Validation of the Defining Characteristics of Disturbance in Self-esteem in Patients with Anorexia Nervosa

June C. Peteron Larson

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VALIDATION OF THE DEFINING CHARACTERISTICS
OF DISTURBANCE IN SELF-ESTEEM IN
PATIENTS WITH ANOREXIA NERVOSA

BY
JUNE C. PETERSON LARSON

A thesis submitted in partial fulfillment
of the requirements for the degree
Master of Science
Major in Nursing
South Dakota State University
1987
VALIDATION OF THE DEFINING CHARACTERISTICS
OF DISTURBANCE IN SELF ESTEEM IN
PATIENTS WITH ANOREXIA NERVOSA

This thesis is approved as a creditable and
independent investigation by a candidate for the degree
Master of Science, and is acceptable for meeting the thesis
requirements for this degree. Acceptance of this thesis
does not imply that the conclusions reached by the candidate
are necessarily the conclusions of the major department.

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VALIDATION OF THE DEFINING CHARACTERISTICS

Title: OF DISTURBANCE IN SELF-ESTEEM

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Abstract (approximately 150 words)

A low self-esteem is a critical, pervasive problem in the lives of clients with eating disorders. The purpose of this study was to validate the defining characteristics of the nursing diagnosis, Disturbance in Self-Esteem, in a specific population group. The purposive, nonprobability sample consisted of 26 females between the ages of 13 and 24 who had a medical diagnosis of Anorexia Nervosa. This study addressed the following question: Does the cluster of defining characteristics for Disturbance in Self-Esteem, as defined by NANDA, occur in clients diagnosed as having Anorexia Nervosa; clients in whom a disturbed self-esteem is manifest.

The Tennessee Self-Concept Scale (TSCS) (Fitts, 1965) was used to assess self-esteem. The mean positive score of the subjects who took part in this study was 280.9, which falls in the 4th percentile, indicating a low self-esteem.

The Self-Esteem Assessment Tool (Norris & Kunes-Connell, 1985) was used to assess the defining characteristics. Descriptive statistics were used to describe the actual frequency of each identified defining characteristic manifest in this sample population. The eight defining characteristics of Disturbance in Self-Esteem do occur in this sample population of subjects with a low self-esteem.

Those defining characteristics which occurred in 77% to 96% of all subjects and appear to be critical indicators of the label Disturbance in Self-Esteem are: lack of follow-through, overly conforming/independent on other's opinions, indecisive, seeks excessive reassurance, minimizes positive/exaggerates negatives regarding self, expresses shame/guilt, and evaluates self as unable to deal with difficult situations. These defining characteristics should be further researched in clinical validation studies.

I give my permission to the College of Nursing, SDSU to publish this abstract in a collection of abstracts from master's projects and theses.
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All the beautiful girls on the eating disorders unit who were willing to share their pain with me, that others might benefit and grow;
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And last, but with most loving thanks -
My family, who believes in me.
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CHAPTER 1

Introduction to the Problem

Introduction

In 1973 nurses across the nation met to begin developing a taxonomy for their profession. The purpose of this meeting was to attempt to clarify those things that nurses identify or diagnose in their patients, and then title, or give a nomenclature to those identified problems. This group of nurses, members of the North American Nursing Diagnosis Association (NANDA), still meet on a biennial basis to continue to develop a diagnostic classification system.

The presently accepted classification system was developed by having groups of participants at the national conferences recall experiences from practice, and then inductively identify a diagnostic category. Collectively, the groups identified diagnostic categories, as well as a list of defining characteristics and possible etiologies for each. These were based on the nurses' own personal experiences.

Statement of the Problem

Although construction of diagnostic titles using the inductive method has been useful to NANDA, it can lead to diagnostic errors. "The best way to avoid errors is to test ideas in the real world" (Gordon, 1982b, p. 192). The
diagnostic titles, or each specific nursing diagnosis needs to be tested, and possible etiologies and defining characteristics must be validated through the research process. This study seeks to validate the work of NANDA. Does the cluster of defining characteristics for Alteration in Self-Concept: Disturbance in Self-Esteem, as defined by NANDA, occur in clients medically diagnosed as having anorexia nervosa, in whom a disturbed self-esteem is manifest?

Significance of the Study

Validation of defining characteristics is necessary to increase the accuracy of diagnostic titles, which is essential to nurses in providing safe nursing care designed to prevent, reduce or eliminate the problem identified in the nursing diagnosis.

Variables

The variables in this study include the occurrence/non-occurrence of each of the eight defining characteristics for Alteration in Self-Concept: Disturbance in Self-Esteem. The defining characteristics of Disturbance in Self-Esteem include:

1. Lack of eye contact.
2. Head flexion, shoulder flexion.
4. Expressions of shame or guilt.
5. Evaluates self as unable to deal with situations or events.
7. Non-participation in therapy (choosing).

Objectives of the Study

The objectives of this study were as follows:
1. Analyze the specific nursing diagnosis of Disturbance in Self-Esteem, within the category of Alteration in Self-Concept.
2. Determine the actual frequency of each identified defining characteristic.
3. Identify the critical cluster of defining characteristics for Disturbance in Self-Esteem.
4. Compare the defining characteristics identified in clients with a disturbance in self-esteem to those assigned to the nursing diagnosis Disturbance in Self-Esteem.
5. Clarify the definition for Disturbance in Self-Esteem.

Definition of Terms

The following terms were used in this study:

Nursing diagnosis. "Nursing diagnosis, or clinical diagnosis made by professional nurses, describe actual or potential health problems which nurses by virtue of their education and experience are capable and licensed to treat" (Gordon, 1982b, p. 2).
**Taxonomy.** "A classification system" (Gordon, 1982, p. 305).

**Classification system.** "The ordering of phenomena in a systematic way for some purpose" (Gordon, 1982, p. 305).

**Nomenclature.** The assignment of names, labels.

**Diagnostic labels.** "The nomenclature of nursing diagnoses" (Kim & Moritz, 1982, p. 4).

**Diagnostic category.** A division in a classification system, which specifically defines a health problem.

**Title.** A label, for the concise description of the individual's actual or potential health problem.

**Etiology.** "Contributing factors; those physiological, situational, or maturational factors that cause the problem or influence its development" (Carpenito, 1983, p. 10).

**Defining characteristics.** A cluster (or grouping) of signs and symptoms that are observed in the person with the problem.

**Cues.** "A cue is defined as information which influences decisions" (Gordon, 1982b, p. 127). Clinical data collected during a purposeful assessment are cues to the health status of a client.

**Inductive reasoning.** "The process of developing generalizations from specific observations" (Polit & Hungler, 1978, p. 19).
Validation. To confirm the validity of something so that it is able to withstand criticism or objection. Clinical information is valid if it accurately represents critical properties of a problem.


Anorexia nervosa. "A struggle for self-respecting identity in which there is excessive concern with the body and its size, and rigid control over eating" (Bruch, 1978, p. x; Bruch, 1977, p. 1).

North American Nursing Diagnosis Association (NANDA). A group of nurses from all regions of the United States and Canada, who represent all elements of the profession, "who have a special interest in articulating those health problems which nurses are licensed and accountable to treat, thereby clarifying the domain of nursing practice" (Kim & Moritz, 1982, p. xviii).

Organization of the Study

This study was organized as follows:

1. Chapter 1 consists of the introduction, statement of the problem, significance of the study, variables, objectives of the study and definition of terms.

2. Chapter 2 reviews selected literature pertinent to the study.

3. Chapter 3 includes a conceptual framework for
Self-Esteem and the purpose of the study.

4. Chapter 4 presents the research design and methodology.

5. Chapter 5 presents the statistical design.

6. Chapter 5 includes the summary, conclusions, implications, limitations and recommendations.
Diagnosis Process

The diagnostic process requires an accurate health assessment of the client, including collection of subjective and objective data. These data are also called signs and symptoms, defining characteristics or cues. The nurse groups the defining characteristics into clusters of like data. Nurses need to identify the probable etiologies, or probable causes of the problem. The nurse interprets the information she/he has gathered, then assigns the diagnostic title which is appropriate for the identified defining characteristic. Once the diagnosis has been made, the nurse independently orders the appropriate nursing care and treatments that will bring about alleviation of the problem. She/he will also include interdependent nursing actions in the nursing plan of care. "The interdependent dimension of nursing refers to those problems or clinical situations that nurses and other health care professionals, most frequently physicians, collaborate to prescribe and treat" (Carpenito, 1983, p. 15).

Hickey (1984) defines the relationship of nursing diagnosis to the nursing process in the following schematic drawing (displayed on page 8).
Nursing Diagnosis: Alteration in Self-Concept

An alteration in self-concept is defined by Kim and Moritz (1982) as "a disruption in the way one perceives one's body image, self-esteem, role performance, and/or personal identity" (p. 308). Carpenito (1983) defines an alteration in self-concept as:

the state in which the individual experiences or is at risk of experiencing a negative state of change about the way he feels, thinks, or views himself. It may include a change in body image, self-esteem, role performance, or personal identity (p. 389).
Common etiological and contributing factors of a disturbance in self-concept are identified by Carpenito (1983):

A. Pathophysiological
   1. Loss of body part(s).
   2. Loss of body function(s).
   3. Severe trauma.

B. Situational
   1. Divorce, separation from or death of a significant other.
   2. Loss of job or ability to work.
   3. Hospitalization; chronic or terminal illness.
   5. Surgery.
   6. Obesity.
   7. Pregnancy.
   8. Immobility or loss of function.

