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The self-esteem of chronically ill adolescents

Nancy Berman Lees

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THE SELF-ESTEEM OF
CHRONICALLY ILL ADOLESCENTS

A Thesis
Presented to the
Faculty of
California State University
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Psychology

by
Nancy Berman Lees
August 1991
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Abstract

Chronic illness can interfere with adolescent peer group participation and have a negative affect on self-concept and self-esteem development. Although the literature indicates few serious problems with self-image development for teenagers with most chronic illnesses, there is evidence of some impairment of self-concept and self-esteem for those with visible disorders. This study hypothesized that adolescents with two visible chronic disorders, cancer and end stage renal disease (ESRD), would have lower physical appearance self-concept and social/peers self-esteem than matched, healthy peers. The subjects were 20 teenage oncology and renal patients and 20 matched controls who completed the Piers-Harris Children's Self-Concept Scale (CSCS) and the Coopersmith Self-Esteem Inventory (SEI). The physical appearance self-concept scores of the chronically ill teenagers were not significantly different from controls, and this lack of significance possibly was an artifact of the sampling or design in the study. The chronically ill group demonstrated significantly lower social/peers self-concept than the controls. These results suggest a need for interventions which can help chronically ill adolescents improve social competencies and peer participation and successfully complete the developmental tasks of adolescence.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>v</td>
</tr>
<tr>
<td>CHAPTER ONE: Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Self-Concept and Adolescence</td>
<td>2</td>
</tr>
<tr>
<td>Self-Concept, Self-Esteem and Chronic Illness</td>
<td>6</td>
</tr>
<tr>
<td>The relationship between chronic illness, self-concept and self-esteem during adolescence</td>
<td>10</td>
</tr>
<tr>
<td>CHAPTER TWO: Method</td>
<td>17</td>
</tr>
<tr>
<td>Subjects</td>
<td>17</td>
</tr>
<tr>
<td>Design and Procedures</td>
<td>18</td>
</tr>
<tr>
<td>Chronically ill group</td>
<td>18</td>
</tr>
<tr>
<td>Control group</td>
<td>18</td>
</tr>
<tr>
<td>Materials and Instruments</td>
<td>19</td>
</tr>
<tr>
<td>CHAPTER THREE: Results</td>
<td>23</td>
</tr>
<tr>
<td>Analysis</td>
<td>23</td>
</tr>
<tr>
<td>Self-Concept</td>
<td>23</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>23</td>
</tr>
<tr>
<td>CHAPTER FOUR: Discussion</td>
<td>28</td>
</tr>
<tr>
<td>APPENDIX A: Consent Forms</td>
<td>37</td>
</tr>
<tr>
<td>APPENDIX B: Instructions</td>
<td>41</td>
</tr>
<tr>
<td>APPENDIX C: Demographic Information</td>
<td>42</td>
</tr>
<tr>
<td>APPENDIX D: Piers-Harris Children's Self-Concept Scale</td>
<td>44</td>
</tr>
<tr>
<td>APPENDIX E: Coopersmith Self-Esteem Inventory</td>
<td>46</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>48</td>
</tr>
</tbody>
</table>
List of Tables

1. Mean Self-Concept and Self-Esteem by Chronic Condition and Gender ........................................ 24
2. Analysis of Variance: Global Self-Concept—Gender by Chronic Condition ........................................ 24
3. Analysis of Variance: Physical Appearance Self-Concept—Gender by Chronic Condition ................. 25
4. Analysis of Variance: General Self-Esteem—Gender by Chronic Condition ..................................... 25
5. Analysis of Variance: Social Self-Esteem—Gender by Chronic Condition ........................................ 27
CHAPTER ONE

Introduction

The teenage years are a period when young people must adjust to a multitude of changes: in their physical appearance, emerging sexuality, peer expectations, independence, moral development, vocational choice and a myriad of other contexts. Teenagers cope with these changes by establishing a unique character for themselves and their peer group. Most teenagers need to be part of a group and identify with their peers. Their peer group anchors them and gives them a feeling of belonging in their rapidly changing universe.

If events outside of the teenager's control intervene, peer group participation may be impaired. Peer group acceptance is very important to the growing adolescent, and circumstances that interfere with peer affiliation and conformity may affect the teenager's successful completion of adolescent developmental tasks (McAnarney, 1985). Chronic illness or disability during adolescence presents a series of events and problems which impact the adolescent's growth and development (McAnarney, 1985). Illness can alter physical appearance, impede feelings of well being, interfere with participation in sports or other activities, affect what the child may eat or drink, interfere with school schedules, and make the teenager feel out of control (Bronheim, 1987). Being part of the group and spending time
with peers helps the adolescent figure out who he/she is and how she/he fits in. McAnarney (1985) reviewed the literature on the social maturation of handicapped and chronically ill adolescents. She found that chronic illness or disability interferes with socialization, having a negative impact on the way teenagers look at, and feel about, themselves—in terms of their self-concept and self-esteem (McAnarney, 1985).

Self-Concept and Adolescence

Early authors considered adolescence to be an exceptionally difficult time of life, characterized by extreme role confusion (Erikson, 1972), storm and stress (Hall, 1904) and lack of equilibrium (Freud, 1958). The teenager was typically pictured as a 'rebel without a cause', thrashing around for meaning and identity, leaving a path of destruction in his wake.

This perception of adolescents as distressed and confused led psychologists to envision teenagers as experiencing serious disruptions in their self-concept development. Authors such as Hall (1904) and Freud (1958) were certain that teenagers are very confused about who they are and how they feel about themselves. Adolescence, according to these authors, is a time of confusion and conflict; therefore, teenagers must experience serious difficulty when trying to develop stable self-concepts. The implication was that the tremendous physical and
psychological changes that occur during adolescence must cause incredible fluctuations in self-concept that are reflected in an all-time low self-esteem (Savin-Williams & Demo, 1984). Rosenberg (1979) described adolescence as a time of self-concept disturbance. He stated that global self-esteem declined during the teenage years, until late adolescence, when it again improved. This 'storm and stress' philosophy was the prevailing theory of adolescent self-image development until the 1970's.

Other researchers have challenged the notion that adolescence is a time of turbulence for all young people. Bandura (1964), for instance, argued that this conventional description of adolescence was wrong. He claimed that these characterizations of adolescence, which were based on studies of psychiatric and delinquent populations and highlighted in media reports, accounted for only 10% of the population (Bandura, 1964). Coleman (1977) reviewed the empirical research on self-concept and self-esteem development during adolescence. He noted that the empirical research demonstrated few self-esteem and self-concept problems during adolescence (Coleman, 1977). Coleman attributed the difference between the prevailing classical view of the stormy period of adolescence and this empirical research to three problems with the classical literature: first, the classical studies were based on clinical, abnormal populations; second, the mass media focus on
sensational adolescent behavior was reflected in these
descriptions; and finally, the classical researchers tended
to overestimate the amount that adolescents could or would
reveal their innermost thoughts and feelings to adults
(Coleman, 1977).

