20	12	41
5. Sharon	98	88	33	24	73	59	36	44	27	12	35	32

As can be seen in Tables V, VI, and VII, none of the mean differences between the total self-concept scores, the consistency scores, or the L-scores proved to be significant differences.

TABLE V

LEVELS OF SIGNIFICANCE OF THE DIFFERENCE BETWEEN
THE INITIAL TOTAL SELF-CONCEPT SCORES AND
AFTER FIVE WEEKS OF PSYCHOTHERAPY

Group	N	M	SD	t	P
I	7	48.00	79.6		
II	7	79.60	26.4	.667	ns

It should be noted in these Tables V, VI, and VII, however, that there were some very great changes in the total self-concept scores. These changes were not consistent or uniform, however. Three self-concept scores increased and two decreased. Nevertheless, the changes were great. For example, Joanne's total self-concept score on the first administration of the scale was 17, while on the second administration, after five weeks of psychotherapy, was 101. Alice's first total self-concept score was 40, while her second score was 112. Betty's total self-concept score increased from 23 to 52. This is an average increase of 65 points for these three individuals. This increase in self-concept scores represents a doubt in true improvement in self-concept. This will be discussed in the next chapter of this paper. Two

TABLE VI

LEVELS OF SIGNIFICANCE OF THE DIFFERENCE BETWEEN
CONSISTENCY SCORES OF SELF-CONCEPT AT THE
BEGINNING AND AFTER FIVE WEEKS OF
GROUP PSYCHOTHERAPY SELF

Group	N	M	SD	<u>t</u>	P
I	5	61.4	9.62		
II	5	50.2	9.36	1.67	ns

scores decreased. The correlation coefficient between the first and second total self-concept scores is .17.

The consistency scores showed all changes in the same direction: that is, all five consistency scores decreased. Self-concepts became more consistent. There was less discrepancy between different definitions of selves. It is believed that this is a positive sign of increased adjustment.

TABLE VII

LEVELS OF SIGNIFICANCE OF THE DIFFERENCE BETWEEN
L-SCORES AT THE BEGINNING AND AFTER FIVE
WEEKS OF PSYCHOTHERAPY

Group	N	M	SD	<u>t</u>	P
I	5	32.2	3.32		
II	5	31.8	8.02	.029	ns

The L-scores showed changes, but these changes were inconsistent. Three scores increased, showing greater truthfulness on the part of these individuals, and two scores decreased, showing less truthfulness than on the previous testing. The mean difference was almost nil. The difference proved not to be significant.

To test the fifth hypothesis, the t-test for unrelated groups was employed. The hypothesis offered was that there should be no significant difference in total self-concept scores between the sexes. The results are summarized in Table VIII.

TABLE VIII
LEVELS OF SIGNIFICANCE BETWEEN TOTAL SELF-CONCEPT
SCORES OF MALES AND FEMALES

Group	N	M	SD	<u>t</u>	P
Female	30	80.73	24.31		
Male	30	80.50	31.94	.032	ns

As can be seen in Table VIII, the hypothesis was confirmed: there was no significant difference between the mean total positive self-concept scores of men and women. The difference between the means was quite small.

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CHAPTER IV

DISCUSSION

It is believed that an individual's adjustment level and emotional health is a function of his self-concept: that is, healthy individuals have a healthy, positive self-concept, while individuals who are maladjusted do not have a good, healthy self-concept. Theories of schizophrenia, such as those of Sullivan and Cameron, emphasize the importance of a poor self-concept and a distorted view of other persons as important factors in the development of schizophrenia (4, p. 203). Horney (7) describes the maladjusted individual (neurotic) in the following terms: "What he wants is so little, only that people should be kind to him, should give him advice, should appreciate that he is a poor, harmless, lonely soul. . . ." The neurotic, according to Adler (1), is one who has set up fictitiously high goals because of intense feelings of inferiority and abnormal need for power. These goals, being unrealistic, are unobtainable, and failure to achieve or live up to one's image of himself results in increased feelings of anxiety and inferiority. Thus, in general, maladjustment is believed to be associated with a poor self-concept and a distorted view of oneself.

