SELF-ESTEEM
ACROSS THE LIFESPAN
This book is dedicated to my three grandsons: Payton Vellenga, Spencer Guindon, and Parker Guindon.

Their healthy self-esteem levels amaze and delight their significant others, especially their Grammy.
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Back in the 1980s, I was asked to create a self-esteem group for a then newly opened women's in-patient unit at a private psychiatric hospital. Since I was interested in women's issues, I eagerly accepted. I asked the hospital staff for some guidance and was told something like, "Oh, you know, just make them feel better about themselves." I asked colleagues if they had materials I might draw on to develop the program and received the same approximate answer. In fact, most everyone looked at me as if I had asked an obvious, elemental question whose answer was known to all, it appeared, but me. The next week, I happened to be going to New York and took the opportunity to stop into the biggest bookstore in Manhattan. To my astonishment, I found rack after rack of books with the word self-esteem in the title. In fact, an entire section of the store was devoted to the subject. There was no question that the idea of self-esteem was popular. I felt slightly embarrassed that I had been totally unaware of this huge area, but as I looked through book after book, I realized that most of them didn’t seem to know much more about how to help people with low self-esteem than I.

I settled on a few of the more promising books and headed home to read, study, and create a program that might work, combining what I could glean from these books with what I already knew about human development (a little), psychology of personality (not much), and the various approaches to individual and group therapy (enough to practice ethically). I ran the group two evenings a week for almost three years, and by trial and error (I hope not much of the latter), I slowly honed a program that seemed to have good results.

A few years later, when I needed to decide on a topic for my doctoral dissertation, self-esteem seemed a natural. This was still before the Internet made literature searches armchair work. I wandered through the University of Virginia library's stacks of journals, old theses and dissertations, and lane upon lane of academic books. It was then that I discovered there was, indeed, an academic body of inquiry on the self-esteem construct. Yet only a relatively few resources defined self-esteem well. I next discovered the monumental works of Morris Rosenberg and Stanley Coopersmith and had my “Aha!” moment. I finally found out what I had assumed everyone else knew: what self-esteem is. However, despite the fact that a substantial body of research on the self-esteem construct existed then (and exists today), I found most people, even those in the helping professions, didn’t seem to be aware of any more of it than I was. I felt like I was somehow the keeper of a well-kept secret.
Over the last 25 years, I have facilitated many self-esteem groups for my clients or addressed their self-esteem needs in individual sessions. I have made presentations, facilitated professional workshops, and taught courses on the subject. I continue to be amazed by how, even today, so many practitioners are not particularly knowledgeable about self-esteem, although they tell me that low self-esteem plagues their clients. It seemed to me that what was needed was accountability in the use of the self-esteem construct that included understanding what it is and what has been shown to effectively enhance it.

Although I have had the luxury of offering self-esteem-specific strategies to clients and to teach students and other practitioners about self-esteem programs that work, I have found that many clinicians are not in a position, especially in a managed care climate, to provide interventions that exclusively address self-esteem issues. Although they recognize the importance of self-esteem enhancement and, more often than not, include it in treatment goals, few practitioners that I have met have the opportunity to specifically create and apply programs that only target self-esteem. That is what led me to consider that self-esteem might be successfully enhanced through the existing interventions that practitioners already use with their clients, if only they learned the same basic information that I had learned. For those that can offer self-esteem programs, I provide an overview of specific self-esteem strategies in this book. For those that may not be able to, I have asked experts on various clinical issues all across the life span to apply the self-esteem knowledge base to their areas of expertise. I am enthusiastic with the result and sincerely hope you will come to share my enthusiasm.

Each contributor has been willing to add to his or her own knowledge of the self-esteem literature. They incorporate principles of self-esteem to address an identified self-esteem issue at a specific developmental stage. They present at least one aspect of self-esteem that is most pertinent to their population and include suitable intervention strategies that support it. They discuss the self-esteem issues of their population, address diversity, include the crucial role of the mental health practitioner, and where relevant, present information on assessment. Each chapter contains a case study for your consideration. I thank these contributors for their hard work and their wholehearted willingness to join me in this project. I have learned much from them.