Many other recent studies also indicated that self-
concept and positive self-esteem are not a problem of
consequence for the majority of adolescents. Daniel Offer's
(1969) longitudinal study of adolescent boys demonstrated
that, on the whole, these youths were happy, responsible and
well-adjusted. Dusek and Flaherty (1981) assessed different
aspects of self-concept in adolescents in a three year
longitudinal and crosssectional study. These authors found
that adolescent self-concept developed in a continuous
manner and that there were no significant changes in self-
concept between the ages of 11 and 18 (Dusek & Flaherty,
1981). These studies encouraged a new understanding of
adolescence self-image which emphasized the relative
constancy of self-concept for most teenagers.

More recent empirical studies support the concept that
self-image and self-esteem development are not a significant
problem for most teenagers. Savin-Williams and Demo (1984)
used longitudinal data and multiple measures of self-esteem
(including the Q-sort, the Rosenberg Self-Esteem Scale, the
Coopersmith Self-Esteem Inventory, a behavior checklist and
peer ratings) to test the stability of self-concept during
adolescence. In addition, Savin-Williams and Demo's (1984) adolescent subjects carried electronic pagers which beeped at random intervals. At these times the teenagers reported their current situation and feelings in a notebook. These authors found that three aspects of self-concept (self-feelings, the presented self and the experienced self) are quite stable during adolescence for the majority of young people (Savin-Williams & Demo, 1984). Offer, Ostrov and Howard (1984) examined the responses of 20,000 youths on the Offer Self-Image Questionnaire for Adolescents. They found that most of these teenagers were functioning well, without experiencing excessive turmoil and stress, and that their self-image was stable and secure. These investigations further demonstrated that the development of a stable self-concept and positive self-esteem was not a dilemma for most adolescents.

Nevertheless, this research does not imply that self-concept formation is uncomplicated for all adolescents. In each of these studies of adolescent self-concept, there was a small percentage of young subjects for whom development of a stable self-concept and positive self-esteem was not so simple. Piers (1969) reported low scores on her self-concept scale for about 10% of the tested population of third to twelfth grade children. Savin-Williams and Demo (1984) identified a small group of subjects (fewer than 10% of the sample at most ages), with widely fluctuating self-
concepts. Offer, Ostrov and Howard (1984) found that most, but not all, of their 20,000 subjects adapted to their changing bodies and emerging sexuality without undue difficulty. These authors concur that there is a small percentage of adolescents who have difficulty with self-concept development.

**Self-Concept, Self-Esteem and Chronic Illness**

Self-concept includes all of the perceptions to which we refer when we say "I" or "me". It is the organization of all of the facets of "self" as we view it. Self-concept answers the question "who and what am I?" (Miller, 1987). Self-concept formation is one of the most significant developmental milestone of adolescence (Richman, Clark, & Brown, 1985).

Self-esteem is the evaluative component of self-concept. Through self-esteem the individual expresses an attitude of self approval or disapproval—of worthiness (Coopersmith, 1967). This overall evaluation of self-worth integrates feelings of self-worth that relate to physical appearance, intelligence, social, and emotional behavior (Coopersmith, 1967).

Since self-concept and self-esteem development tend to be stable for most teenagers (Offer, Ostrov & Howard, 1984, Savin-Williams & Demo, 1984, Dusek & Flaherty, 1981), it may take major disruptive life events or experiences to upset this process. Savin-Williams and Demo (1984) speculated
that adolescents with unstable self-images, 'oscillators',
experienced traumatic events during childhood which
precipitated their unsteady self-image. Chronic illness can
certainly be one of these disruptive influences (Bronheim,
1987). Whereas the average teenager catapults through life
with an energy level that exhausts most onlookers, the ill
youngster's stamina is frequently impaired (McAnarney,
1985). While other children are interacting with their
friends, at school or the local gathering place, eating at
fast food restaurants or doing things with their families;
chronically ill children are visiting doctor and/or
hospital, taking treatments and lab tests, following special
diets, or just resting because they don't feel well enough
to do anything else (Bronheim, 1987). Researchers have
found that chronic illness can restrict adolescents' social
contacts (McAnarney, 1985), reduce their social support
network (Melzer, Leadbeater, Reisman, Jaffe, & Lieberman,
1989) and result in the perception that their social life is
different from that of other teenagers. Living with a
chronic illness or disability may disrupt the adolescent's
life to the extent that it impairs the development of his or
her self-concept and self-esteem.

Physical attractiveness is crucial for teenage girls
while athletic prowess and masculinity are more important to
boys (Ogundari, 1985). Adolescence is a time of self-
analysis. Self-concept is related, in part, to how well
teenagers think they fit in with their peer groups norm of 'attractiveness'. At a time of life when children are scrutinizing their appearance and spending endless hours in front of the mirror so they can produce the desired impression, illness and medications can drastically alter the adolescent's looks. Chronically ill teenagers are aware of, and concerned with, any personal deviations from the 'acceptable' norm (Neff, 1978; Beardslee & Neff, 1978). Excessive facial and body hair, bloating, yellowed skin, a hairless head, retarded physical growth—these characteristics are seldom part of the body image and first impression that the teenager wants to attain. Chronic illness often results in either subtle or obvious alterations in appearance which may effect self-concept (McAnarney, 1985).

Sexual maturity and sexual attraction are critical issues during adolescence. However, alterations in physical appearance, reduced opportunities for socialization, and possible reduction in sex drive that can accompany chronic illness can seriously impede the adolescent's sexual maturation. Physical differences, such as extremely short stature (Neff, 1978), make the teenager feel less attractive to the opposite sex. Young cancer patients, for example, are quite concerned with hair loss (alopecia) and its effect on their sexual attractiveness (Wilber, 1986). Social contacts are often reduced, limiting opportunities for
normal sexual experimentation (McAnarney, 1985). Some therapies and medications, as well as the illness itself, reduce sex drive and sexual performance (Fritz & Williams, 1988). Thus, sexuality is an additional domain in which the chronically ill adolescent may be fighting an uphill battle to maintain a positive sense of self.