C. Maturational
   1. Infant and pre-school: deprivation.
   2. Young adult: peer pressure, puberty.
   3. Middle-aged: signs of aging (graying or loss of hair), reduced hormonal levels (menopause).
   4. Elderly: losses (people, function, financial, retirement).
D. Other

1. Women's movement.
2. Sexual revolution (p. 389).

Disturbance in self-concept is manifested in a variety of ways. The given defining characteristics include:

1. Refusal to touch or look at a body part.
2. Refusal to look in a mirror.
3. Unwillingness to discuss a limitation, deformity or disfigurement.
4. Refusal to accept rehabilitation efforts.
5. Inappropriate attempts to direct own treatment.
6. Denial of the existence of a deformity or disfigurement.
7. Increasing dependence on others.
9. Refusal to participate in own care or take responsibility for self-care (self-neglect).
10. Self-destructive behavior (alcohol, drug abuse).
11. Displaying hostility toward the healthy.
12. Withdrawal from social contacts.

Disturbance in self-concept has been described as a diagnosis that is "too abstract and vague for clinical usefulness" (Gordon & Sweeney, 1979, p. 1). Kim and Moritz (1982) report that further development in defining and developing each of the four sub-sets of Alteration in Self-Concept: (a) self-esteem, (b) body image, (c) role performance, and (d) personal identity, is recommended.

The nursing diagnosis of Disturbance in Self-Esteem currently approved for research studies by NANDA is described as follows:

Problem: Disturbance in Self-Esteem: negative feelings or conceptions of self (social self, self capabilities).

Etiologies: Loss of significant roles, unrealistic self expectations.

Defining Characteristics:
1. Lack of eye contact.
2. Head flexion, shoulder flexion.
4. Expressions of shame or guilt.
5. Evaluates self as unable to deal with situations or events.
7. Non-participation in therapy (choosing).

In order for the nurse to be therapeutic, she/he needs to have the knowledge and tools necessary to identify the signs and symptoms (defining characteristics) of a Disturbance in Self-Esteem, analyze these and make the inferences necessary to assign the diagnostic title. This requires an accurate definition of the problem, etiologies, and cluster of defining characteristics. A review of the concept of self-esteem follows.

The Concept of Self-Esteem

Cantor (1980) describes self-esteem as the reputation we have with ourselves; the belief that we are competent to live and enjoy life, and are worthy to do so.

Coopersmith (1967), in his book Antecedents of Self Esteem, defines self-esteem in terms of evaluative attitudes toward the self:

By self-esteem, we refer to the evaluation which the individual makes and customarily maintains with regard to himself; it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful and worthy (p. 4).
Rogers (1961) presents self-concept as one's image of oneself. Included is an awareness of being and of function; what I am and what I can do. Rogers (1961) and Erikson (1968) share a belief that a person's self-concept includes not only his perception of what he is really like, but also that which he would like most to be and which he thinks he ought to be. It is the "body self vs. the ideal self" (Erikson, 1968, p. 211).

Human beings have a basic need for love, acceptance, and respect from the significant others in one's life (Coopersmith, 1967; Erikson, 1968; Rogers, 1961). Coopersmith's (1967) study results suggest that "individuals with a low self-esteem receive less affection than those with a more favorable self-regard" (p. 169). Rogers (1967) emphasizes the need for unconditional positive regard, an environment in which the individual is valued and loved for what he is.

Coopersmith (1967) identified four major factors that contribute to the development of self-esteem:

1. Respectful - accepting and concerned treatment from significant others - we value ourselves as we are valued.

2. A history of successes, and the status and position held in the world - it is by living up to aspirations in areas that he regards as personally significant that the individual achieves self-esteem.
3. Values and aspirations - success and power and attention are perceived in the light of personal goals and values.

4. Manner of responding to devaluation - minimizing, distorting or suppressing demeaning actions by others to defend self-esteem (p. 37).

Coopersmith (1967) has identified conditions and experiences that seem to be associated with the development of positive and negative self-attitudes. Successes, values and aspirations, and defenses are important concepts in the development of self-esteem.

1. Success - the term success has a different meaning to each individual. There are four criteria employed for defining success.
   a) Power - the ability to influence and control others.
   b) Significance - the acceptance, attention, and affection of others.
   c) Virtue - adherence to moral and ethical standards.
   d) Competence - successful performance in meeting demands for achievement.

2. Values and Aspirations - individuals have formed different values during their lifetime and ascribe different levels of importance to various successes.
3. Defenses - an individual's manner of dealing with threat and uncertainty is an attempt to defend his self-esteem against feelings of incompetence, and powerlessness (p. 38-41).

**Expressions of Self-Esteem**

This study is concerned with the expressions of self-esteem, specifically the signs and symptoms that are expressive of a disturbance in self-esteem. The literature review indicates that individuals who have a positive self-esteem are happier and more productive in society, while the individuals with a negative or low self-esteem experience feelings of distress, inadequacy, and tend to withdraw from people. They live in a markedly different world. The individuals with a positive self-esteem experience the same events in a different way and have different expectations for the future than the individuals with a low self-esteem.

Individuals with a positive self-esteem expect to be accepted and respected by others, and expect to be successful in the endeavors they encounter. They believe in themselves and have a favorable appraisal of themselves. "The individual with a high self-esteem feels capable of coping with adversity and competent enough to achieve success" (Coopersmith, 1967, p. 261).

The individuals with a negative or low self-esteem are preoccupied with themselves and their difficulties, and
are extremely self-conscious. They lack trust in themselves. They set lower aspirations for themselves and expect to fail. They desire success, but do not believe in their ability to achieve. The individuals with a low self-esteem feel helpless, vulnerable and inadequate. "Such convictions of helplessness are learned reactions to self-responses and the responses of others" (Coopersmith, 1967, p. 261).

Anorexia Nervosa and Self-Esteem

Bruch (1977), a foremost investigator of anorexia nervosa views this problem as "a struggle for a self-respecting identity" (p. 1). Bruch (1978) believes the core issue in anorexia nervosa is a dissatisfaction with the self, an overwhelming sense of ineffectiveness.

I have formulated the concept that this excessive concern with the body and its size, and the rigid control over eating, are late symptoms in the development of youngsters who have been engaged in a desperate fight against feeling enslaved and exploited, not competent to lead a life of their own. In this blind search for a sense of identity and selfhood, anorexic youngsters will not accept anything that their parents, or the world around them, have to offer. They would rather starve than continue a life of accommodation (p. x). The focus of Bruch's (1978) inquiry was on pre-illness features of anorexia nervosa. Three areas of
disturbed psychological functioning were characteristic:

1) Severe disturbances in the body image, the way they see themselves; 2) misinterpretations of internal and external stimuli, with inaccuracy in the way hunger is experienced as the most pronounced symptom; 3) a paralyzing underlying sense of ineffectiveness, the conviction of being helpless to change anything about their lives. It is against this background of feeling helpless vis-a-vis life's problems that the frantic pre-occupation with controlling the body and its demands must be understood (p. x).

Those who suffer from anorexia nervosa come from homes that seem relatively stable. They were well fed and well clothed as children, and were given the best educational opportunities. The perplexing question asked by practitioners is "how successful and well functioning families fail to transmit an adequate sense of confidence and self-value to these children" (Bruch, 1978, p. 39).

The parents are described as overprotective, where "loyalty and protection take precedence over autonomy and self-realization" (Minuchin, Rosman, & Baker, 1978, p. 59). The family is typically child-oriented. The parents express great concern over the child's activities and expect excellence in all that is done. The children develop an obsessive concern for perfection in an attempt to fulfill
their parent's dream. The children are keenly aware of themselves and how others respond to their actions. They believe they must do just as the parents have planned and expected them to do. They learn to act just as the family expects. Because of a concern about their effect on others, especially their parents, they hesitate to do anything on their own and become increasingly dependent on their parents' approval (Bruch, 1977; Minuchin et al., 1978).

Individuals with anorexia nervosa:

Grow up confused in their concept about the body and its functions and deficient in their sense of identity, autonomy, and control. In many ways they feel and behave as if they have no independent rights, that neither their body nor their actions are self-directed, or not even their own. They misperceive or misinterpret their bodily sensations, they do not see themselves realistically and they suffer from an all pervasive conviction of being ineffective, of having no control over their own life or in relation to others (Bruch, 1978, p. 39).

Individuals with anorexia nervosa highly value family loyalty. They feel greatly responsible for not embarrassing their family in any way. The individuals expect family members to focus on their actions, and comment on them. "Large areas of their psychological and bodily functioning remain the subject of others' interest and
control long after they should become autonomous" (Minuchin et al., 1978, p. 59).

As children, the individuals with anorexia nervosa lag behind developmentally; they have not developed the skills necessary for dealing with their own age level. With the onset of adolescence, conditions change. The children find that their desire to be like their peers, and to associate with them, comes in direct conflict with their parents' values and ideals. The children no longer feel they are living a life of their own. They no longer trust in their inner feelings and choices, they feel they are the property of their parents; helpless under the influence of internal urges and external demands (Bruch, 1978).