I continue to refine and add to my own knowledge, both professionally and personally. I am grateful to every one of the legitimate and responsible self-esteem writers for what they have taught me over the years, although I have known them only through their writings. I am perhaps most grateful for every client and every student who has tested me and challenged me as I have tried to assist them with their self-esteem needs. They have taught me about the nobleness of the human spirit even in the worst of personal circumstances.
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Section I

Introduction

Self-esteem as an area of inquiry has a rich history. Subsumed under the category of self-concept (the totality of thoughts and feelings about the self [Rosenberg and Owens, 2001]), it has been researched for more than a century. Today, it is also highly popularized, as a Web search or a visit to any bookstore shows. For example, one branch of a well-known bookstore on just one day contained 42 books on the subject. A recent Google search on the word *self-esteem* brought up over 3 million sites, while a book search under Amazon.com yielded more than 135,000 results. Although mental health practitioners and educators have available to them a massive amount of information about esteem-enhancing programs from academic, field/clinical-based, and popular/commercial sources, the majority of them seem to recommend ways to enhance self-esteem without regard to any evidence of what actually works. A few available resources are based on sound research, some on anecdotal material, and far too many on opinion, personal experience, or insight alone.

A continued proliferation of self-esteem research and its popularity in the trade media attests to the widely held belief of its significance as a personality variable. Self-esteem appears to be a wonder trait, a solution for all one’s problems. Yet, most people do not seem to have a clear understanding of the construct. As a result, many helping professionals from various disciplines who routinely include self-esteem in their strategies do so without having accurate knowledge about it.

The goal of this book is to help clinicians have a good conceptualization of what self-esteem is and how interventions for specific populations can address underlying self-esteem issues. This first part of the book addresses the definitional maze (Smelser, 1989) that is self-esteem, discusses its controversies, and presents information on intervention strategies that actually can make a difference.
REFERENCES


What Is Self-Esteem?

MARY H. GUINDON

INTRODUCTION

Researchers and clinicians from many disciplines focus on self-esteem as an area of importance. Self-esteem affects motivation, functional behavior, and life satisfaction, and is significantly related to well-being throughout life. It is possible that behaviors meant to maintain and enhance a positive sense of self are universal, that self-esteem is a basic human need (Greenberg, 2008). What individuals choose to do and the way they do it in part may be dependent upon their self-esteem. Low self-esteem has been shown to be related to many negative phenomena, including higher rates of teen pregnancy, alcohol and drug abuse, and violence, depression, social anxiety, and suicide. Such factors as gender, race, economic level, sexual orientation, immigrant status, and more seem to influence its levels (Twenge & Campbell, 2002; Twenge & Crocker, 2002). In fact, the need for positive self-esteem may be a significant feature of mainly European/American cultures (Heine, Lehman, Markus, & Kitayama, 1999).

The Diagnostic and Statistical Manual of Mental Disorders (DSM–IV–TR; American Psychiatric Association, 2000) includes self-esteem among diagnostic criteria for several mental disorder categories, and it is correlated strongly with depression. In a recent study of 1,190 individuals attending psychiatric outpatient services, Silverstone and Salsali (2003) concluded that all psychiatric patients suffered some degree of lowered self-esteem, with the lowest levels in patients diagnosed with depressive disorders, eating disorders, and substance abuse. Those with comorbid diagnoses, especially when one of the diagnoses was a depressive disorder, tended toward lower self-esteem than those without dual or multiple diagnoses. They found “a vicious cycle between low self-esteem and onset of psychiatric disorders. Thus, low self-esteem increases the susceptibility for development of
psychiatric disorders, and the presence of a psychiatric disorder, in turn, lowers self-esteem” (para. 4).

Yet self-esteem’s conceptualization and operationalization have been inconsistent, and many writers have criticized its meaning and usage. For example, countless studies have been conducted on student self-esteem and academic performance. Factors influencing students’ low academic performance point to low self-esteem as either an antecedent or consequent component. In general, high self-esteem appears to be a consequence of having experienced success. Other research, however, suggests that there is no positive correlation between self-esteem and academic achievement (Baumeister, Campbell, Krueger, & Vohs, 2003; Forsyth, Lawrence, Burnett, & Baumeister, 2007; Ginter & Dwinell, 1994). This lack of consistency and consensus means mental health practitioners and educators may be making their own assumptions about self-esteem’s nature, relying on common sense. This is misleading and contributes to an impression of preciseness in treatment planning where none exists. Consequently, clients’ concerns may not be addressed, and strategies meant to impact their levels of self-esteem may not fit them.