The myriad of rapid biological and psychological changes that adolescents experience may make them more self-conscious of their feelings and bodily signs than are individuals of other ages. In addition to this natural self-involvement, adolescents who encounter new or difficult situations, such as changing schools or experiencing illness, tend to monitor their feelings, physical signs, and discomforts, even more thoroughly than their peers (Mechanic, 1983). Heightened self-awareness can have a negative effect on self-concept. This self-monitoring, or symptom monitoring, makes youngsters more sensitive to changes, leads to more feelings of unhappiness and results in negative self-evaluation and lower self-regard (Mechanic, 1983). This leads to negative social comparisons and lowered self-esteem. Adams and Weaver (1986) and Garrick, Ostrov and Offer (1988) both found that adolescents who complained of a large number of physical symptoms showed disturbances in self-concept, whereas adolescents who were free of physical complaints had 'average' self-concepts. It is likely that this sensitivity to physical symptoms could
contribute to reduced self-esteem in disabled or sick teenagers.

Any of these factors, such as the alteration of physical appearance, interference with normal sexuality, and increased sensitivity to physical symptoms, may augment inadequate self-concept formation and impair positive self-esteem in adolescents who suffer from chronic disabilities or illnesses.

The relationship between chronic illness, self-concept and self-esteem during adolescence. Although clinicians have maintained that most chronic illness puts the adolescent at risk for low self-esteem (Miller, 1987), the research results are unclear. Fairly recently, researchers have looked at the self-concept and self-esteem of adolescents who suffer from chronic disorders such as asthma, diabetes, cerebral palsy, cystic fibrosis, and spina bifida. Some of these disorders are visible, such as cerebral palsy (Magill & Huribut, 1986) and meningomyelocele (spina bifida) (MacBriar, 1983 and Kazak, 1986); while other illnesses are not as noticeable to other people, for example asthma (Kashani, Konig, Shepperd, Wilfley, & Morris, 1988a, Hazzard & Angert, 1986, Ostrov & Ostrov, 1986) or diabetes (Gross, Delcher, Snitzer, Bianchi, & Epstein, 1985, Brown, 1985, and Evans & Hughes, 1987).

Several researchers have examined self-concept development in asthmatic teenagers. Heilveil and Schimmel
(1982) investigated self-concept in 8-15 year old asthmatic children. They hypothesized that asthmatic children would have lower self-concept scores than a healthy group. However, their results demonstrated that the asthmatic and normal groups had similar self-concepts. In fact, there was a negative relationship between the severity of the illness and the child's level of anxiety and unhappiness (Heilveil & Schimmel, 1982). Other studies which looked at self-concept in asthmatic adolescents replicated the finding that asthmatic teenagers are not experiencing reduced self-concept and/or self-esteem (Kashani et al., 1988a; Hazzard & Angert, 1986; Ostrov & Ostrov, 1986).

These studies disagreed on the possible explanation of the lack of differences between the self-concept of asthmatic and healthy teenagers. Hazzard and Angert (1986) suggested that their unexpected results might be due to compensatory denial of problems which the ill adolescent utilizes to maintain a positive self-concept. Kashani et al. (1988a) proposed that increased attention by health care professionals and family might offset any psychosocial problems encountered by the young subjects. Ostrov and Ostrov (1986), however, submitted that asthma simply does not have a negative impact on the self-image development of teenagers, and that the current psychogenic theories of asthma and the assumptions that adolescents with asthma have coping difficulties should be reevaluated.
Studies which explored the self-image of diabetic children also found few problems with self-concept and self-esteem in the ill groups. Gross et al. (1985) compared the self-concept scores (Piers-Harris Children's Self Concept Scale) of insulin dependent diabetic children and preteens with nondiabetic peers and found no self-concept differences between the two groups. Brown (1985) investigated the self-concept of young diabetics and found that these children had, for the most part, high scores on the Piers-Harris Children's Self Concept Scale. Evans and Hughes (1987) also found that diabetic children and adolescents, aged 10-17, had high self-concept scores. These studies indicate that diabetic teenagers are not encountering problems with self-concept development. The researchers suggest that family support (Evans & Hughes, 1987), knowledge about diabetes and active participation in their care (Brown, 1985), and good diabetic control (Gross et al., 1985) facilitate the development of stable self-concept and positive self-esteem in children and adolescents with diabetes.

Researchers have also examined the self-concept of adolescents with cystic fibrosis (Cowen, 1984; Kashani, Barbero, Wilfley, Morris, & Shepperd, 1988b; Simmons, Corey, Cowen, Keenan, & Robertson, 1987; Lewis & Khaw, 1982) and sickle cell disease (Hurtig & White, 1986; Lemanek, Moore, Gresham, Williamson, & Kelley, 1986). In these studies, the self-concept scores of chronically ill adolescents did not
differ significantly from other teenagers.

Thus, the literature described above indicates that adolescents who suffer from asthma, diabetes, cystic fibrosis or sickle cell disease are not at risk for disturbances in self-concept development. In this study, it is suggested that these are relatively 'invisible' disorders. Other than absences from school, there are very few overt symptoms that set these children apart from their peers. Their physical appearance may not differ greatly from other teenagers and, unless they tell their friends about their illnesses, others may not even know they are sick. Their medication regimes and special health needs can often be mainstreamed into the average teenage life without too much difficulty.

There are, however, other adolescents afflicted with illnesses and disabilities that do make the children look different and/or behave differently from their friends, possibly affecting their peer group participation and acceptance. These teenagers may be more at risk for self-concept and self-esteem problems than adolescents with less visible illnesses. Adolescents may look different due to physical handicaps or anomalies or as a result of the symptoms or treatment of chronic illnesses.

Children with physical handicaps often look noticeably different from their peers. There is some evidence that these conditions effect self-concept. Harvey and Greenway
(1984) administered a self-concept scale to physically disabled youngsters and found that these children had significantly lower self-images than either siblings or age-matched controls. Magill and Huribut (1986) assessed adolescents who had cerebral palsy. The disabled girls in their study had lower self-concept in the physical and social domains. Adolescents with meningomyelocele (spina bifida) were also found to be at risk for lower self-concept (MacBriar, 1983 and Kazak, 1986). Unlike the diabetes, cystic fibrosis and asthma, mentioned above, these disorders entail visible physical disabilities which may result in the teenager looking different from her/his peers.

If being physically different from peers is a factor in the disruption of self-concept and self-esteem of chronically ill teenagers, then adolescents with noticeable illnesses and handicaps would be expected to manifest a poorer self-image than do either teenagers with less visible conditions or healthy peers. Although the majority of the research on self-esteem and chronic disease has looked at younger children, rather than adolescent subjects, these studies do show an impaired self-concept in encopretic children (Owens-Stively, 1987), children with epilepsy (Ferrari, Mathews & Barabas, 1983) and children and adolescents with Tourette's syndrome (Edell & Motta, 1989). These are all conditions in which the young victims look or act quite different from their peers.
There are some chronic illnesses, such as end stage renal disease (ESRD) and cancer, which cause adolescents to look quite different from their friends. Teenagers on renal dialysis can experience edema that distorts their features, excessive weight loss, or unhealthy skin color. They may be of unusually small stature and often have a visible dialysis shunt or catheter and/or distorted veins (Neff, 1978). Renal and oncology patients often take medication that causes a 'moon face' (cushinoid features), unusual amounts of facial and body hair (hirsuitness) or the round stomach and thin legs that accompany steroid therapy (Melzer et al., 1989). Young oncology patients sometimes suffer from excessive thinness and bruising, unhealthy skin color, and loss of hair (Rechner, 1990). Wilber (1986) noted that hair loss is a primary concern of teenage cancer patients. Thus, teenagers with ESRD or cancer can look quite different from their peers and may find it hard to participate in the popular fads of hairstyle and dress.