According to Bruch (1978), "the most persistent worry and strain is in relation to family and home. Though considered the perfect child, the patient lives in a continuous fear of not being loved and acknowledged" (p. 54). One young girl stated, "I knew they loved me - I made sure they would" (Bruch, 1978, p. 54), and then explained that under no circumstances would she do anything that might deserve criticism.

During adolescence the anorexic children attempt to make changes and become more independent. This is unacceptable to the parents. Bruch (1977), in her work of psychotherapy with patients suffering from anorexia nervosa, has come to believe that the "illness begins as an expression
of this struggle that is not being acknowledged" (p. 3).
A young girl's account of her life's influences are evident in this case history from Bruch's (1978) work.

I was trying to be somebody my parents wanted me to be, or at least the person I thought they wanted me to be. Maybe it was all my own feelings that sensed that Daddy wanted me to be a good student and to have the right friends, for he never stated it outright. I just kind of felt it deep down inside. It was like in the atmosphere or in the air around me. It was really a self-imposed pressure because he never outwardly asked me to study. I did the best I could, but I guess it wasn't good enough. I failed in all ways (p. 81, 82).

**Summary of Literature Review of Self-Concept and Anorexia**

Individuals who accept themselves and perceive themselves to be worthy of love and affection, competent and successful in their endeavors, will continue to grow and develop their potentialities and lead happy and productive lives. On the other hand, if they perceive themselves to be unlovable, worthless, incompetent, and cannot accept themselves, their life will be that of self-doubt. They will be fearful of being hurt and much of their energies will be used to defend themselves.
Individuals have to believe they can succeed if they are to have success in anything. Individuals who see themselves as failures will be failures. Self-esteem and how the individuals perceive themselves will have a profound effect on their lives.

A core issue in anorexia nervosa is a dissatisfaction with the self, an overwhelming sense of ineffectiveness. Individuals with anorexia nervosa are in search of a sense of identity and selfhood. They feel helpless in dealing with life's problems. Typically, clients with anorexia nervosa are highly self-critical and experience themselves as inadequate in most areas of social or personal functioning. Developmentally, the individuals were never given an opportunity to fulfill their desires. Everything that they were allowed to do was to accomplish others' dreams and desires, especially their parents. All their actions were observed, excellence was expected. The anorexics then learned to demand perfection from themselves in order to please others (Bruch, 1978).

Anorexics are deficient in their sense of identity, autonomy and control. They feel overwhelmingly ineffective and out of control. Developmentally, they lag behind others their age, because they have not developed the skills necessary for dealing with their own age level. Adolescence becomes a time of crises and anorexia nervosa begins as an expression of this struggle that is not being acknowledged.
by parents who find their children's impending independence unacceptable.

Summary of Review of the Literature

1. Human beings have a basic need for love, acceptance, and respect from the significant others in their lives.

2. Human beings have a need for unconditional love - being loved for "who" they are, not because of "what" they are.

3. A history of successes in areas the individuals personally regard as significant, boosts their self-esteem.

4. It is through achieving their own personal values and goals that individuals achieve a favorable perception of themselves.

5. Individuals who accept themselves and perceive themselves to be worthy of love and affection will lead a happy and productive life.

6. Individuals who perceive themselves as unlovable, worthless, and incompetent will live a life of self-doubt, with little chance of success.

7. A core issue in anorexia nervosa is a dissatisfaction with the self, an overwhelming sense of ineffectiveness.

8. The anorexics environment fails to allow them to develop a sense of autonomy, a sense of competency, a
feeling of trust in themselves. They are filled with self-doubt.

9. The anorexic's life is one of accommodating to others' wishes and desires, accomplishing that which others expect them to do. They no longer trust their own choice of actions.

10. Anorexia nervosa becomes an expression of the struggle for independence.
CHAPTER 3

Conceptual Framework of Self-Esteem

Kim and Moritz (1983) define a disturbance in self-concept as "a disruption in the way one perceives one's body image, self-esteem, role performance, and/or personal identity. These four sub-components in turn have their own etiologies and defining characteristics" (p. 308).

Figure 2 (page 24) represents the interrelationships of the components of self-concept.

Interrelationships of Sub-Components of Self-Concept

Individuals with a disturbance of self-esteem feel unworthy of love, incompetent, and of no value to themselves or to society. This perception of themselves will have an overwhelming effect on their ability to perform expected roles, on their identity or awareness of being, and on the individuals' perception of their bodies. All of the components make up the self-concept, a generalized idea of the self. Each component affects the other components in varying ways. If the individuals have a healthy, positive self-esteem, they will believe they are worthy of love and acceptance, they will be confident of their abilities to perform role functions, they will be more accepting and aware of who they are, and have an accepting attitude of themselves with a satisfying body concept (Kim & Moritz, 1982). The sub-component of self-esteem was further developed in this study.
Figure 2. Conceptual Model of Self-Concept. Defining characteristics of a disturbance in self-concept are: (1) critical characteristics or cluster of characteristics specific to the subcategory; (2) characteristics or cluster of characteristics shared by subcategories, but not common to all subcategories; (3) characteristics or cluster of characteristics common to all subcategories. (From Kim & Moritz, 1982, p. 308)
Components of Self-Esteem

"Basic self-esteem is derived from the reflected appraisals of significant others developmentally" (Norris & Kunes-Connell, 1985, p. 749). It is formed early in life. Acceptance and love by the parents, clearly defined and enforced limits, and a feeling of respect for the individual are the main antecedents of this component of self-esteem. If these needs are met, the individual will likely develop a positive self-esteem, or (high self-esteem).

Functional self-esteem is depicted as "temporary and varies from day to day and moment to moment in response to situations" (Norris & Kunes-Connell, 1985, p. 748). The basic self-esteem is healthy, or positive, but an event has occurred which has a temporary effect on the individuals' self-esteem. It may be a surgery, perhaps it results in loss of a body part that affects the individuals' body image. Perhaps the individuals usually receive A's, but have failed a final exam. This is incongruent with their value system and will temporarily affect the self-esteem.

Defensive self-esteem "defends against the perceived gap between the ideal and real self" (Norris & Kunes-Connell, 1985, p. 748). This occurs in individuals with a low self-esteem. When individuals do not accept themselves, much of their energies will be used to defend, rather than to explore and to actualize themselves. The negative attitude towards themselves makes them highly sensitive to
criticism, unable to cope with being blamed, scolded or laughed at. They are extremely bothered if others have a low opinion of them.

Norris and Kunes-Connell (1985) have proposed the following conceptual model for the components of self-esteem.

*Functional Self-Esteem*  
(varies day to day and moment to moment in response to situations)

*Defensive Self-Esteem*  
(defends against perceived gap between ideal and real self)

*Basic Self Esteem*  
(derived from the reflected appraisals of significant others developmentally)

Figure 3. Conceptual Model of the Components of Self-Esteem  
(From Norris & Kunes-Connell, 1985, p. 748).
Based on this conceptual model, Norris and Kunes-Connell (1985) have developed the following definition of self-esteem disturbances.

**SELF-ESTEEM DISTURBANCE**

Negative feelings or conceptions of self (social self or self capabilities) - Negative self-perceptions (valuing)

**Problem:** Defensive Self-Esteem

**Etiology:** Defense against pain and/or anxiety of negative self-evaluation

**Defining Characteristics:**
- Denial of manifest problems
- Projection of blame or self-responsibility
- Grandiosity (unrealistic or exaggerated expressions of self-competency)
- Lack of follow-through
- Non-participation in therapy
- Self-neglect

**Problem:** Low Self-Esteem (Basic Level)

**Etiology:**
- Learned Helplessness
- Unrealistic Self-Expectations
- Loss (Early-Significant)

**Defining Characteristics:**
- Lack of eye contact
- Head and shoulder flexion
- Self-negating verbalizations
- Expression of shame or guilt
- Evaluates self as unable to deal with situations or events
- Lack of follow-through
- Non-participation in therapy
- Self-neglect

**Problem:** Low Self-Esteem (Functional level decrease)

**Etiology:**
- Losses
- Changes in Self or Body Image
- Behavior incongruent with value system

**Defining Characteristics:**
- Denial of manifest problems
- Projection of blame or self-responsibility
- Grandiosity (unrealistic or exaggerated expressions of self-competency)
- Lack of follow-through
- Non-participation in therapy
- Self-neglect

**Defining Characteristics:**
- Lack of eye contact
- Head and shoulder flexion
- Self-negating verbalizations
- Expression of shame or guilt
- Evaluates self as unable to deal with situations or events
- Lack of follow-through
- Non-participation in therapy
- Self-neglect

Figure 4. Proposed Definition of the Nursing Diagnosis - Self-Esteem Disturbance for Further Research and Application. (From Norris & Kunes-Connell, 1985, p. 758).
The purpose of this study is to add validity and credibility to the nursing diagnosis of Alteration in Self-Concept: Disturbance in Self-Esteem, as defined by NANDA.
Diagnostic terms are arbitrary descriptions of the client's problem. "Of major concern is whether the cluster of defining characteristics to which the label refers, actually occurs as an entity in clinical situations" (Gordon & Sweeney, 1979, p. 8). Gordon and Sweeney (1979) have identified three basic models for identifying and validating diagnostic nomenclature using principles of descriptive research.

**Method of Data Collection**

The Nurse-Validation Model, as proposed by Gordon and Sweeney (1979) was used for this study. This consists of tabulating the occurrence of each defining characteristic for a given diagnostic title. The study sought to validate the defining characteristics of the nursing diagnosis, Disturbance in Self-Esteem, as defined by NANDA.