The dichotomy between self-esteem’s popularity in the public consciousness and the professional body of knowledge leads to misconception and confusion. Try this example:

Betsy, an attractive 16 year old, well dressed and stylish, walks into a crowded party. She is at the top of her junior class, takes two AP classes, is a cheerleader, and has lots of friends. Upon request and encouragement, she sings a contemporary song with perfection. Several other guests rush over to compliment her on her talent. Later, she whispers to her best friend, “So what if I can sing? What difference does it make? I still feel really bad about myself. I guess I have low self-esteem.”

Is she talking about how she measures up to other singers? The fact she has a rip in her new silk blouse? That she thinks she is overweight? That she earned a 97 rather than 100 on her last exam? How she manages her part-time job? Her overall level of confidence? In short, what does she mean?

Despite myriad resources, most people do not know how to answer this basic question. Furthermore, it seems that few mental health practitioners actually use resources that are well grounded in the existing body of knowledge. How can this be? How can something so well known to the general public be so perplexing? It seems to be that “the popular definition of self-esteem may not match the psychological definition of self-esteem” (Koch, 2006, p. 262). Given the ubiquitous nature of self-esteem, the assumption that it needs to be attended to, the availability of both responsible and problematic resources, and the lack of consistency and consensus in the field, practitioners need an accurate understanding of self-esteem if they are to use interventions that impact positive self-esteem development and enhancement. As long as clinicians continue to write “increase self-esteem” on treatment plans without a good knowledge of what it is or what can help, there is a fundamental need for this information.
Self-esteem is first of all a construct, and constructs are by necessity grounded in theory and concomitant research. Self-esteem is not something we can see, but we believe it to exist through its artifacts. To know its artifacts, we must first examine self-esteem’s definitional maze (Smelser, 1989) because any theory—and intervention—depends on how it is defined.

Over 30 years ago, Wells and Marwell (1976) classified ways of defining self-esteem. Their landmark work stands today. They exhaustively studied the existing self-esteem works up to that time and came to the conclusion that definitions fall into four distinct categories resulting in different perspectives. In the object/attitudinal approach, the self is an object of attention just like any other thing. We can have thoughts, feelings, and behaviors toward anything that is an object. Thus, we can also have these reactions toward ourselves, in this case toward that part of ourselves we call self-esteem. The relational approach is the relationship or difference between sets of attitudes. It is also reactional. For example, we can have varying and different thoughts, feelings, and behaviors when comparing our ideal self with our real self, or between our aspirations and our achievements. Wells and Marwell found this to be the most common type of definition. The psychological responses approach, as its name suggests, concerns psychological or emotional reactions toward the self. We can feel either positive or negative about some element of ourselves, such as our behavior or our appearance. Self-esteem defined this way is affective in nature. The fourth type is the personality function/component approach. Self-esteem is seen as being a part of personality (a construct itself), the self, or self-system, which is that part of personality concerned with motivation and self-regulation. For example, individuals evaluate themselves according to how they conform to socially sanctioned standards. Wells and Marwell thus categorized definitions as attitudinal toward the self as the object of attention; as relational between different sets of self-attitudes; as psychological responses toward the self; and as a function of personality, a part of the self-system. Despite these varying ways to defining self-esteem, Wells and Marwell concluded that nearly all definitions of self-esteem consist of two primary aspects: evaluation and its emotional experience or affect.

Smelser (1989) posited that cognitive, affective, and evaluative elements are the universally accepted components of self-esteem. These components indicate the possibility of different artifacts. The cognitive element expresses a part of the self in descriptive terms. It answers the question of what kind of person one is, such as secure, outgoing, or smart. The affective element is the positive or negative aspect of each of these attributes, or its valence. It determines whether self-esteem is high or low. The evaluative element is the level of worthiness assigned to each attribution. It is based on an ideal societal standard.