The present study is intended to test the theory that maladjustment is associated with a poor self-concept and a distorted view of oneself. The results presented in Table I, as presented in Chapter III, showed that the total positive self-concept score of hospitalized patients was significantly higher than a group of college students. These results seem inconsistent or contradictory with the theory previously presented. Self theory can account for the present results, however. Self theory contends that tensions arise when the organism strives to satisfy needs not consciously admitted and to respond to experience denied by the conscious self. Anxiety is felt when the individual is aware of this tension or discrepancy. The more perceptions of experience inconsistent with the concept of the self there are, the more rigid is the organization of the self-structure. When the self can no longer defend itself against the deep threats, a psychological breakdown or disintegration occurs. The anxiety is reduced by denial or distortion of perceived experience. Sullivan (8), similarly, states that anxiety appears when anything spectacular happens that is not welcome to the self.

Most of the subjects in the hospitalized group in the present study were psychotic and had experienced a severe psychological breakdown. Because of the severity of disintegration in this population, their revealing of their self-concept was highly defensive. For these hospitalized individuals, a distortedly high self-concept of a compensatory nature is believed to have been obtained. It is concluded

that the present study supports the belief that a high self-concept can compensate for underlying negative attitudes.

The present findings are not inconsistent with previous studies, for other investigators have found that defensiveness and denial seem to be main defenses of individuals who have experienced a severe psychological break (5, p. 419).

Not only is one's total self-concept score believed to be related to the level of one's adjustment, but also one's consistency score, the discrepancy between different aspects of self-concept, is believed to be related to one's level of adjustment. Individuals who have a consistent view of themselves are believed to be better adjusted than those individuals who are not consistent in viewing themselves. There is a discrepancy in viewing different aspects of self-concept in the maladjusted. This discrepancy is believed to produce tension and the tension produces anxiety. That consistency is related to the level of adjustment which tends to be confirmed by the present study. (See Table II.) The hospital population was significantly more inconsistent in the self-concept than the normal population. The effect of the defensiveness and denial, as presented previously, is unknown. It may be that if the process of denial and distortion were not present, inconsistency may have been even more pronounced. Present results indicate the mean difference between consistency scores of a normal population and a maladjusted hospital population to be significant at the .1 per cent level of significance. Hospitalized subjects in the experiment were

inconsistent in self-concept. The self-concept of the "adjusted" college population seems to have a higher degree of organization and to be more consistent in self-definition. The present results seem to indicate that consistency of self-concept may be a better indication of emotional condition or level of adjustment than a total self-concept score.

Both the total positive self-concept score and the consistency of self-concept have been used to evaluate the level of adjustment and also the degree of improvement in psychotherapy. Using these two criteria in regard to five women undergoing group psychotherapy, it was found that during the course of psychotherapy both the total self-concept and the consistency of the self-concept improved. The mean self-concept of the group increased from 48 to about 80. The consistency score decreased from about 61 to 50. This indicates that there was less discrepancy between different aspects of self-concept after five weeks of psychotherapy. From these two criteria, taken in isolation, it would seem that psychotherapy improved the level of adjustment. However, in light of the first hypothesis revealing the possibility of defensiveness and denial operating in the case of high self-concept scores, the criteria of total self-concept scores should be scrutinized more carefully. In two of the cases in the group there was a very great jump in total self-concept, Alice and Joanne. It is believed by this investigator that in both of these cases the rise in self-concept is unrealistic, and there was no concomitant change in behavior. And, in the