**Subjects**

A purposive, nonprobability sample was used for this study. Subjects were limited to female clients, between the ages of 13 and 24, who were admitted to an eating disorders unit, and who had a medical diagnosis of anorexia nervosa. The diagnosis of anorexia nervosa fits into the component of basic self-esteem, and the problem is a low basic self-esteem, which is a long-term problem. The literature describes the
the anorexic population as primarily between pre-adolescence and the age of 25. The investigator communicated with a Registered Nurse (RN) on the eating disorder unit on a weekly basis to obtain information concerning admission of clients who fit the requirements of the sample population.

**Approach**

Prior to collection of data, the research proposal was presented to and approved by the University Human Subjects Committee and to the Nursing Studies Advisory Committee at the hospitals where the research was conducted (Appendix A). An information letter and consent form was read and signed by each subject prior to data collection (Appendix D). A parent or guardian's signature was obtained if the consenting subject was a minor. The subjects were informed that every effort would be taken to maintain confidentiality and anonymity. Data collection was carried out when the subjects were completing Step II or early in Step III, a phase in the treatment program. This assured that data collection in relation to progress in the treatment program was uniform.

The variables of this study were the occurrence/non-occurrence of each of the defining characteristics for Disturbance in Self-Esteem. The extraneous variables of age and sex were controlled by limiting the subjects to females aged 13 to 24.

**Research Tools**

The primary method of data collection was the
Self-Esteem Assessment tool developed by Norris and Kunes-Connell (1985) (Appendix F). The assessment tool was developed to assess a disturbed self-esteem based on the NANDA characteristics for Disturbance in Self-Esteem. Both subjective and objective data were assessed. Categories for assessment included self-description, self-report of strengths and weaknesses, self-rating of level of self-esteem, and identification of influencing or etiological factors associated with self-report of low self-esteem. The tool was revised, with permission of the authors, for purposes of assessing lack of follow through. Additional questions pertaining to job history, length of employment and personal goals were asked. The assessment tool required that the researcher interview each subject for approximately 30 minutes in a room which allowed for privacy. The subjects' verbal responses to the open-ended questions were recorded. During the interview process, the researcher observed the client for the presence of signs and symptoms indicating the presence of defining characteristics. The subjects' posture, eye contact, dress and hygiene, general appearance, affect and manner were assessed. Those defining characteristics present in a subject were recorded on a master sheet, and then tabulated for frequency of occurrence. Additional characteristics identified by the investigator were recorded. These were also tabulated for frequency of occurrence.

A paper and pencil tool, the Tennessee Self-Concept
Scale (TSCS), was used to assess the overall level of self-esteem (Appendix E). It consists of 100 self-descriptive statements, is self-administering, can be used with subjects aged 12 or higher, has a sixth grade reading level, and is applicable to people ranging from well-adjusted to psychotic. Most subjects completed the scale in 10 to 20 minutes. The reported test-retest reliability coefficients range from 0.60 to 0.92 for all major sub-scales with the majority exceeding 0.80. The reliability coefficient of 0.92 was found on the total positive score, considered by Fitts (1965) as the most important single score on the TSCS. An instrument is considered valid when it measures what it is supposed to measure and when scores on it correlate with scores on another instrument designed to measure the same traits. Items on the TSCS were retained only if there was unanimous agreement by a panel of seven judges of clinical psychology that it was correct. An empirical approach to validity was also employed. Statistical comparison of 360 psychiatric patients with 626 of the normal non-patient population was conducted. Statistically significant differences were found between patients and non-patients on nearly every score utilized on the scale at the .001 level (Fitts, 1965).

Demographic data were collected regarding age, number of siblings in family, subject's placement in sibling order, sex and age of each sibling, subject's marital status, parent's marital status, religious preference, educational
preparation and grade level of subject, parent's education, family yearly income, where subject lives and if she has a job. These data were used to try to identify possible etiological factors.
CHAPTER 5
Statistical Design and Results

The objectives of this study included:

1. Analyze the specific nursing diagnosis of Disturbance in Self-Esteem, within the category of Alteration in Self-Concept.

2. Determine the actual frequency of each identified defining characteristic.

3. Identify the critical cluster of defining characteristics for Disturbance in Self-Esteem.

4. Compare the defining characteristics identified in clients with a disturbance in self-esteem to those assigned to the nursing diagnosis, Disturbance in Self-Esteem.

5. Clarify the definition of Disturbance in Self-Esteem.

The specific nursing diagnosis of Disturbance in Self-Esteem within the category of Alteration in Self-Concept was analyzed. The Self-Esteem Assessment Tool (Appendix F) was used to assess occurrence/nonoccurrence of defining characteristics of Disturbance in Self-Esteem and the TSCS was used to measure the individuals' self-esteem (Norris & Kunes-Connell, 1985).

Descriptive statistics were used to describe the actual frequency of each identified defining characteristic of the nursing diagnosis, Disturbance in Self-Esteem, as
defined by NANDA. Table 1 presents a master sheet of the
tabulation of frequencies for each defining characteristic
identified in the nursing diagnosis of Disturbance in
Self-Esteem. Table 2 presents a master sheet of the
frequencies of additional characteristics that have been
identified as possible defining characteristics. The
frequency of each of the defining characteristics present in
this sample population is represented in the histogram in
Figures 5 and 6.

Lack of follow through, overly conforming/dependent
on other's opinions, indecisive, seeks excessive reassurance,
minimizes positive/exaggerates negatives regarding self,
expresses shame/guilt, and evaluates self as unable to deal
with difficult situations are defining characteristics which
occurred in greater than 75% of the subjects in this study.
These occurred in 77% to 96% of all subjects and appear to
be critical indicators of the label Disturbance in Self-
Esteem. Table 3 presents the percentage of all subjects
perceived by the investigator to manifest the defining
characteristics of Disturbance in Self-Esteem, as defined
by NANDA, and the percentage of all subjects perceived by
the investigator to manifest additional defining
characteristics (Table 4).

Eye contact, head and shoulder flexion, and self-
neglect were extremely difficult to assess in this sample.
As clients receiving treatment in the eating disorder unit,
Table 1

Master Sheet of the Tabulation of Frequencies for each Defining Characteristic

<table>
<thead>
<tr>
<th>Subject Number</th>
<th>Lack of eye contact</th>
<th>Head and Shoulders Flexion</th>
<th>Self-Negating Verbalizations</th>
<th>Expressed as unable to deal with difficult or guilt situations</th>
<th>Lack of follow through</th>
<th>Non-participation in therapy</th>
<th>Self-Neglect</th>
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</tbody>
</table>
**Table 2**  
**Master Sheet of the Frequencies of Additional Characteristics**

| SUBJECT NUMBER | Inde- | Dependent | Non- | Passive | assur- | excessive | Projection | of | Grandio- | relationship | Difficulty | of | Overly | Feelings | Unable | to Lack | Lack | express of | Feelings | Express of |
|---------------|------|-----------|------|---------|-------|-----------|------------|---|----------|-------|------------|----------|----------|-----|---------|---------|----------|--------|---------|---------|----------|
| 1             | x    | x         |       |         |       |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 2             | x    | x         | x     |         | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 3             | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 4             | x    | x         | x     |         |       |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 5             | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 6             | x    | x         |       |         |       |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 7             | x    | x         |       |         |       |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 8             | x    | x         | x     |         | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 9             | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 10            | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 11            | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 12            | x    | x         |       |         |       |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 13            | x    | x         |       |         |       |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 14            | x    | x         |       |         |       |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 15            | x    | x         |       |         |       |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 16            | x    | x         | x     |         | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 17            | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 18            | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 19            | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 20            | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 21            | x    | x         |       |         |       |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 22            | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 23            | x    | x         | x     |         |       |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 24            | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 25            | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
| 26            | x    | x         | x     | x       | x     |           |             |   |          |       |            |          |           |     |         | x       |           |         |         |         |
Figure 5. Frequency of Each of the Defining Characteristics.
Figure 6. Frequency of Each of the Defining Characteristics.
Table 3

Percentage of all Subjects Perceived by the Investigator to Manifest the Defining Characteristics as Defined by NANDA

<table>
<thead>
<tr>
<th>Defining Characteristic</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of eye contact</td>
<td>62%</td>
</tr>
<tr>
<td>Head and shoulder flexion</td>
<td>18</td>
</tr>
<tr>
<td>Self-negating verbalizations</td>
<td>96</td>
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<tr>
<td>Expressed shame or guilt</td>
<td>81</td>
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<tr>
<td>Evaluates self as unable to deal with difficult situations</td>
<td>81</td>
</tr>
<tr>
<td>Lack of follow through</td>
<td>81</td>
</tr>
<tr>
<td>Nonparticipation in therapy</td>
<td>58</td>
</tr>
<tr>
<td>Self-neglect</td>
<td>31</td>
</tr>
</tbody>
</table>
Table 4
Percentage of all Subjects Perceived by the Investigator to Manifest Additional Defining Characteristics

<table>
<thead>
<tr>
<th>Defining Characteristics</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indecision</td>
<td>77%</td>
</tr>
<tr>
<td>Overly conforming/dependent on others</td>
<td>96</td>
</tr>
<tr>
<td>Nonassertive/passive</td>
<td>73</td>
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<tr>
<td>Seeks excessive reassurance</td>
<td>85</td>
</tr>
<tr>
<td>Denial</td>
<td>4</td>
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<tr>
<td>Projection of blame</td>
<td>8</td>
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<tr>
<td>Gradiosity</td>
<td>0</td>
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<tr>
<td>Difficulty in relationships</td>
<td>73</td>
</tr>
<tr>
<td>Inferior</td>
<td>65</td>
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<tr>
<td>Overly sensitive</td>
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<tr>
<td>Feelings of failure</td>
<td>15</td>
</tr>
<tr>
<td>Moody</td>
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<tr>
<td>Insecure</td>
<td>31</td>
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<tr>
<td>Unable to express self</td>
<td>38</td>
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<tr>
<td>Lack of trust</td>
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</tbody>
</table>
the subjects themselves were aware of their eye contact and posture. Clients with anorexia nervosa are overly concerned about their appearance and strive to be perfect, thus their self-care and appearance regarding hair and make up do not reflect self-neglect. This may have resulted in a decreased frequency of these characteristics in this sample.