How these and other self-esteem researchers came to their conclusions is based on the history of previous conceptualizations about self-esteem. “Each usage is relative to the particular theoretical context in which it occurs, since it is from that theory that self-esteem gets its definition and, consequently, its meaning” (Wells & Marwell, 1976, p. 229). If we are to apply strategies meaningfully, we must come to a consensus on how we define self-esteem. To reach consensus, we should be
well informed of past and current definitions. Mruk (2006) reminds us that definitions worth examining must pass the test of time, and that “every major definition is important because each one can show us some things about self-esteem that can only be seen from that particular point of view” (p. 9). We will now look at the main theories and key scholars that show the evolution of the construct across time.

HISTORY OF SELF-ESTEEM AS A CONSTRUCT

The study of self-esteem is not new. The concept of self-esteem has probably always been part of the human psyche. Campbell and Foster (2006) have argued for its evolution as an early human trait that “likely provided information about social standing and performance …” (p. 345). Nevertheless, self-esteem as a distinct concept in all likelihood first appeared during the European Age of Enlightenment. John Milton (cited in Leonard, 2003) may have coined the word self-esteem when he wrote in *An Apology for Smectymnuus* in 1642: “Nothing profits more than self-esteem, grounded on what is just and right.”

However, its beginnings as a modern psychological concept can be traced to William James (1890), who is generally credited as the earliest investigator of self psychology. He defined self-esteem as self-appreciation consisting of feelings and emotions toward the self. As a product of the scientific, positivistic period of time, he conceptualized self-esteem as an equation of self-evaluation—a ratio of our “pretensions” divided by our “successes” (p. 310). He believed there to be a connection among values, success, and competence. He proposed that one carries an average level of self-feeling at all times regardless of objective reality. That is, self-esteem is a trait. Individuals have a baseline feeling of worth, value, liking, and acceptance. Hence, James’s definition is affective. One’s trait level of self-esteem is relatively independent of objective circumstances, in contrast to state self-esteem, in which self-esteem changes in response to the successes and failures in one’s life.

Cooley (1902) also viewed self-esteem as affective. Perhaps best known for his conceptualization of the looking-glass self, in which the understanding of the self is determined by perceptions of others’ judgments, Cooley observed that who we believe ourselves to be is very much tied to our social environment. Significant others are the social mirror into which we look to discover their opinions toward us. We imagine our self to be what others think us to be, including all of our aspects, such as our character, looks, behaviors, and so forth.

Mead (1934) viewed the self as a product of interactions in which individuals experience themselves as reflected in the behavior of others. Although Mead did not address directly the concept of self-esteem, he discussed self-evaluation as an attitude toward self. In contrast to James and Cooley, his view is cognitive in nature. Mead believed that the self develops from the continual interaction of the *I* (the subjective, private, experiencing part of the self) with the *Me* (the objective, social aspect of the self). The *I* consists only of the awareness of experiences of thinking and feeling and is present from infancy. The *Me* grows gradually in children as they develop the ability to perceive objects distinct from themselves. For Mead, individuals experience themselves through their perceptions of the outside environment and community. The self is a product of the social world. The *Me*
distinguishes attributes of the self from the perspective of this “generalized other” of society. “Mead’s formulation implies a process through which the judgments of numerous significant others are somehow psychologically weighted in order to produce an overall sense of self-worth as a person” (Harter, 1999, p. 19). James, Cooley, and Mead believed the self-image to be influenced by the social environment, particularly through the individual’s perceived appraisal by others.

Several early personality theorists contributed to our understanding of self-esteem. Neo-Freudian Karen Horney (1950) stated that each person is born with a unique potential, and that self-esteem derives from achieving it. Harry Stack Sullivan (1953) posited that self-esteem is the social need to be accepted and liked and to belong that is derived from social interaction mediated by reflected self-appraisal. Self-esteem is maintained by conforming to social expectations. Alfred Adler (1956) theorized that people construct their own views of self. They strive for meaning; they work toward the goal of wholeness and for superiority. Although he did not define self-esteem directly, he used the term self-acceptance, which entails perceptions of competence and achievement. He said that false superiority is an inefficient way of gaining self-esteem. He believed in coping rather than avoiding life’s problems. Gordon Allport (1961) saw the development of self-esteem as a central issue for early childhood. He equated self-esteem to the sense of pride that comes from recognition that one can do things on one’s own. White (1963) stated that self-esteem has two sources: an internal source of a sense of accomplishment and an external source of affirmation from others. He described self-esteem as a developmental process and recognized competence as a key factor.