Most studies in this area have investigated global self-concept and self-esteem but not the specific physical appearance and social/peers components of self-concept and self-esteem. If it is important to adolescent self-concept and self-esteem development to participate in and be accepted by their peer group, then it is hypothesized that adolescents who have disabilities or illnesses that significantly alter their appearance have a poorer physical
self-concept than healthy peers. In addition, it is hypothesized that these physical 'differences' have a detrimental effect on the chronically ill adolescent's perception of his/her social and peer interactions. These hypotheses were examined in this study. In the studies cited above, the research addressed these issues by examining the general or global self-concept and self-esteem scores of the subjects. This study, however, examined two specific components of self-concept and self-esteem: the physical appearance factor of self-concept and the social/peers component of self-esteem.

It was hypothesized that a group of chronically ill adolescents would not differ from healthy teenagers on measures of Global Self-concept (Piers-Harris Self-concept Scale for Children) and General Self-esteem (Coopersmith Self-esteem Inventory). However, it was also hypothesized that chronically ill adolescents (cancer and ESRD patients) would have lower self-concept scores on the Physical Appearance subscale of the Piers-Harris Self-concept Scale for Children and lower scores on the Social Self-Peers subscale of the Coopersmith Self-esteem Inventory than a control group of adolescents.
CHAPTER TWO

Method

Subjects

The experimental subjects were 11 adolescent cancer patients (13 to 18 years old, $M=15.7$); and 9 adolescent renal (dialysis and post-transplant) patients (age 13 to 18, $M=15.3$). None of the subjects had mental disabilities or any physical disability other than that resulting from the chronic condition. Eleven of the chronically ill subjects were male and nine were female. The ethnic composition of the sample was: 37.5% Caucasian, 30% Hispanic, 10% Asian, 10% Native American and 5% Afro-American, 7.5% other or decline to answer. Eleven experimental subjects lived with both parents, five lived with one parent, three lived with a parent and other adult, and the remaining subject lived with grandparents.

From a group of 120 adolescent controls, 20 were matched with the chronically ill subjects for sex, age, family composition (adults with whom they lived, as noted above), and SES. Any control who was currently undergoing medical treatment for an illness or disorder, or who reported an acute, continuing or chronic ailment, was not selected as a match.

The chronically ill group was obtained from the Pediatric Oncology and Nephrology services at two major teaching University Medical Centers, the University of
California at Los Angeles Medical Center and Loma Linda University Medical Center. The control subjects were students in social science classes at a local high school. Permission was obtained from each child and a parent or guardian prior to their participation in the study.

Design and Procedures

**Chronically ill group.** Fifty test packets were distributed to potential subjects either by the physicians or nurses, during office visits and clinics. These packets contained separate informed consent forms for the parent(s) and the child to sign (Appendix A). The packets also contained specific directions for completing the measures (Appendix B), a page of demographic questions about the adolescent, family and illness (Appendix C), the Piers-Harris Children's Self-concept Scale (Appendix D), and the Coopersmith Self-Esteem Inventory (Appendix E). These paper and pencil measures took each subject from 45 minutes to an hour to complete. All subjects were able to complete the packets without assistance. When the subjects had completed the information, they returned the packet, in a sealed envelope, to the nurse or doctor. To ensure confidentiality, the consent forms were separated from the other measures before the information was recorded and coded.

**Control group.** Separate informed consent forms to be signed by parent/guardian and subject were distributed to
the subjects three days before the test packet was to be administered. All students who returned the permission slips completed the packet on the scheduled test date. The contents of the packet were identical to those given to the chronically ill group. The students completed the packets during a class period and they placed the packets, in sealed envelopes, in a box by the classroom door as they left the room. Information was numbered and coded to ensure subject confidentiality.

Materials and Instruments

This study used one measure of self-concept—the Piers-Harris Self-Concept Scale for Children; and one measure of self-esteem—the Coopersmith Self-Esteem Inventory.

1. The Piers-Harris Children's Self-Concept Scale (CSCS). The Piers-Harris Children's Self-Concept Scale is a self-report measure of children's perception of themselves. It measures children's self-concept as they view their behavior, intellectual and school status, physical appearance and attributes, anxiety, popularity, and satisfaction. The results can be analyzed to give one score of global self-concept and scores on each of sub-scales listed above (Piers & Harris, 1969). For the purposes of the current study, the entire scale was administered but only the global self-concept and physical appearance sub-scale were scored and analyzed.

The Piers-Harris is one of the most popularly used
self-concept scales. It appears in many studies that are examining the manner in which different aspects of adolescence are related to self-concept—for example, personality characteristics and self-concept (Marton, Golombek, Stein & Koranblum, 1988; Schneider & Leitenberg, 1989) and weight perception of young girls (Forehand, Faust & Baum, 1985). It is commonly used to measure self-concept of chronically ill children and adolescents (Harvey & Greenway, 1984; Simmons, et al., 1987, Cozzi, Tryon & Sedlacek, 1987; Lemanek et al., 1986; Hurtig & White, 1986). The scale is frequently utilized, and well accepted for use, with this type of test population.

The test is made up of 80 declarative statements. The child responds 'yes' or 'no' as to whether these statements describe him or her most of the time. The Piers-Harris Self-Concept Scale requires a third grade reading level and takes about 20 minutes to complete (Keyser & Sweetland, 1987). Reliability and validity have been tested with children in grades 4 to 12, with reliabilities .88 to .93 and test-retest reliabilities from .62 to .96 (Piers, 1984). The Piers-Harris correlation with the Coopersmith Self-Esteem Inventory and other self-concept measures range from .32 to .85 (Johnson, Redfield, Miller & Simpson, 1983). In addition, high scores on The Children's Depression Inventory correlate with lower self image as measured by the Piers-Harris (Saylor, 1984). Other studies have also found a
relationship between low self-concept and external locus of control (Keyser & Sweetland, 1987).