A number of defining characteristics, in addition to those included in the definition of Disturbance in Self-Esteem, were perceived by this investigator to be manifest in this sample. The following characteristics were perceived to occur at a frequency of 65% or greater: (a) indecisive, (b) overly conforming/dependent on others' opinions, (c) nonassertive/passive, (d) seeks excessive reassurance, (e) difficulty in relationships, and (f) feelings of inferiority.

The TSCS. (Fitts, 1965) was administered to each subject. Fitts (1965) identifies the total positive score as the most important single score, which:

reflects the overall level of self-esteem. Persons with high scores tend to like themselves, feel that they are persons of value and worth, have confidence in themselves, and act accordingly. People with low scores are doubtful about their own worth; see themselves as undesirable; often feel anxious, depressed, and unhappy; and have little faith or confidence in themselves (p. 2).
This investigator found the Mean Total Positive Score of the subjects who took part in this study was 280.9, which falls in the 4th percentile, indicating a low self-esteem. The mean for the normative group was 345.57, which is at the 50th percentile.

The Total Positive Score consists of scores which measure identity, self-satisfaction, behavior, physical self, moral-ethical self, personal self, family self and social self. The mean score of each of these scores is low in this subject group and are listed in Table 5. Table 6 lists the means, standard deviations, and reliability coefficients of the normative group on each score of the TSCS.

An assessment of defensive self-esteem is built into the TSCS. Defensive self-esteem is the report of a high self-esteem by an individual who makes a deliberate attempt to defend the self, and present a positive, favorable picture of the self (Fitts, 1965; Norris & Kunes-Connell, in press). The Self-Criticism Score (SC) of the TSCS reflects responses to 10 items which are mildly derogatory statements, which most people admit as being true for them. Low scores indicate defensiveness, a deliberate effort to present a favorable picture of themselves. An extremely high score indicates the individual lacks in defenses. The mean SC of this group was 38.38, which is at the 60th percentile. A more subtle measurement of defensiveness is the Defensive Positive Scale (DP). A high DP score indicates
Table 5
Tennessee Self-Concept Scale Means and Standard Deviations of Variables

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<tr>
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<td>Column E = Social Self</td>
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Table 6

Tennessee Self-Concept Scale Means, Standard Deviations, and Reliability Coefficients

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<th>Reliability***</th>
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<td>Col. B.</td>
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<td>Col. C.</td>
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<td>Col. D.</td>
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<tr>
<td>Col. E.</td>
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<td>2.96</td>
<td>.68</td>
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*This distribution so extremely skewed that conventional parametric statistics are meaningless, so the Median is used on Profile Sheet. Actual mean is 7.3 but about 68% of non-patients score below mean.

**This standard deviation erroneously reported as 6.0 on Score Sheet.

***Reliability data based on test-retest with 60 college students over a two-week period.
a positive self-description stemming from defensive distortion. A significantly low DP scale means that the person is lacking in the usual defenses for maintaining even minimal self-esteem (Fitts, 1965). The mean DP in this study was 38.27, which is at the 38th percentile, which does not deviate sharply from the norm.

The definition for Disturbance in Self-Esteem needs clarification. The definition presently accepted by NANDA is: "negative feelings or concepts of self (social self, self-capabilities)" (Norris & Kunes-Connell, 1985, p. 949). Based on the subjects' responses to questions during the interview using the Self-Esteem Assessment Tool developed by Norris & Kunes-Connell (1985), and scores on the TSCS, this investigator defines a disturbance in self-esteem as negative feelings about the self (how one "feels" about the self); a negative self-perception of one's value, worth and capabilities. The "feeling" component is strong.

Demographical data were collected. The mean age of the subjects in this sample was 18.27 years, with a standard deviation of 2.66. The minimum age was 13 and the maximum age was 24. The mean for years of education completed was 12.0, which coincides with the mean age of 18. The sample is generally representative of the population. One finding was that 36% of the subjects' mothers had 12 or fewer years of education and 64% of them had greater than 12 years of education. In comparison, the subjects'
fathers had fewer years of education than the mothers, with 41.7% of fathers having 12 years of education or less and 58.3% of the fathers having greater than 12 years of education. Demographic data are presented in Table 7. The demographic tool used by the investigator is located in Appendix G.
### Table 7

**Demographic Data (Page 1)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
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Table 7 (Continued)
Demographic Data (Page 2)

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Table 7 (Continued)

Demographic Data (Page 3)

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### Table 7 (Continued)

Demographic Data (page 4)

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<td><strong>Placement in Sibling Order</strong></td>
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CHAPTER 6
Summary, Conclusions, Implications, Limitations and Recommendations

Summary and Conclusions

Individuals with a medical diagnosis of anorexia nervosa were purposely selected for the sample population in the study. The literature review supported a medical diagnosis of a disturbed self-esteem in patients with anorexia nervosa. The TSCS Total Positive Score indicates the subjects in this study do have a low self-esteem and the DP score indicates a defensive self-esteem is not present.

The frequency of the defining characteristics of the nursing diagnosis, Disturbance in Self-Esteem, was determined for this sample population. The eight defining characteristics of Disturbance in Self-Esteem, as defined by NANDA, do occur in subjects with a low self-esteem. A number of characteristics, in addition to those defining characteristics of Disturbance in Self-Esteem as defined by NANDA, were perceived by this investigator to be manifest in the subjects in this sample. Many of these additional characteristics occurred at a frequency of 65% or greater.

Critical defining characteristics were identified as lack of follow through, overly conforming/dependent on others' opinions, indecisive, seeks excessive reassurance, minimizes positive/exaggerates negatives regarding self, expresses

53
shame/guilt, and evaluates self as unable to deal with difficult situations or events.

A defensive self-esteem was not identified in this sample population, thus, this study did not clarify the differentiation between basic self-esteem, functional self-esteem, and defensive self-esteem as identified by Norris and Kunes-Connell (1985) in their proposed definition of Self-Esteem Disturbance.

Implications of the Study

The additional characteristics identified in this study to occur in 65% or more of the subjects studied should be considered as defining Characteristics of Disturbance in Self-Esteem and should be subjected to further validation studies.

Limitations

A review of the literature supports that individuals with anorexia nervosa have a low self-esteem. TSCS scores in this study further support this. This investigator perceives anorexics to suffer from a low self-esteem at the basic level as identified by Norris and Kunes-Connell (1985) (Figure 4, page 26).

This study did not identify a defensive self-esteem in subjects with anorexia nervosa, and thus was unable to assess the definition of defensive self-esteem.

The nonprobability sample size of 26 limits the generalizability of this study.
A third limitation of the study is the possibility of subjectivity on the part of the investigator, especially in relation to the occurrence/nonoccurrence of defining characteristics manifest in the subjects. The Self-Esteem Assessment Tool (Appendix F) asked direct questions that elicited appropriate responses indicating occurrence/nonoccurrence of these characteristics. Also a limitation of this study is the difficulty in assessing lack of eye contact and head and shoulder flexion. These variables may have been more evident and more easily assessed at the time of admission to the eating disorders treatment unit.

Recommendations

A number of characteristics have been identified to occur in subjects with a disturbed self-esteem in previous studies (Norris & Kunes-Connell, 1985; Norris & Kunes-Connell, in press) as well as in this study. The following definition of Disturbance in Self-Esteem is recommended for further study:

**Disturbance in Self-Esteem:** negative feelings of self (how one "feels" about the self); a negative self-perception of one's value, worth and capabilities.

**Problem:** Low basic self-esteem.

**Etiology:**

- Lack of acceptance by others
- Lack of successes
- Devaluation throughout life
High expectations from family (pressure)

Traumatic life event, i.e., divorce of parents, alcoholic parent, abuse, death of family member

Learned helplessness

Unrealistic self-expectations

Early significant loss (Norris & Kunes-Connell, 1985)

**Defining Characteristics:**

Lack of eye contact

Head and shoulder flexion

Self-negating verbalizations; minimizes positive/exaggerates negative regarding self

Expression of shame or guilt

Evaluates self as unable to deal with situations or events

Lack of follow through

Nonparticipation in therapy

Self-neglect (Norris & Kunes-Connell, 1985)

Overly conforming/dependent on other's opinions

Indecisive

Seeks excessive reassurance

Nonassertive/passive (Norris & Kunes-Connell, in press)

**Difficulty in relationships**

**Feelings of inferiority**

** - Defining characteristics identified by this researcher.
References


APPENDIX A

College of Nursing Human Subjects Forms
Determination of Research Involvement
With Human Subjects
Graduate Program
College of Nursing
South Dakota State University

Definition of Human Subjects
This term describes any individual who may be at risk as a consequence of participation as a subject in research, development, or related activities. Subjects may include patients; outpatients; donors of organs, tissues and services; and normal individuals, including students or others who are placed at risk during training in medical, psychological, sociological, educational, and other types of activities. Of particular concern and meriting special consideration are those subjects in groups with limited civil freedom. These include prisoners and residents of clients of institutions for the mentally ill and mentally retarded. Minors are also of particular concern. The unborn and the dead will be considered subjects only under conditions and to the extent permitted by law and regulation.