Humanists also described self-esteem. Rogers (1951) defined self-esteem as the extent to which people like, value, and accept themselves. He believed that the self develops from a combination of what is experienced and what is interjected, derived from values and affective preferences. The individual conceptualizes an ideal self, or the “person you would like to be”; the actual self-image, or the “person you think you are”; and the true self, or the “person you actually are.” The more congruent are these three aspects of the self, the healthier the self-esteem.

In his hierarchy of human needs, Maslow (1968) included self-esteem as a basic need, second only to self-actualization. He defined it as “the desire for strength, for achievement, for adequacy, for mastery and competence, … and for independence and freedom” (p. 45).

Morris Rosenberg (1965, 1979) and Stanley Coopersmith (1967) were the first researchers to develop theories of self-esteem as a significant personality construct grounded in empirical methods. Although they researched different populations, they reached similar conclusions.

Rosenberg (1965) researched the development of the self-image during adolescence and its consequences for adolescents and adults. He emphasized the self-image as a global aspect of the personality. He concluded that self-esteem is an attitude toward a specific object, the self. Each characteristic of the self is evaluated and results in an estimate of that characteristic. Every element of the self is evaluated according to a value that has developed during childhood and adolescence. Feedback from others, particularly significant others, is a key element of self-esteem (Rosenberg, 1979). This feedback can be actual or perceived.
Rosenberg recognized a dual nature in self-esteem. It is at once a situational evaluation and a general one. Self-esteem is a combination of specific estimates of the individual’s numerous and varied characteristics. Although this process can be out of awareness, people assign varying negative or positive values to each characteristic—or domain—and add them together. This results in a general evaluation of the self. Furthermore, people place importance on, or weigh, some domains more than others. The weight of each value will vary depending upon how important that particular characteristic is to the individual. In other words, how much each constituent characteristic matters to the individual determines the weight given, or its salience. Perceived reactions from others, particularly significant others, is an important element of self-esteem. People socially rank and evaluate many elements, including their personal attributes, life roles, and present circumstances. Consequently, the individual’s sense of personal worth can be contingent upon the perceived prestige of the element. Therefore, a person’s global self-esteem is based “not solely on an assessment of his constituent qualities but on an assessment of the qualities that count” (Rosenberg, 1979, p. 18). For example, an individual may place a weak negative evaluation on looks, a medium negative evaluation on physical prowess, a weak positive evaluation on mathematical ability, and an extremely high evaluation on social sense and belongingness. Together these would add up to an overall positive sense of self-esteem, assuming these qualities were particularly salient. Conversely, if belongingness and mathematical ability were not important and physical prowess was most important, overall self-esteem would be negative. Nevertheless, although Rosenberg discussed specific estimates of various parts of the self, he argued for a unidimensional concept of self-esteem that he termed global self-esteem, or “the feeling that one is ‘good enough’” (1965, p. 31).

Coopersmith (1967) researched the development of self-esteem in presecondary school children and believed self-esteem to be a complex phenomenon consisting of self-evaluation and manifestations of defensive reactions to that evaluation. Comprised of two parts—subjective expression and behavioral manifestation—self-esteem is a self-evaluation of personal worthiness. It is a judgmental process in which “performance, capacities, and attributes” (Coopersmith, 1981, p. 5) are examined according to personal standards and values that developed during childhood. As an acquired trait, individuals learn their worth initially from their parents, which is then reinforced by others. Coopersmith addressed true self-esteem (seen in those who actually feel worthy and valuable) and defensive self-esteem (seen in those who feel unworthy but who cannot admit this threatening information). This definition focuses on the “relatively enduring estimate of general self-esteem rather than on specific and transitory changes in evaluation” (Coopersmith, 1981, p. 5).