2. Coopersmith Self-Esteem Inventory (SEI). The Coopersmith Self-Esteem Inventory was originally designed to examine the construct of self-esteem in children ages 5 to 15. It was later expanded to include older adolescents and an adult scale. The data can be analyzed to give scores for the General Self and the three sub-scales: Social Self-Peers, Home-Parents, and School-Academic (Coopersmith, 1967). The current study administered the entire measure but only scored and reported general self-esteem and the social self-esteem subscale of the SEI.

The Coopersmith measures are among the best known and most widely used self-esteem instruments (Mitchell, 1985). The measures are commonly used with children 8 to 17. They are especially popular in school settings (the original target populations). Coopersmith derived the measure directly from his theory of self-esteem and its relationship to academic performance. The SEI is an extremely popular and very well accepted instrument for assessing self-esteem in children and adolescents (Mitchell, 1985).

There is little information about the construct validity of the SEI. However, the inventory was shown to have convergent validity with the Piers-Harris CSCS and the Coopersmith Behavior Academic Assessment Scale (Johnson, Redfield, Miller, & Simpson, 1983). In 1985, Chiu found
that the SEI had convergent validity with 11 of 24 measures of self-image which included sociometric questions, teacher's ratings for popularity, and teacher's ratings for self-esteem. Omizo, Amerikaner and Michael (1985) found that the Coopersmith discriminated between learning disabled and emotionally disturbed children and was predictive of feelings of satisfaction and communication satisfaction with parents. Demo (1985) demonstrated that this measure, the Rosenberg Self-Esteem Scale and a personal interview were all valid in measuring experienced self-esteem. Reliability coefficients .80 or above have been consistently reported for the Coopersmith long form, the form used in this study (Keyser & Sweetland, 1984).
CHAPTER THREE

Results

Analysis

Four 2 (gender) X 2 (condition: chronically ill/healthy) ANOVAS were performed on the dependent variables: global self-concept, physical self-concept (Piers-Harris CSCS), general self-esteem and social self/peers (Coopersmith SEI). Further analyses were done incorporating ethnicity and income, but did not yield any significant findings or trends. Mean scores are shown on Table 1.

Self-Concept

As seen in Table 2, global self-concept was not significantly different for chronically ill compared to control subjects. The gender by chronic condition interaction for global self-concept was also not significant (see Table 2).

Physical appearance self-concept was not significantly different for chronically ill and healthy adolescents in this study (see Table 3). There was a trend for males to have higher physical appearance self-concept scores, $M=10.27$, than females, $M=8.89$, however this difference was not significant. There was no significant interaction of gender and chronic condition for physical self-concept.

Self-Esteem

As shown in Table 4, general self-esteem was not
### Table 1

**Mean Self-Concept and Self-Esteem Scores by Chronic Condition and Gender**

<table>
<thead>
<tr>
<th></th>
<th>Self-Concept</th>
<th></th>
<th>Self-Esteem</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>Global</td>
<td>Physical</td>
<td>General</td>
<td>Social</td>
</tr>
<tr>
<td>Chronically Ill</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>64.27</td>
<td>9.63</td>
<td>19.91</td>
<td>6.73</td>
</tr>
<tr>
<td>Girls</td>
<td>62.44</td>
<td>8.78</td>
<td>19.67</td>
<td>6.11</td>
</tr>
<tr>
<td>Combined</td>
<td>63.45</td>
<td>9.25</td>
<td>19.80</td>
<td>6.45</td>
</tr>
<tr>
<td>Control</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Boys</td>
<td>64.18</td>
<td>10.91</td>
<td>19.27</td>
<td>7.73</td>
</tr>
<tr>
<td>Girls</td>
<td>61.89</td>
<td>9.00</td>
<td>20.00</td>
<td>6.44</td>
</tr>
<tr>
<td>Combined</td>
<td>63.15</td>
<td>10.05</td>
<td>19.60</td>
<td>7.15</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>64.23</td>
<td>10.27</td>
<td>19.59</td>
<td>7.23</td>
</tr>
<tr>
<td>Girls</td>
<td>62.17</td>
<td>8.89</td>
<td>19.83</td>
<td>6.28</td>
</tr>
</tbody>
</table>

### Table 2

**Analysis of Variance: Global Self-Concept—Gender by Chronic Condition**

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Sum of Squares</th>
<th>F-Value</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronicity</td>
<td>1</td>
<td>0.90</td>
<td>0.03</td>
<td>p&lt;.87</td>
</tr>
<tr>
<td>Gender</td>
<td>1</td>
<td>42.04</td>
<td>1.24</td>
<td>p&lt;.27</td>
</tr>
<tr>
<td>Chronicity by Gender</td>
<td>1</td>
<td>0.53</td>
<td>0.02</td>
<td>p&lt;.90</td>
</tr>
<tr>
<td>Error</td>
<td>36</td>
<td>1224.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>1268.40</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3

Analysis of Variance: Physical Appearance Self-Concept–Gender by Chronic Condition

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Sum of Squares</th>
<th>F-Value</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronicity</td>
<td>1</td>
<td>6.40</td>
<td>1.19</td>
<td>p&lt;.28</td>
</tr>
<tr>
<td>Gender</td>
<td>1</td>
<td>18.96</td>
<td>3.54</td>
<td>p&lt;.06</td>
</tr>
<tr>
<td>Chronicity by Gender</td>
<td>1</td>
<td>2.73</td>
<td>0.51</td>
<td>p&lt;.48</td>
</tr>
<tr>
<td>Error</td>
<td>36</td>
<td>193.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>221.10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4

Analysis of Variance: General Self-Esteem–Gender by Chronic Condition

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Sum of Squares</th>
<th>F-Value</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronicity</td>
<td>1</td>
<td>0.40</td>
<td>0.03</td>
<td>p&lt;.86</td>
</tr>
<tr>
<td>Gender</td>
<td>1</td>
<td>0.58</td>
<td>0.05</td>
<td>p&lt;.83</td>
</tr>
<tr>
<td>Chronicity by Gender</td>
<td>1</td>
<td>2.33</td>
<td>0.19</td>
<td>p&lt;.67</td>
</tr>
<tr>
<td>Error</td>
<td>36</td>
<td>449.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>452.40</td>
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</tr>
</tbody>
</table>
significantly different for chronically ill compared to control subjects. There was also no significant interaction of gender by chronic condition for general self-esteem (see Table 4).

Chronically ill adolescents had significantly lower social self-esteem scores, $M=6.45$, than did their healthy peers, $M=7.15$, $F(1,36)= 5.98$, $p<.02$ (see Tables 1 and 5). There was also a significant main effect for gender ($F(1,36)=10.9$, $p<.002$): the boys had higher social self-esteem scores, $M=7.23$, than the girls, $M=6.28$, (see Tables 1 and 5). The gender by condition interaction was not significant for social self-esteem.