The proposed master's research project/thesis titled VALIDATION OF THE DEFINING CHARACTERISTICS OF DISTURBANCE IN SELF-ESTEEM has been discussed regarding whether it involves human subjects. We (advisor and student) have determined that

A. (Check one)

X Human subjects are not involved because__________

X Human subjects are involved because clients with anorexia nervosa will be asked to complete the Tennessee Self-Concept Scale and will be observed for signs and symptoms of a disturbance in self-esteem.

B. (Check one)

X The student will initiate contact with the University Human Subjects Committee and proceed according to established University guidelines.

The student need not forward his/her proposal to the Human Subjects Committee.

Signature: Student
Signature: Project/Thesis Advisor

Date: March 7, 1986 Date: __________________________

Duplicate of form submitted 3/7/86

cc: Advisor
    Student
    Dean of Nursing's Office
    Graduate Program Office
Definition of Human Subjects
This term describes any individual who may be at risk as a consequence of participation as a subject in research, development, or related activities. Subjects may include patients; outpatients; donors of organs, tissues and services; and normal individuals, including students or others who are placed at risk during training in medical, psychological, sociological, educational, and other types of activities. Of particular concern and meriting special consideration are those subjects in groups with limited civil freedom. These include prisoners and residents of clients of institutions for the mentally ill and mentally retarded. Minors are also of particular concern. The unborn and the dead will be considered subjects only under conditions and to the extent permitted by law and regulation.

The proposed master's research project/thesis titled Validation of the Defining Characteristics of Disturbance in Self-Esteem has been discussed regarding whether it involves human subjects. We (advisor and student) have determined that

A. (Check one)

Human subjects are not involved because

Human subjects are involved because

B. (Check one)

\_\_\_\_ The student will initiate contact with the University Human Subjects Committee and proceed according to established University guidelines.

\_\_\_\_ The student need not forward his/her proposal to the Human Subjects Committee.

Signature: Student
Date:

Signature: Project/Thesis Advisor
Date:

cc: Advisor
Student
Dean of Nursing’s Office
Graduate Program Office
APPENDIX B

Request for Approval of Research Project
Involving Human Subjects

Master's Program in Nursing
College of Nursing
South Dakota State University
Brookings, S.D. 57007
REVISIONS OF RESEARCH STUDY
SIoux Valley Hospital
Research Application
Nursing Studies Advisory Committee

(This revision will address changes in original proposal in order to clarify
the study) Date: June 6, 1986

Name and Position Unit/Department Telephone

I. Investigator: June Larson, R.N., B.A. 253-2461
S.D.S.U. Graduate Nursing Student

Associate: Marty Dunlap, R.N., B.S.N., Eating Disorders Unit

III. Title of proposed activity: Validation of the Defining Characteristics
of Disturbance in Self-Esteem

IV. Time frame for study:
June, 1986 - Jan., 1987

VIII. Methodology:
2. Subjects - (sampling technique)
   b) purposive, nonprobability sample

4. Method of collecting data:
The primary investigator will train Marty Dunlap, the assisting
R.N., in regard to the methods of assessment and the specific
signs and symptoms which are the defining characteristics of a
disturbance in self-esteem. Data will be collected by the primary
investigator and the R.N. from the eating disorders unit.
The primary investigator will check with the eating disorder unit
weekly to determine if a subject is present who meets the criteria
for admission to this study. A client must be in Step II at this
point. The tools will be administered to the subjects at the end
of Step II, just prior to progressing into Step III.
A quiet room will be necessary for administration of the tools. Objective data will be gathered during administration of the Assessment Tool for Self-Esteem Disturbance by Norris and Kunes-Connell. The frequency of occurrence of each defining characteristic will be tabulated on a master sheet. The subject’s verbal response to the questions asked will be recorded. The Tennessee Self-Concept Scale is a self-administered test in which subjects will complete statements describing the self-concept and self-esteem. The Assessment Tool for Self-Esteem Disturbance by Norris and Kunes-Connell has been revised (with permission of Joan Norris) for purposes of this study. Lack of follow through will be assessed by collection of subjective data. Subjects will be asked questions related to a lack of follow through in pertinent situations.
REVISIONS OF RESEARCH STUDY
SIOUX VALLEY HOSPITAL
RESEARCH APPLICATION
NURSING STUDIES ADVISORY COMMITTEE

(This revision will address changes in the original proposal in order to clarify the study)

Date: July 1, 1986

Name and Position: Telephone

I. Investigator: June Larson, R.N., B.A.  253-2461
   S.D.S.U. Graduate Nursing Student

II. Title of proposed activity: Validation of the Defining Characteristics of Disturbance in Self-Esteem


VIII. Methodology

2. Subjects (sampling technique)
   b. purposive, nonprobability sample

4. Method of collecting data

   June Larson, the investigator, will check with the eating disorders unit weekly to determine if a subject is present who meets the criteria for admission to this study. A client must be in Step II at this point. The tools will be administered to the subjects at the end of Step II, just prior to progressing into Step III. A quiet room will be necessary for administration of the tools. The Tennessee Self Concept Scale is a self-administered test in which subjects will complete statements describing the self-concept and self-esteem. Upon completion of the Tennessee Self-Concept Scale, objective data will be gathered during administration of the Assessment Tool for Self-Esteem Disturbance by Norris and Kunes-Connell. The frequency of occurrence of each defining characteristic will be tabulated on a master sheet.
The subject's verbal response to the questions will be recorded. The Assessment Tool for Self-Esteem Disturbance by Norris and Kunes-Connell has been revised (with permission of Joan Norris) for purposes of this study. Lack of follow through will be assessed by collection of subjective data. Subjects will be asked questions related to a lack of follow through in pertinent situations.
Please type; use supplemental sheets as needed. Submit 7 copies, including a signature copy to the Nursing Administration Secretary. Each copy should have all relevant materials, e.g., consent form(s), questionnaires, other. For information call

Name and Position Department/Unit Telephone

I. Investigator: June Larson, RN SDSU Graduate 253-2461
   Associates:
   An RN; preferably the Head Nurse on the eating disorders unit.

II. Names of other persons responsible for performing or supervising procedures.


IV. Time frame for study (i.e., give exact dates desired for collection of data and completion of report).
   May 1, 1986 - December 1, 1986

V. Location (including specific departments/units involved) where data will be obtained.
   Eating Disorders Unit

VI. State significance or importance of proposed study to patient care? Professionals?
   Validation of defining characteristics to assure accurate diagnostic titles is necessary for nurses in providing safe nursing care designed to prevent, reduce or eliminate the problem identified in the nursing diagnosis.
VII. Purpose(s)/Objectives

The purpose of this study is to add validity and credibility to the nursing diagnosis of Disturbance in Self-Esteem. The objectives of the study are:

1. Analyze the specific nursing diagnosis of disturbance in Self-Esteem, category of Disturbance in Self-Concept.

2. Determine the actual frequency of each identified defining characteristic.

3. Identify the critical cluster of defining characteristics for disturbance in self-esteem.

4. Compare the defining characteristics identified in clients with a disturbance in self-esteem to those assigned to the NANDA nursing diagnosis of disturbance in self-esteem.

5. Clarify the definition for Disturbance in Self-Esteem.

VIII. Methodology (i.e., experimental, quasiexperimental, etc.)

1. Approach (i.e., experimental, quasiexperimental, etc.)

This is a descriptive research, using the Nurse-Validation Model, as proposed by Gordon and Sweeny (1979). Defining characteristics listed for disturbance in self-esteem will be tabulated when they are present in a client. The actual frequency of each defining characteristic will be determined. Defining characteristics that occur in high frequency will be the critical cluster of defining characteristics for disturbance in self-esteem. Additional signs and symptoms observed by the investigators will also be recorded.

2. Subjects

a. Approximate number and ages:

<table>
<thead>
<tr>
<th>How many</th>
<th>Age Range</th>
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</thead>
<tbody>
<tr>
<td>20-25 subjects</td>
<td>13-24</td>
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</table>
b. Criteria for selection and exclusion. (sampling technique)

Accidental sampling, or a sample of convenience will be used in the selection of subjects for this study.

c. When and where will subjects be approached and by whom? If subjects will be approached at times other than when collecting data, please specify (i.e., patients may be approached to determine if they will participate in study that will begin in future weeks/months.)

A subject may be approached by myself or the assisting RN a few hours prior to data collection to determine if he/she will participate in the study. I will have contact with each subject during the data collection, and at no other times following that.

d. Steps taken to avoid causing potential subjects to be or feel coerced?

Prior to beginning data collection, subjects will be informed that they are free to drop out of the study at any time.

e. Will subjects receive an inducement, e.g., payment, services without charge, extra course credit? If so, what amount of how? What is the reason for the inducement?