Following their original works and not particularly related to them, self-esteem as a popular phenomenon exploded during the human potential movement of the 1960s and 1970s. Self-esteem now entered the national consciousness. The centrality of self-esteem to success and well-being has since become part of American culture. Helping professionals, teachers, and parents have made efforts to increase self-esteem in the belief that high self-esteem will result in a plethora of positive outcomes, but with little substantive evidence (Baumeister et al., 2003; Swann,
Chang-Schneider, & Larsen McClarty, 2007). As an example, the California Task Force to Promote Self-Esteem and Personal and Social Responsibility (1990) embarked on an ambitious program to promote enhancing self-esteem as a method of bolstering its state’s economy and cure social problems. It published a committee-generated definition based on task force recommendations. Stated as its official definition was, “Appreciating my own worth and importance and having the character to be accountable for myself and to act responsibly toward others” (California Task Force, p. 1). This was a notable exception to academic definitions. Later on, Dr. Sidney B. Simon spawned a self-esteem industry with the development of the IALAC (I am loveable and capable) curriculum.

The search for the meaning of self-esteem and the refining of its definition continues to this day. Nathaniel Branden (1969) defined self-esteem as a standard by which one judges oneself, an estimate, an emotion, and as “the experience that we are appropriate to life and to the requirements of life” (1992, p. 8). His early work was the first to clearly include both competence and worthiness. He added the dimension of the relationship between personal self-efficacy and self-respect.

Epstein’s (1973) cognitive-experiential self theory (CEST) views self-esteem as a basic human need. Self-enhancement is a basic motive. Self-esteem is conceptualized as a consequence of one’s understanding of the world and others, and who one is in relation to them. The self strives to maintain equilibrium through compromises among various motives. This accounts for how low- or high-self-esteem people respond to positive and negative feedback differently. Two experiences most directly affecting self-esteem are success/failure and acceptance/rejection (Epstein, 1979). Epstein noted that there are different levels of self-esteem: global, intermediate, and situational. Global is the general evaluation of the self. Intermediate involves specific domains, such as competence, lovability, self-control, and body appearance. Situational is the day-to-day manifestation of self-esteem that varies with circumstances. Global and intermediate self-esteem affect situational self-esteem.

Gecas (1982) differentiated between self-esteem based on a sense of competence, power, or efficacy and self-esteem based on a sense of virtue or moral worth. Self-esteem based on competence involves effective performance and is associated with self-attribution and social comparison processes. Self-esteem based on self-worth is associated with values and norms of personal and interpersonal conduct. These two aspects are interrelated; sense of worth may be affected by sense of competence, and vice versa.

Harter (1999) discussed both global and domain-specific evaluations of the self. In reviewing the literature she came to the conclusion that it is necessary “to distinguish between self-evaluations that represent global characteristics of the individual (e.g., ‘I am a worthwhile person’) and those that reflect the individual’s sense of adequacy across particular domains such as one’s cognitive competence (e.g., ‘I am smart’), social competence (e.g., ‘I am well liked by my peers’), athletic competence (e.g., ‘I am good at sports’), and so forth” (p. 5). Harter reiterated Mead’s and Cooley’s contentions that evaluations of the self are a social construction that develops in childhood from the perceived opinions of significant others. Children internalize the standards and values of important significant others,
“including the values of the larger society” (p. 13). She pointed out that general self-esteem is not a summary of self-evaluations of different domains.

Brown (1993) supported conceptualizing self-esteem in terms of global feelings separate from specific self-evaluation. He made a case for global self-esteem affecting specific self-evaluations, not the reverse. Rather than seeing a qualitative difference between specific and global self-esteem, Wylie (1974) and Gurney (1986) proposed a hierarchic relationship. Evidently, generalizations cannot be made from the global to the specific or from the specific to the global (Harter, 1999).

Mruk (1995, 2006), in presenting his phenomenological theory of self-esteem, reviewed previous definitions and presented self-esteem in a two-factor theory in which an interaction between worthiness and competence occurs. He has conceptualized a self-esteem matrix showing a continuum of low to high competence-based self-esteem and low to high worthiness-based self-esteem. His work has substantiated worth and competence as the major elements in defining self-esteem. A similar line of inquiry presents self-esteem as self-competence and self-liking. Self-competence corresponds “to one’s history of success and failure in meeting goals” (Tafarodi & Milne, 2002, p. 467), and self-liking derives from “appraisals of worth conveyed by others or reflexively generated by the ‘generalized other’ of self-judgment” (p. 468).