26
Table 5

Analysis of Variance: Gender by Chronic Condition—Social Self-Esteem

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Sum of Squares</th>
<th>F-Value</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronicity</td>
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<td>4.90</td>
<td>5.98</td>
<td>p&lt;.02*</td>
</tr>
<tr>
<td>Gender</td>
<td>1</td>
<td>8.93</td>
<td>10.90</td>
<td>p&lt;.002*</td>
</tr>
<tr>
<td>Chronicity by Gender</td>
<td>1</td>
<td>1.10</td>
<td>1.34</td>
<td>p&lt;.25</td>
</tr>
<tr>
<td>Error</td>
<td>36</td>
<td>29.47</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>44.40</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p<.05
CHAPTER FOUR
Discussion

In this study the social self-esteem of the chronically ill adolescents was significantly lower than that of their healthy peers. These results support the hypothesis that chronic illness has a negative impact on the adolescent's feelings of social competence and confidence in peer interactions. This finding agrees with recent studies that describe changes in, and/or limitations of, chronically ill adolescents' social environments such as the restriction of social contacts (McAnarney, 1985), reduced social support (Melzer et al., 1989), and the perception that their social life is different from that of other teenagers (Rechner, 1990).

McAnarney (1985) suggested that the social experiences of adolescents with chronic illness or physical disabilities differ from those of their healthy peers: school absences affect participation in school activities, there may be reduced opportunities for everyday, informal interactions with peers both in and out of school, and there is often restriction from some peer activities due to the inability of the disabled teenager to keep up physically with his/her peers or because he/she feels ill or different.

In addition, the ill teenager's social environment may be 'changed' or 'different' from the norm due to the chronic illness. In a phenomenological study of the adolescent's
experience of cancer, Rechner (1990) reported that adolescent cancer patients try to keep the part of their lives that is affected by cancer separate from their normal adolescent social world. However, according to these teenagers, this segregation sometimes does not work, and when the two worlds come together the teenagers experience changes in their social lives and friendships. The consequence of these changes brought on by the illness is a redefinition of the adolescent cancer patient's social world (Rechner, 1990). The social support system of chronically ill adolescents is also impaired. Melzer et al. (1989) found that adolescents who had renal transplants named fewer significant others and fewer unrelated and opposite-sex peers in their social networks.

The reduction in peer group support and the alteration of the chronically ill adolescent's social context can result in social adjustment problems. Young adolescents with chronic illness have difficulty with social adjustment (Eiser, 1990). Children who have been hospitalized, and those who have been seriously ill, are at risk for having their social development arrested (Clark, Striefel, Bedlington & Naiman, 1989). Thus, adolescents who are experiencing chronic illness suffer social deficits which may be reflected in poorer social self-esteem.

During adolescence the frame of reference of the individual changes from the family to the peer group, which
then becomes the new context for developmental change. Havighurst (1972) identified nine developmental tasks of adolescence. According to Havighurst, adolescents must accept their physique and male or female role, develop peer relations with both sexes, gain emotional independence from their parents and other adults, become confident of their future economic independence, select and prepare for an occupation, develop civic interest and competence, become socially responsible, prepare for marriage and family life, and build a value system that is in harmony with the world. McAnarney (1985) stated that the primary accomplishments of adolescence are identity formation and independence and the fundamental goals of this time of life are: to emerge from adolescence with a secure identity, a positive sense of self, and the capability of engaging in an intimate relationship with another person; to become physically and psychosocially independent from the family, and to establish a vocational goal (McAnarney, 1985). Successful completion of these tasks and goals requires the adolescent to move away from the family as the main source of support and interest and to increase social involvement.

The peer group is the major setting in which adolescents experiment with their search for identity and prove their independence (McAnarney, 1985). In this study, chronically ill or disabled teenagers, whose social contacts were impeded by their illness, manifested poorer social and
peer self-esteem. Since the peer group and social contacts are the primary settings in which teenagers accomplish these important tasks of adolescence, the restriction of the chronically ill teenager's social context and the impairment of the child's social self-esteem negatively affects the adolescent's developmental progress and may ultimately impact the adolescent's ability to mature into an independent adult.

As expected, the chronically ill and control group did not differ on the measures of Global Self-concept (CSCS) or General Self-esteem (SEI). These findings were in agreement with the results of many other investigations which determined that chronically ill children do not demonstrate lower general self-concept and/or self-esteem scores than healthy controls (Vance, & Pless, 1983; Heilveil & Schimmel, 1982; Kashani, et al. 1988a; Hazzard & Angert, 1986; Gross et al., 1985; Brown, 1985; Evans & Hughes, 1987; Cowen, 1984; Simmons, Corey, Cowen, Keenan, & Robertson, 1987; and others).

The results of this study did not, however, support the hypothesis that chronically ill adolescents would have a poorer physical appearance self-concept than their healthy peers. There are two possible explanations for this: a limitation in the type of sample used in this study may have affected these results, or these chronically ill adolescents may not, in actuality, have poorer self-concept about their
physical appearance than other, healthy teenagers.

In this study the nurse passed out and collected test packets during clinic times. This manner of data collection for the chronically ill subjects in this sample inadvertently resulted in an experimental sample composed of subjects who were in remission from, or quite stable with, treatment of the disease (six of the subjects were in remission from cancer, five subjects were one and a half to two years after a successful renal transplant and three more subjects had been transplanted more than two years previously). In this study most of the chronically ill subjects were experiencing a mild to moderate level of severity of symptoms. It is possible that this particular group of teenagers perceived few or no physical 'differences' or changes due to illness, but may have perceived these differences in the more acute phases of the disease. At this point in successful treatment many, in fact most, of the physical changes that occur during the more acute phases of illness may no longer be present (VanDiemen-Steenvorde, Donkerwolcke, & Brackel, 1987).

Alterations in physical appearance may primarily have a detrimental effect on self-concept when the disease is severe and there are more changes in physical appearance. Recent evidence does indicate poorer body image in adolescents who are immediately post renal transplant (Melzer et al., 1989), concerns about body integrity in
children undergoing cancer treatment (Neff & Beardslee, 1990), and the importance of hiding physical symptoms and 'passing' as normal, for adolescents experiencing alterations in appearance due to cancer (Rechner, 1990). This implies that difficulties with self-concept relating to physical appearance should improve when the cancer is in remission or when a long time period has passed since successful renal transplantation. A replication of the current study which utilizes more severely ill adolescents, might demonstrate the hypothesized differences in physical appearance self-concept.