case of Sharon, in which there was a decrease in self-concept, it is believed that this decrease was a move toward a more realistic self-concept. This serves to indicate that a change in self-concept scores may not be a valid indication of progress in psychotherapy. In light of the results obtained in the testing of the first hypothesis, that a total self-concept score can indicate level of adjustment, it can be questioned. What is needed in this case is some measure of what would represent a realistic self-concept for each individual in the group. In this way an increase in self-concept score may represent an improvement if it is toward a more realistic self-concept, but likewise a decrease in self-concept could represent an increased level of adjustment if the decrease is toward a more realistic self-concept. All this serves to indicate the lack of a valid set of criteria of improvement in psychotherapy. It should also be noted that participation in psychotherapy is no guarantee of improvement nor preventive of further deterioration. This is a confounding factor in obtaining a valid criterion for improvement in psychotherapy. In the present study, perhaps a sociometric rating by other members of the group could have provided a criterion of realistic self-concept against which change in self-concept could have been compared. It is felt that this is a major weakness of the present study.

One could also expect that with successful psychotherapy there would be less defensiveness and greater truthfulness in defining oneself. One measure of truthfulness in the present

study is the L-score. It can be concluded from the present study that there was little change in truthfulness of the group as a whole. There were individual changes, however. This score, like total self-concept and consistency, may be used as a criterion of improvement of change due to psychotherapy.

Other studies have indicated that there may be great differences in self-concept among different types of mental illness. It is believed that psychosis represents a greater disintegration in self-concept than neurosis. Studies have indicated that there is a great difference in the self-concepts of neurotics and psychotics. Results in the present study as well as other studies have indicated that due to defensiveness the self-concept of psychotics is distortedly high. The self-concept of neurotics has been found to be significantly lower (6, p. 83).

Little can be concluded concerning the instability of self-concept, as measured by the correlation coefficient between the first and second administration to the psychotherapy group. First, there is a tendency for the reliability of self-ratings to decrease as the time interval between ratings increases (10, p. 52). Thus, some change due to time can be expected. Most studies indicate that for a four-week period the reliability should be around .80 (2, p. 605; 3, p. 215). The present coefficient was .17, which is much lower than would ordinarily be expected. Second, it is believed by some investigators that stability of self-concept is a

characteristic of maladjustment (2, p. 203). This could account for the low correlation coefficient. Another factor to be considered is the effect of psychotherapy itself. The psychotherapy may have been the dominant factor in effecting a change in the self-concept. Also, introspection, even without psychotherapy, tends to alter self-ratings (9, p. 208). Since no effort was made to control these factors, no conclusions can be reached.

It was hoped that the present study could confirm the previous finding that there is a difference in self-concept between the psychotic and the nonpsychotic hospital patients. However, because of the lack of psychoneurotics in the hospital population, this hypothesis could not be properly tested. The present results indicate no difference between psychotic and nonpsychotic patients.

Rating scales differ as to the effect of the sex of the individual responding to the scale. Females tend to score higher on some self-concept scales. Present testing indicates that no such sex differences are present in The Tennessee Department of Mental Health Self-Concept Scale.

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CHAPTER V

CONCLUSIONS

The hypothesis that there is a difference in the total self-concept scores between a hospitalized, mentally ill group and a group of college students was tested. The results showed that there was a significant difference in the self-concept scores between the two groups. The hospital group had significantly higher self-concept scores than did the college group. These results were accounted for in terms of defensiveness, distortion, and denial on the part of individuals who have undergone severe psychological breaks.

The hypothesis that there is a difference in consistency of self-concept between a hospitalized, mentally ill group and a college group was confirmed. The college group was significantly more stable in their self-concept than was the hospitalized group. It was suggested that the consistency of self-concept may be a better measure of the level of adjustment of the individual than a total self-concept score. Also it was suggested that the consistency of self-concept may have been distorted from its true relationship to mental illness by the operation of the mechanism of denial.

The hypothesis that there is a difference in self-concept between psychotic patients and nonpsychotic subjects

could not be confirmed by the present study. The lack of an adequate number of neurotics in the hospitalized subjects is believed to have prevented a fair test of the hypothesis.