In recent years the emphasis in definitions has shifted to various aspects of self-esteem. Contributors to the self-esteem body of knowledge continue to further refine the construct. Collective self-esteem refers to the positivity of the self-concept derived from identifying oneself as a member in one or more social groups. Level of self-worth is mainly based on the emotional significance attached to a specific social group and one’s role in it (Luhtanen & Crocker, 1992). Collective self-esteem is an especially important factor to understand when working with those who are not ethnic members of the traditional White Euro-American culture, or who are marginalized by it.

Contingent self-esteem refers to feelings about the self that are dependent upon measuring up to external sources of perceived standards and expectations (Crocker, 2006; Crocker & Wolfe, 2001; Deci & Ryan, 1995). “Contingent self-esteem is experienced by people who are preoccupied with questions of worth and esteem, and who see their worth as dependent upon reaching certain standards, appearing certain ways, or accomplishing certain goals. It is not just that they are motivated, but also that they are strongly motivated by the desire to appear worthy to self and others,” whereas noncontingent self-esteem “characterizes persons for whom the issue of self-esteem is not salient, largely because they experience themselves on a fundamental level as worthy of esteem and love” (Ryan & Brown, 2003, p. 72). Those with contingent self-esteem issues “are preoccupied with their standings on specific evaluative dimensions (e.g., How attractive am I?) and how they are viewed by others (Do people think I am smart?) …” (Kernis & Goldman, 2006, p.79).

Implicit self-esteem refers to unconscious self-evaluations (Kernis, 2003; Koole, Dijksterhuis, & van Knippenberg, 2001). It is “the introspectively unidentified (or inaccurately identified) effect of the self-attitude on evaluation of self-associated and self-dissociated objects” (Greenwald & Banaji, 1995, p. 11). Explicit self-esteem
is conscious and may be influenced by the need for positive self-presentation. Yamaguchi et al. (2007) have suggested that while explicit self-esteem may not be universal, implicit self-esteem may very well be universal, based on their studies of students in Japan, China, and the United States.

An emphasis on the difference between state and trait self-esteem has also emerged. Self-esteem lability is a trait: one’s excessive reactions to everyday stressors and positive and negative occurrences. Self-esteem can be stable or unstable (Trzesniewski, Donnellan, & Robins, 2003), and secure or fragile (Kernis, Lakey, & Heppner, 2008). These and other newer developments in conceptualizing self-esteem keep the discipline vibrant and open to debate and controversy.

**SELF-ESTEEM DEFINED**

With such variation in definitions in the literature, we must clarify self-esteem as defined in this book. In reviewing the history of the self-esteem construct we can come to some conclusions. First and foremost, self-esteem is an attitude, namely, the individual’s evaluation of the self-concept. Competence and achievement appear to be integral elements of self-esteem, and these two elements appear to be intertwined with a judgment of self-worth. Worth is dependent on societal values and in part is shaped and maintained through the perceived judgment of opinions and feedback from significant others. Moreover, self-esteem appears to be dual in nature. It is at once a general evaluation (global) and a specific evaluation of elements of the self (selective). This means, as many theorists have suggested, that individuals attach evaluations to all the different qualities and aspects of the self that vary in importance to them. They also sum these qualities, presumably unconsciously, to generate an overall evaluation of the self. Furthermore, self-esteem appears to vary across different areas of experience and according to role-defining characteristics. Self-esteem, then, seems to fluctuate, influenced by “changing roles, expectations, performances, responses from others, and other situational characteristics” (Demo, 1985, p. 1491). It appears to be situational—high at one moment or low at another—depending upon to which specific identity element, or domain, such as academic ability or achievement, physical prowess, body image, or family and peer relationships, the individual attends. People may have positive attitudes about the self in general, but, in certain circumstances, feel better or worse about themselves. Furthermore, it is possible to have a good overall self-esteem level, but have low self-esteem about a specific trait or quality, especially when that trait has a high meaning or significance. When a trait or group of traits is especially salient, global self-esteem can be affected.