Subjects will not receive an inducement.

f. Risk

- Nature and amount of risk (include side effects), substantial stress, discomfort, or invasion of privacy involved.

The subjects may feel some embarrassment in responding to the questions, may feel uncomfortable in answering questions about themselves. The amount of risk is minimal.

- Compare the expected risk with the expected benefit.

The expected benefits far outweigh expected risks. The expected benefits are an improvement in nursing care for clients with a disturbance in self-esteem.
- Plan for handling possible adverse effects.

The head nurse on the unit will be asked to take part in the interview process to assure that the unit is aware of the client's responses. I will attempt to offer a supportive environment and will allow the client to drop out of the study if the situation is extremely stressful to him/her.

3. Research Tool/Procedures. Provide a brief description of the sequence and methods to be used. If the tool is new or adapted, has it been properly pretested? Is evidence for the reliability and validity of the tool presented?

Participants will be assessed for the occurrence of defining characteristics of disturbance in self-esteem by the investigator and a nurse trained in regards to the methods of assessment. The frequency of occurrence of each defining characteristic will be tabulated on a master data sheet. Demographic data will be collected prior to collection of data regarding self-esteem. Two tools will be used in the collection of data regarding self-esteem. The Tennessee Self-Concept Scale consists of 100 self-descriptive statements, is self-administering, can be used with subjects aged 12 or higher, has a sixth grade reading level, and is applicable to people ranging from well-adjusted to psychotic. It has been tested for reliability and validity. This tool is appropriate in the validation of the subjective defining characteristics of disturbance in self-esteem. The overall level of self-esteem will be assessed as the most important single score.

A second tool, the Self-Esteem Assessment by Norris and Kunes-Connell (1985) will be utilized to assess each of the defining characteristics of disturbance in self-esteem; both subjective and objective data will be collected. Verbal data will be collected from the subject by the nurse-interviewer. During this interview process, the nurse will observe the client for signs and symptoms indicating the presence of the objective defining characteristics of disturbance in self-esteem. The subjects posture, eye contact, dress and hygiene, general appearance, affect, manner, and follow through of activity will be assessed. This tool has been used in two previous studies assessing the defining characteristics of disturbance in self-esteem.
4. Method of collecting data. Provide a detailed, step-by-step description of how data will be collected, i.e., who collects what data, where, how and when; include a copy of your tool; if any materials and/or equipment are required, indicate how they will be provided. (Attach sheets)

The primary investigator will train the assisting RN in regard to the methods of assessment and the specific signs and symptoms which are the defining characteristics of a disturbance in self-esteem. Data will be collected by the primary investigator and the RN from the eating disorders unit. A quiet room will be necessary for administration of the tools. Data will be collected at a time identified as acceptable by the staff on the eating disorders unit. Objective data will be gathered during administration of the Self-Esteem Assessment Tool by Norris and Kunes-Connell (1985). The frequency of occurrence of each defining characteristic will be tabulated on a master sheet. The subjects' verbal response to the questions asked will be recorded. The Tennessee Self-Concept Scale is a self-administered test in which subjects will complete statements describing the self-concept and self-esteem.

5. If not subjects, specify involvement of nursing staff (i.e., time, role in collecting data).

One RN from the unit will be invited to participate in this study. The time commitment for this RN will be approximately 1 hour per subject, approximately 20-25 hours over the course of the study.

XI. Confidentiality and anonymity

1. Will participation be anonymous (that is, investigator will have no way to identify subjects by appearance, name or data)?
   Yes [X] No [ ] If yes, how assured?

Participation will be anonymous. The Data Collection Tools will carry a code number to assure that the tools completed by each subject will be looked at as a unit and help prevent mix-up of the tools between subjects. No name will be associated with the coding process.

2. Where participation is not anonymous, steps to insure confidentiality.
3. Provision for controls over access to documents and data?

Data will be stored in a locked filing cabinet in investigator's office. Patient documents will not be read by the investigator.

X. Consent Forms

Will written consent form(s) be used? Written consent is required in most cases (in addition to an oral explanation).

1. If no, explain why a written consent form will not be used.

2. If no, is a statement attached describing what participants will be told? Participants should be informed of elements below.

Does (Do) the consent form(s) include:

Name, position, department, and telephone number of investigator(s)?

Copy for subject?

Signature and date lines to be completed by investigator, subject, parent or legal guardian, and subject advocate, as applicable?

The following information in simple language appropriate to the reader:

1. Purpose—what the objectives are and why the study is being conducted?

2. Benefits to be expected or knowledge hoped to be gained?

3. Procedures to be followed, time involved for each, and total time?

4. Nature and amount of risk, substantial stress, discomfort, or invasion of privacy involved?

5. Appropriate alternative procedures that might be advantageous or available to subject?

6. Costs to the subject may immediately or ultimately be forced to bear?

7. Reimbursement of costs or other inducement the subject will receive?

8. Voluntary nature of participation and freedom to withdraw at any point without penalty or jeopardizing medical care?

9. Opportunity to ask questions before consenting?

10. Assurance that subject's identity will remain confidential or is anonymous?
XI. Recommendations and action:

A. Faculty Sponsor Margaret J. Hegge, RN, EdD
(for student) Typed name

Date 4/2/86
Approve X
Disapprove

B. Nursing Studies
Advisory Committee

C. Institutional
Review Committee Chairperson's signature

Subject to the following conditions:

Period of approval from __________, through __________

Valid only as long as approved procedures are followed.

January, 1986
APPENDIX C

Permission Forms for Hospitals
December 16, 1986

June C. Peterson-Larson, RN
The Graduate School of Nursing
South Dakota State University
Brookings, South Dakota 57006

Dear Mrs. Peterson-Larson:

The Clinical Research Committee at St. Luke's Regional Medical Center met Friday, December 12, 1986 to consider the research proposal which you recently submitted. Following discussion, the committee approved your study entitled "The Validation of the Defining Characteristics of Disturbance in Self-Esteem in Patients With Anorexia Nervosa".

Please find enclosed the institutional consent form required for the study.

At the conclusion of this study, please submit for the committee's information the total number of patients entered to the study, any adverse effects to the patients, and a summary of the results.

Please feel free to contact me if I may provide additional information regarding the committee's action.

LDF/sb

Enclosure
Based on the Clinical Research Committee's (I.R.B.) review and approval, you are authorized to conduct data collection at St. Luke's Regional Medical Center for the research proposal entitled "Validation of the Defining Characteristics of Disturbances in Self Esteem in Patients with Anorexia Nervosa".

Individual patient consent and permission granted by the patient's personal physician are required prior to commencing data collection.

December 16, 1986
APPENDIX D

Information Letter
This is a study in which you will be asked to answer questions concerning your feelings about yourself. The purpose of the study is to identify common characteristics present in population groups in the health care system. This information will be useful to the nurse in planning specific nursing care that will assist the individual in regaining optimal health.

You will complete a questionnaire which consists of descriptive statements to help you describe yourself as you see yourself. This will take 20-30 minutes to complete. You will also be asked to respond to questions during a 30 minute interview. Participation in this study is your choice, and you are free to withdraw at any time without any penalty to you. Withdrawing from the study would not affect the care you receive. If you have any questions, please feel free to ask at any time during this study.

To maintain confidentiality and anonymity, your name is not on the questionnaire. The code in the upper right hand corner will help prevent mix-up of the tools. All reported findings will be reported collectively as a group, no individual characteristics will be identified. Your responses to the questions will be reviewed by myself and will not be available on this hospital unit for the staff nurses or your physicians.

There is no cost to you as a participant in this study and you will receive no payment for taking part in the study.

Please sign below indicating your willingness to take part in this study.

Patient signature ___________________________ Date _______________
Consenting Adult (if patient is a minor)

Investigator ___________________________
June Larson, R.N.
SDSU Graduate Nursing Student
Telephone: (605)253-2461
APPENDIX E

Tennessee Self-Concept Scale
**MEAN SCORES OF SAMPLE: 26 CLIENTS WITH A DIAGNOSIS OF ANOREXIA NERVOSA**

**Tennessee Self-Concept Scale**

**Profile Sheet**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Total</th>
<th>Total</th>
<th>Total</th>
<th>EMPIRICAL SCALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSY</td>
<td>36</td>
<td>15</td>
<td>29</td>
<td>281</td>
</tr>
<tr>
<td>CI</td>
<td>106</td>
<td>82</td>
<td>52</td>
<td>56</td>
</tr>
<tr>
<td>NE</td>
<td>58</td>
<td>58</td>
<td>52</td>
<td>57</td>
</tr>
<tr>
<td>CO</td>
<td>29</td>
<td>29</td>
<td>29</td>
<td>93</td>
</tr>
<tr>
<td>POSITIVE SCOPES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMP</td>
<td>104</td>
<td>104</td>
<td>104</td>
<td>104</td>
</tr>
<tr>
<td>VARIABILITY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DISTRIBUTION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Clinical and Research Form**

*Note: The raw scores are the empirical scaling at CI, PSY, and CO are presented in reverse order so that lower raw scores are associated with higher T-scores.*
MEANING OF TENNESSEE SELF-CONCEPT SCALE SCORES


2. True-False Ratio (T/F). Indicates tendency to agree or disagree regardless of item content.

3. Net Conflict. Measures extent of conflict between responses to positive items and responses to negative items in the same area of self-perception.