A group of five women who were undergoing psychotherapy was used to test the hypothesis that self-concept increases or becomes more positive during the course of psychotherapy. It was concluded that with such a small group statistical treatment of the data was inadequate. Observation of the data revealed that the mean self-concept of the group did increase greatly, but that this "improvement" in self-concept was an adequate criterion for improvement in level of adjustment due to psychotherapy was questioned. The lack of an adequate realistic measure of self-concept, the lack of a valid objective criterion for evaluating psychotherapy, and the lack of proper controls in evaluating changes due to psychotherapy were pointed out.

The present study indicates that the consistency of self-concept is the most uniform change found in the group undergoing psychotherapy. All consistency scores showed definite improvement: that is, the self-concept of everyone in the therapy group became more consistent after five weeks of group therapy. Consistency was suggested as a possible index of the level of adjustment of the individual.

A final hypothesis tested was that no significant difference in the total self-concept scores exists between the sexes on the Tennessee Department of Mental Health Self-Con-

cept Scale. The results indicate that unlike some other measures of self-rating, the TDMH Self-Concept Scale does not possess any significant differences in the way that men and women respond to it. This seems to be an advantage of the present scale.

APPENDIX

TDMH--SELF-CONCEPT SCALE

1. I have a healthy body.
4. I am full of aches and pains.
7. I am neither too fat nor too thin.
10. I don't feel as well as I should.
13. I take good care of myself physically.
16. I do poorly in sports and games.
19. I am a decent sort of person.
22. I am a moral failure.
25. I am satisfied with my moral behavior.
28. I wish I could be more trustworthy.
31. I am true to my religion in my everyday
life.
34. I sometimes use unfair means to get
ahead.
37. I am a cheerful person.
40. I am a hateful person.
43. I am satisfied to be just what I am.
46. I am not the person I would like to be.
49. I can always take care of myself in
any situation.
52. I change my mind a lot.
55. I have a family that would always help
me in any kind of trouble.

- ✓
_____ 58. I am not loved by my family.
- _____ 61. I am satisfied with my family
relationships.
- ✓
_____ 64. I am too sensitive to things my family
says.
- ✓
_____ 67. I try to play fair with my friends and
family.
- ✓
_____ 70. I quarrel with my family.
- ✓
_____ 73. I am a friendly person.
- _____ 76. I am mad at the whole world.
- ✓
_____ 79. I am as sociable as I want to be.
- ✓
_____ 82. I should be more polite to others.
- ✓
_____ 85. I try to understand the other fellow's
point of view.
- _____ 88. I do not feel at ease with other people.
- ✓
_____ 91. I do not always tell the truth.
- ✓
_____ 92. Once in a while I think of things too
bad to talk about.
- ✓
_____ 93. I get angry sometimes.
- _____ 2. I like to look nice and neat all the
time.
- ✓
_____ 5. I consider myself a sloppy person.
- _____ 8. I am neither too tall nor too short.
- _____ 11. I would like to change some parts of
my body.
- _____ 14. I feel good most of the time.
- _____ 17. I often act like I am "all thumbs."

- _____ 20. I am a religious person.
- _____ 23. I am a bad person.
- _____ 26. I am as religious as I want to be.
- _____ 29. I ought to go to church more.
- _____ 32. I do what is right most of the time.
- _____ 35. I sometimes do very bad things.
- _____ 38. I have a lot of self-control.
- _____ 41. I am a nobody.
- _____ 44. I am as smart as I want to be.
- _____ 47. I despise myself.
- _____ 50. I solve my problems quite easily.
- _____ 53. I do things without thinking about them
first.
- _____ 56. I am an important person to my friends
and family.
- _____ 59. My friends have no confidence in me.
- _____ 62. I treat my parents as well as I should.
- _____ 65. I should trust my family more.
- _____ 68. I do my share of work at home.
- _____ 71. I give in to my parents.
- _____ 74. I am popular with women.
- _____ 77. I am not interested in what other
people do.
- _____ 80. I am satisfied with the way I treat
other people.
- _____ 83. I am no good at all from a social
standpoint.