One explanation for this finding may be that chronically ill adolescents with more severe symptoms and physical alterations due to illness suffer from deficits in physical appearance self-concept, whereas teenagers who are more stable with fewer physical symptoms do not. Physical self-concept may, therefore, improve as the number of symptoms are reduced. Alternatively, the passage of time since onset of the illness may allow the adolescent to adjust to physical changes, whether or not the number of symptoms decrease, so that his or her physical self-concept also stabilizes. Finally, there is the possibility that, contrary to the expectations of this author, changes in physical appearance due to illness are not concerns for chronically ill adolescents. The unraveling of these issues provides an important direction for future research.
The findings of this study indicate a need for further research that more specifically examines the self-image of teenagers with ESRD and cancer, particularly in the social/peer and physical appearance domains. These issues need to be explored with a sample made up of more severely ill teenagers, so that the effects of more frequent treatment and hospitalization and more pronounced physical symptoms can be evaluated. Self-concept and self-esteem should be examined both at different levels of severity of illness and at different times during the progress of the illness (for example, onset, treatment and remission).

Although both renal and oncology patients were grouped into one chronically ill category, adolescents who are undergoing these two very different illnesses should be studied separately, as their problems and experiences are unique. Dialysis and renal transplantation are also quite different and have distinctive side effects and physical symptoms, so future studies should separately examine the self-image of adolescent ESRD patients who are experiencing these two treatments. The one category may have obscured the contribution of one of the disorder's effects on physical appearance self-concept.

In addition, phenomenological studies which explore the content of the social world of the chronically ill adolescent in comparison to healthy peers. Such a study might examine the number of social contacts and friends,
amount of involvement in peer activities, and so forth. This information may assist in an understanding of the social difficulties of these teenagers which are resulting in their lower social self-esteem. In interviews, the teenagers might disclose thoughts and feelings about the effect of their illness on physical appearance and social activities that are not divulged in the more standard self-report measures. The results of this study also indicate a need for interventions specifically designed for the adolescent population. Since chronic illness has a negative impact on the adolescent's social functioning and social self-esteem, interventions must be developed which improve the chronically ill or disabled adolescent's social network. Some researchers have addressed the need for interventions for chronically ill or disabled children. For example, Clark et al. (1989) proposed a family-focused social skills development program for children with chronic illnesses. Social skills training programs which are specifically designed to meet the special developmental requirements of adolescence are also needed. These interventions should assist chronically ill adolescents in attaining important social competencies and encourage these teenagers to take part in the peer and school activities that have such an significant role in their social maturation. The vital nature of peer group affiliation and conformity in the attainment of adolescent developmental tasks (McAnarney,
1985) underscores the need for programs and interventions which maximize the chronically ill adolescent's successful involvement with peers. These interventions should target skills which are particularly important for adolescent peer affiliation and participation, such as training chronically ill adolescents in group entry skills, when needed; teaching them ways of masking physical differences, when desired, to enhance conformity (wearing scarves, hats, wigs makeup application, clothing selection, etc.), and assisting them in dealing with their emerging sexuality in the context of their illness. Programs of this nature will help these children effectively complete the developmental tasks of adolescence and to successfully move on to their next life stage: to become mature, well-adjusted, secure, and independent adults.
Dear Student,

We are currently very interested in learning about adolescents and how they feel about themselves, their activities and their relationships with their peers. The way we gather this information is to ask teens to fill out a simple questionnaire. This questionnaire will only take about 45 minutes for most teenagers to complete. We would like you to participate in this research project. The information we gather is completely confidential and will only be processed and reported in a group form. No names or identities will be connected to any responses on the questionnaire.

This information will help researchers like myself understand the way teenagers feel about different aspects of their lives. By completing this questionnaire you can help us better understand how you feel about yourself. The results of this study may also be used to develop programs that will help teens feel better about themselves.

When the study is completed in the Fall of 1991, you can receive a copy of the results if you wish. To get a copy of the results, please send a stamped, self-addressed envelope to:

Nancy Lees, c/o Dr. M. Liss
Department of Psychology
California State University, San Bernardino
5500 University Parkway
San Bernardino, Ca. 92407-2397

We would appreciate it if you would participate in this research project. Fill out the permission slip below and return it, with the completed questionnaire, in the envelope provided.

Thank you,

Nancy Lees, Graduate Student

Marsha Liss, Phd., Psychology Professor
I would like to fill out this questionnaire that will look at how I feel about myself and some other aspects of my life. This information will be used in a research project only, by Nancy Lees, Graduate Student, CSUSB.

I understand that no names will be used and that each questionnaire is assigned a number for the purposes of collecting the information.

________________________  _________________________
Student Signature          Date
Dear Parent,

We are currently very interested in learning about adolescents and how they feel about themselves, their activities and their relationships with their peers. The way we gather this information is to ask teens to fill out a simple questionnaire. This questionnaire will only take about 45 minutes for most teenagers to complete. We would like your son or daughter to participate in this research project. The information we gather is completely confidential and will only be processed and reported in a group form. No names or identities will be connected to any responses on the questionnaire.

This information will help researchers like myself understand the way teenagers feel about different aspects of their lives. By allowing your child to complete this questionnaire you can help us better understand adolescents. The results of this study may also be used to develop programs that will help teens feel better about themselves.

When the study is completed in the Fall of 1991, you can receive a copy of the results if you wish. To get a copy of the results, please send a stamped, self-addressed envelope to:

Nancy Lees, c/o Dr. M. Liss
Department of Psychology
California State University, San Bernardino
5500 University Parkway
San Bernardino, Ca. 92407-2397

We would appreciate it if you would participate in this research project. Fill out the permission slip below and return it, with the completed questionnaire, in the envelope provided.

Thank you,

Nancy Lees, Graduate Student

Marsha Liss, Phd., Psychology Professor
I give permission for my son/daughter __________________ to fill out this questionnaire that will look at how he/she feels about him/herself and some other aspects of his/her life. This information will be used in a research project only, by Nancy Lees, Graduate Student, CSUSB.

I understand that no names will be used and that each questionnaire is assigned a number for the purposes of collecting the information.

Parent or Guardian Signature ___________________ Date ___________________
Appendix B
Instructions

This packet contains three paper and pencil surveys which we would like you to complete so that we can better understand how teenagers feel about themselves. The first page has some simple questions that tell a little more about the group of students who are completing the questionnaire.

The second portion of the packet consists of 80 statement. Please read each statement carefully and mark it 'yes' if the statement usually applies to you. Mark 'no' if the statement doesn't usually apply to you.

The third section of the packet has 58 simple statements which you need to mark as 'like me' if they apply to you a lot of the time, and 'unlike me' if they do not apply to you very often.

Please answer all of the items honestly. Your answers are completely confidential and no answers will be connected to any particular person. We will look at this data in group form only. Your honest answers will assist us in learning more about how teenagers feel, and helping them feel better about themselves.

If any of the questions or statements make you feel uncomfortable or unhappy please talk to a counselor or teacher who can help you with these feeling.