4. Total Conflict Scores. Represent sum of positive-negative discrepancies regardless of sign.

5. Total P Score. Reflects the overall level of self-esteem. This is the most important single score.

6. Row 1 P Score—Identity. Reflects the individual's description of his basic identity.


8. Row 3 P Score—Behavior. Measures the individual's perception of his own behavior or the way he functions.

9. Column A—Physical Self. Presents individual's view of his body, his state of health, his physical appearance, skills, and sexuality.


11. Column C—Personal Self. Reflects the individual's sense of personal worth and feeling of adequacy as a person.

12. Column D—Family Self. Reflects one's feelings of adequacy, worth, and value as a family member.
13. Column E—Social Self. Reflects person's sense of adequacy and worth in his social interaction.

Variability Scores
14. Total V. High scores mean that person's self-concept is so variable from one area to another as to reflect little unity or integration.
15. Column Total V. Measures and summarizes variations within the columns.
16. Row Total V. Sum of the variations across rows.
17-22. Distribution Scores (D). Measures individual's certainty about the way he sees himself.

Empirical Scores
24. General Maladjustment Scale (GM). General index of adjustment-maladjustment without clues as to nature of pathology.
25. Psychosis Scale (psy). Items differentiating psychotic patients from other groups.
26. Personality Disorder Scale (PD). Items differentiating this broad diagnostic category (PD) from other groups (e.g., psychotic or neurotic states).
27. Neurosis Scale (N). High scores represent high similarity to neurotic group from which the scale was derived.
28. Personality Integration Scale (PI). Items differentiating the PI group from other groups. The PI group was comprised of people judged as average or better in terms of level of adjustment or degree of personality integration.
29. Number of Deviant Signs (NDS). Represents a count of the number of deviant features of all other sources. The NDS score is the best index of psychological disturbance in the TSCS (Fitts, 1965).
APPENDIX F

Self-Esteem Assessment
ASSESSMENT TOOL FOR SELF ESTEEM DISTURBANCE

Joan Norris, R.N., Ph.D. and Mary Kunes-Connell, M.S.N.

Objective Data

1. Eye contact (consider stage of relationship and individual's cultural norms)
   Observations and Responses
   - poor eye contact

2. Posture
   - head and shoulder flexion (not physiologically based)

3. Self Care
   - avoids accepting self care responsibility (self neglect of hygiene, appearance, health habits, and environmental sanitation)

Subjective Data

1. How would you describe yourself as a person?
   Observations and Responses
   - Record self-negating verbalizations, evaluations of inadequacies, strongly negative feelings, regarding the self

2. How do you feel about yourself as a person?
   - Could you rate how you feel about yourself on a scale of 1-10 (1 being very poor and 10 being very good)
   Observations and Responses
   - Be alert to numerical indicators in lower ranges and explore further
   Record any evasive patterns of behavior, including: denial, projection of blame, or grandiose statements, rationalize failures (defensive self-esteem)

3. What kinds of things do you like and not like about yourself?
Subjective Data

4. What do you consider your strengths and weaknesses?

5. Are there any past or present events in your life that made you feel good/bad about yourself?

6. Have there been times in your life when you felt particularly good or bad about yourself?

7. Are there any changes that you would wish for yourself? (If so, describe)

8. Have there been situations in your life (or aspects about yourself) that you feel powerless to change? (Describe)

Observations and Responses

(Remember that the ability to acknowledge and accept human weaknesses or failings is healthy - is there a balance of strengths and weaknesses reported?)

If self esteem (low) is identified and acknowledged, identify duration and causes (if known)

- Consider any evidence of passivity, over dependence, non-assertiveness, need for conformity or excessive reassurance in either observed behaviors or subjective statements.

- Does the person demonstrate an attitude of arrogance/superiority and rate the self highly? Is there evidence of poor relationships with others (social or occupational)?
Overall, could you rate, on a scale of 1-10, your ability to deal with situations or events in your environment? (1 being very poor ability to 10 being very good ability)

9. How would other people describe you?

10. How would you describe your ability to get along with people?

11. How do you feel in social situations such as parties or meeting strangers (e.g., shy, extroverted, confident)?

12. When did you first seek treatment from (Non-participation in therapy) a physician? What treatments were indicative of noncompliance with prescribed? Have you ever been necessary medical regiment/passivity hospitalized for this disorder before? or dropping out of therapy program? Have you ever seen a different physician other than the present one, for this disorder? If so, did you follow the prescribed treatment? Have you ever dropped out of a treatment program?
13. Do you ever decide to do something, and then find it difficult or impossible to carry through and complete the task or commitment? (Describe) Record any situation describing dropping out of activities related to own goals or if does not perform stated/intended activities (indicates lack of follow through).

Have you ever dropped out of activities related to your own goals or needs? (Describe)

Describe jobs you have had. How long were you employed at each? Reason for leaving?
### SUMMARY CHECK LIST

<table>
<thead>
<tr>
<th><strong>Observations</strong></th>
<th><strong>Subjective Statements</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- lack of eye contact</td>
<td>- lack of follow through</td>
</tr>
<tr>
<td>- head/shoulder flexion</td>
<td>- self negating verbalizations</td>
</tr>
<tr>
<td>- lack of follow through</td>
<td>- expressed shame/guilt</td>
</tr>
<tr>
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<td>- evaluates self as unable to deal with situations/events</td>
</tr>
<tr>
<td>- overly dependent/conforming</td>
<td>- *denial or rationalization of manifest problems</td>
</tr>
<tr>
<td>- nonparticipation in therapy</td>
<td>- *projection of blame/self responsibility</td>
</tr>
<tr>
<td>- passive/nonassertive</td>
<td>- *grandiosity</td>
</tr>
<tr>
<td>- self neglect</td>
<td>- *<em>&quot;Superior&quot; attitude; difficulty with relationships (<em>defensive traits)</em></em></td>
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</tr>
<tr>
<td>- minimizes positive and exaggerates negative feedback regarding self</td>
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If low self-esteem is subjectively acknowledged by the patient, identify:
1) duration (basic vs. functional), and 2) influencing factors (etiologies).

Tool revised to assess lack of follow through with subjective data rather than objective data.
### DEFINING CHARACTERISTICS

<table>
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<th>Objective characteristics:</th>
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</tr>
<tr>
<td>*(signifies defensive traits)</td>
</tr>
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If low self esteem is subjectively acknowledged by the patient, identify (1) duration (basic vs. functional) and (2) influencing factors (etiologies).
APPENDIX G

Demographic Data
DEMOGRAPHIC DATA

The following items are background information. Please use one answer only for each item (unless indicated otherwise).

1. Age __________

2. Education
   a) Are you currently enrolled? _____ Yes _____ No
   b) Years of education completed __________

3. Private vs. Public Education - choose all that are appropriate
   a) public grade school
   b) private grade school
   c) public high school
   d) private high school
   e) public college
   f) private college

4. Race/ethnic origin
   a) white
   b) black
   c) Asian, Oriental
   d) American Indian
   e) Alaskan Native
   f) Mexican American
   g) Puerto Rican
   h) Other

5. Religion preference
   a) Protestant
   b) Catholic
   c) Jewish
   d) No preference
   e) Other

6. Size of community in which you currently live:
   a) under 2500
   b) 2500-5000
   c) 5001-7500
   d) 7501-10,000
   e) 10,001-15,000
   f) 15,001-20,000
   g) 20,001-30,000
   h) 30,001-40,000
   i) 40,001-50,000
   j) 50,001-75,000
   k) 75,001-100,000
   l) greater than 100,000
7. Marital status
   ___ a) single
   ___ b) married
   ___ c) separated
   ___ d) divorced
   ___ e) widowed

8. Parent's marital status
   ___ a) married
   ___ b) separated
   ___ c) divorced
   ___ d) widowed

9. Mother's age
   ___ a) 25-35
   ___ b) 36-45
   ___ c) 46-55
   ___ d) 56-65
   ___ e) 66-75
   ___ f) 76 or above

10. Father's age
    ___ a) 25-35
    ___ b) 36-45
    ___ c) 46-55
    ___ d) 56-65
    ___ e) 66-75
    ___ f) 76 or above

11. Mother's education
    a) Currently enrolled? _____ Yes _____ No
    b) Years of education completed _______

12. Father's education
    a) Currently enrolled? _____ Yes _____ No
    b) Years of education completed _______

13. Parent's combined yearly income
    a) $10,000 or less
    b) $10,001-$15,000
    c) $15,001-$20,000
    d) $20,001-$25,000
    e) $25,001-$30,000
    f) $30,001-$35,000
    g) $35,001-$40,000
    h) $40,001-$45,000
    i) $45,001-$50,000
    j) Greater than $50,000
14. Number of brothers
   a) none  
   b) one  
   c) two  
   d) three  
   e) four  
   f) five or more

15. Number of sisters
   a) none  
   b) one  
   c) two  
   d) three  
   e) four  
   f) five or more

16. What is your placement in your family?
   a) oldest  
   b) middle child  
   c) youngest  
   d) only child  
   e) other ____________

17. If you have a sister or more than one, what are their ages?

18. If you have a brother or more than one, what are their ages?

19. Who do you live with?
   a) parents  
   b) girlfriend  
   c) boyfriend  
   d) other

20. Do you have a job?
   a) yes  
   b) no
   If yes, what do you do? ____________