- ✓
_____ 86. I see good points in all the people I
meet.
- _____ 89. I do not forgive others easily.
- ✓
_____ 94. Sometimes, when I am not feeling well,
I am cross.
- ✓
_____ 95. I do not like everyone I know.
- ✓
_____ 96. I gossip a little at times.
- _____ 3. I am an attractive person.
- _____ 6. I am a sick person.
- _____ 9. I like my looks just the way they are.
- ✓
_____ 12. I should have more sex appeal.
- ✓
_____ 15. I try to be careful about my appearance.
- ✓
_____ 18. I am a poor sleeper.
- ✓
_____ 21. I am an honest person.
- _____ 24. I am a morally weak person.
- _____ 27. I am satisfied with my relationship to
God.
- ✓
_____ 30. I shouldn't tell so many lies.
- ✓
_____ 33. I try to change when I know I'm doing
things that are wrong.
- ✓
_____ 36. I have trouble doing things that are
right.
- _____ 39. I am a calm and easy-going person.
- _____ 42. I am losing my mind.
- ✓
_____ 45. I am just as nice as I should be.
- ✓
_____ 48. I wish I didn't give up as easily as I
do.

- _____ 51. I take the blame for things without
getting mad.
- ✓ _____ 54. I try to run away from my problems.
- _____ 57. I am a member of a happy family.
- ✓ _____ 60. I feel that my family doesn't trust me.
- _____ 63. I understand my family as well as I
should.
- ✓ _____ 66. I should love my family more.
- _____ 69. I take a real interest in my family.
- ✓ _____ 72. I do not act like my family thinks I
should.
- _____ 75. I am popular with men.
- _____ 78. I am hard to be friendly with.
- _____ 81. I try to please others, but I don't
overdo it.
- _____ 84. I ought to get along better with other
people.
- _____ 87. I get along well with other people.
- _____ 90. I find it hard to talk with strangers.
- ✓ _____ 97. ~~Once in a while~~, I laugh at a dirty
joke.
- ✓ _____ 98. ~~At times~~ I feel like swearing.
- ✓ _____ 99. I would rather win than lose in a game.
- ✓ _____ 100. Once in a while I put off until tomor-
row what I ought to do today.

The Tennessee Department of Mental
Health Self-Concept Scale
(Score Sheet)

Name	Age	Sex	Diagnosis
Number	Date of Test	Group	

How the Individual Perceives Himself

In terms of:	His physical characteristics, appearance, etc.			His moral-ethical characteristics			Psychological characteristics		
Abstract description (What he is)	1	2	3	19	20	21	37	38	39
			P			P			P
	4	5	6	22	23	24	40	41	42
			N			N			N
		Net	P		Net	P		Net	P
Self satisfaction (How he feels about himself)	7	8	9	25	26	27	43	44	45
			P			P			P
	10	11	12	28	29	30	46	47	48
			N			N			N
		Net	P		Net	P		Net	P
Functioning or behavior (What he does)	13	14	15	31	32	33	49	50	51
			P			P			P
	16	17	18	34	35	36	52	53	54
			N			N			N
		Net	P		Net	P		Net	P

Net Positive Score _____

Consistency Score _____

Distribution: Category 5 4 3 2 1
 No. of items ----- Total

Score Sheet--Continued

Primary group membership			Secondary group membership			Net Positive Score	Consistency Score	L-Score
55	56	57	73	74	75			
		P _____			P _____			91 _____
58	59	60	76	77	78			92 _____
		N _____			N _____			
	Net	P _____		Net	P _____	_____	_____	93 _____
61	62	63	79	80	81			94 _____
		P _____			P _____			95 _____
64	65	66	82	83	84			96 _____
		N _____			N _____			
	Net	P _____		Net	P _____	_____	_____	97 _____
87	68	69	85	86	87			98 _____
		P _____			P _____			99 _____
70	71	72	88	89	90			100 _____
		N _____			N _____			
	Net	P _____		Net	P _____	_____	_____	Tot. _____
		_____			_____	Tot.	Tot.	
		_____			_____	Tot.	Tot.	

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