When you are finished with the packet, seal it in the envelope and leave it in the box at the door on your way out.

Thank you,

Nancy Lees, Graduate Student, CSUSB
Appendix C
Demographic Information

Male _____ Female _____ Age _____
Class in School _____

Please indicate your ethnic background (optional)
___ Black
___ Hispanic
___ Asian
___ Native American
___ Caucasian

What is your approximate family income?
___ up to $20,000 per year
___ $20,000 to $30,000 per year
___ $30,000 to $40,000 per year
___ $40,000 to $50,000 per year
___ more than $50,000 per year

How many brothers and sisters do you have? ___

Do you live with:
___ one parent
___ both parents
___ a parent and another adult
___ other (please describe) _______________________

What is the highest grade/educational level finished by your parents?

Some High School _____ _____
High School Graduate _____ _____
Some College _____ _____
Finished Two-Year College (Associate of arts) _____ _____
Finished Four Year College (Bachelor's Degree) _____ _____
Post Graduate Degree (Phd, MD., JD., MA., etc) _____ _____

What is your mother's occupation? _______________________
What is your father's occupation? _______________________

Are you currently seeing a doctor or other professional to be treated for any recurring physical illness or disorder? (Yes or No) _____ If yes, please describe.
Do you have any special plans for your future, for example, when you finish High School or College?

What kinds of activities, extracurricular events and hobbies do you enjoy?

Are there some activities that you used to do, or that your friends do, in which you are unable to participate because of an illness, treatment or condition? Please describe these:

How much time do you think you spend each week on your physical appearance?

Please list the cosmetics, toiletries, hair care products, etc. that you use:
Appendix D

Piers-Harris Children's Self-Concept Scale

1. My classmates make fun of me yes no
2. I am a happy person yes no
3. It is hard for me to make friends yes no
4. I am often sad yes no
5. I am smart yes no
6. I am shy yes no
7. I get nervous when the teacher calls on me yes no
8. My looks bother me yes no
9. When I grow up, I will be an important person yes no
10. I get worried when we have tests in school yes no
11. I am unpopular yes no
12. I am well behaved in school yes no
13. It is usually my fault when something goes wrong yes no
14. I cause trouble to my family yes no
15. I am strong yes no
16. I have good ideas yes no
17. I am an important member of my family yes no
18. I usually want my own way yes no
19. I am good at making things with my hands yes no
20. I give up easily yes no
21. I am good in my school work yes no
22. I do many bad things yes no
23. I can draw well yes no
24. I am good in music yes no
25. I behave badly at home yes no
26. I am slow in finishing my work yes no
27. I am an important member of my class yes no
28. I am nervous yes no
29. I have pretty eyes yes no
30. I can give a good report in front of the class yes no
31. In school I am a dreamer yes no
32. I pick on my brother(s) and sister(s) yes no
33. I my friends like my ideas yes no
34. I often get into trouble yes no
35. I am obedient yes no
36. I am lucky yes no
37. I worry a lot yes no
38. My parents expect too much of me yes no
39. I like being the way I am yes no
40. I feel left out of things yes no
41. I have nice hair yes no
42. I often volunteer in school yes no
43. I wish I were different yes no
44. I sleep well at night yes no

44
45. I hate school  
yes  no

46. I am among the last to be chosen for games  
yes  no

47. I am sick a lot  
yes  no

48. I am often mean to other people  
yes  no

49. My classmates in school think I have good ideas  
yes  no

50. I am unhappy  
yes  no

51. I have many friends  
yes  no

52. I am cheerful  
yes  no

53. I am dumb about most things  
yes  no

54. I am good-looking  
yes  no

55. I have lots pep  
yes  no

56. I get into a lot of fights  
yes  no

57. I am popular with boys  
yes  no

58. People pick on me  
yes  no

59. My family is disappointed in me  
yes  no

60. I have a pleasant face  
yes  no

61. When I try to make something, everything seems to go wrong  
yes  no

62. I am picked on at home  
yes  no

63. I am a leader in games and sports  
yes  no

64. I am clumsy  
yes  no

65. I games and sports, I watch instead of play  
yes  no

66. I forget what I learn  
yes  no

67. I am easy to get along with  
yes  no

68. I lose my temper easily  
yes  no

69. I am popular with girls  
yes  no

70. I am a good reader  
yes  no

71. I would rather work alone than with a group  
yes  no

72. I like my brother (sister)  
yes  no

73. I have a good figure  
yes  no

74. I am often afraid  
yes  no

75. I am always dropping or breaking things  
yes  no

76. I can be trusted  
yes  no

77. I am different from other people  
yes  no

78. I think bad thoughts  
yes  no

79. I cry easily  
yes  no

80. I am a good person  
yes  no
<table>
<thead>
<tr>
<th></th>
<th>Like Me</th>
<th>Unlike Me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Things usually don't bother me</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I find it very hard to talk in front of the class</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>There are lots of things about myself I'd change if I could</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>I can make up my mind without too much trouble</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>I'm a lot of fun to be with</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I get upset easily at home</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>It takes me along time to get used to anything new</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I'm popular with kids my own age</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>My parents usually consider my feelings</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I give in very easily</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>My parents expect too much of me</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>It's pretty tough to be me</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Things are all mixed up in my life</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Kids usually follow my ideas</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>I have a low opinion of myself</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>There are many times when I'd like to leave home</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>I often feel upset in school</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>I'm not as nice looking as most people</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>If I have something to say, I usually say it</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>My parents understand me</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Most people are better liked than I am</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>I usually feel as if my parents are pushing me</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>I often get discouraged at school</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>I often wish I were someone else</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>I can't be depended on</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>I never worry about anything</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>I'm pretty sure of myself</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>I'm easy to like</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>My parents and I have a lot of fun together</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>I spend a lot of time daydreaming</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>I wish I were younger</td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>I always do the right thing</td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>I'm proud of my school work</td>
<td></td>
</tr>
</tbody>
</table>
34. Someone always has to tell me what to do
35. I'm often sorry for the things I do
36. I'm never happy
37. I'm doing the best work that I can
38. I can usually take care of myself
39. I'm pretty happy
40. I would rather play with children younger than I am
41. I like everyone I know
42. I like to be called on in class
43. I understand myself
44. No one pays much attention to me at home
45. I never get scolded
46. I'm not doing as well in school as I'd like to
47. I can make up my mind and stick to it
48. I really don't like being a boy (girl)
49. I don't like to be with other people
50. I'm never shy
51. I often feel ashamed of myself
52. Kids pick on me very often
53. I always tell the truth
54. My teachers make me feel I'm not good enough
55. I don't care what happens to me
56. I'm a failure
57. I get upset easily when I'm scolded
58. I always know what to say to people
References