It is this very dual nature that leads to imprecise strategies intended to enhance or remediate self-esteem issues, resulting in the possibility that a practitioner may be addressing one quality or attribute in the client when another quality or attribute altogether may be of concern to the client. “Jane, for example, may have a strong sense of general, or global, self-esteem, but may manifest feelings of low self-esteem about the size of her nose, or her inability to do math; may exhibit feelings of high self-esteem about her popularity among her peers; and may temporarily show characteristics of low self-esteem when she is in a situation where
she feels incompetent or demeaned by someone important to her” (Guindon, 2002, p. 206). Or, “John may play the piano exceptionally well but if it doesn’t matter to him, if this accomplishment carries a low weight, his counselor’s well-intentioned validation of his piano-playing skill as a way to bolster his self-esteem is ineffective” (Guindon, 2002, p. 207).

Consequently, mental health clinicians and others who are concerned about self-esteem in those who receive their services need ways to address self-esteem by conceptualizing a consistent definition that has utility. To that end and for the purposes put forth in this book, the following is a general definition grounded in the professional literature:

Self-esteem is “the attitudinal, evaluative component of the self; the affective judgments placed on the self-concept consisting of feelings of worth and acceptance which are developed and maintained as a consequence of awareness of competence and feedback from the external world.” (Guindon, 2002, p. 207)

Furthermore, we must recognize that self-esteem is not one entity. We can assume self-esteem exists as a self-esteem system made up of a global component and a selective component. It consists of interrelated concepts that can be addressed separately:

Global self-esteem: An overall estimate of general self-worth; a level of self-acceptance or respect for oneself; a trait or tendency relatively stable and enduring, composed of all subordinate traits and characteristics within the self.

Selective self-esteem: An evaluation of specific and constituent traits or qualities within the self; at times situationally variable and transitory, that are weighted and combined into an overall evaluation of self, or global self-esteem. (Guindon, 2002, p. 207)

These definitions allow us to assess and attend to different domains of the self—those traits and circumstances within individuals that most matter to them. To operationalize self-esteem, we need to recognize that accomplishment and achievement are manifestations of competence that can be addressed in counseling and psychotherapy. We also need to recognize that societal, family, and personal values play major roles in the sense of worthiness and self-acceptance and can likewise be addressed. Both areas emphasize the need to understand the extent that salience (i.e., weight) plays in each individual’s level of selective self-esteem. The contributors to this book present information that explicitly speaks to the issues of their expertise. They connect what they know to be effective in treating their populations to one or more specific elements that make up the self-esteem system. They show us how and in what ways their interventions and strategies can address self-esteem issues. Practitioners who include self-esteem in their treatment plans thus have a framework from which to work responsibly.
SELF-ESTEEM APPRAISAL

Accurate appraisals about self-esteem level and stability help us plan interventions that have the best chance of working. The practitioner’s decision needs to match the client’s experience (Figure 1.1).

If a client’s experience of her self-esteem is low, and the practitioner correctly decides the client has low self-esteem, he can then develop effective and appropriate treatment goals to attempt to raise it. If he is incorrect, he will falsely attribute manifest behaviors and feelings to low self-esteem and his attempts at increasing self-esteem are unwarranted. On the other hand, if the client’s experience of her self-esteem is adequate or high, and the practitioner correctly decides the client has no self-esteem issues, self-esteem is not a treatment goal. If he is incorrect, he might then develop unwarranted and ineffective treatment goals and inappropriate interventions. Clearly, informed choices through appraisal are necessary.

Unfortunately, evidence points to the fact that few clinicians actually use methods to assess self-esteem. As an example, I investigated perceptions and practices pertaining to self-esteem among 418 participants, mainly school counselors, in New Jersey. A majority of the total survey participants (73.4%) indicated that they had specialized knowledge or training about self-esteem. Nevertheless, when asked if they used assessment methods to determine students’ self-esteem levels, only 57 (13.6%) of the 418 survey participants answered yes. A majority of 81.8% answered no, and 19 respondents did not answer the question (Guindon, 1996).

What can we make of the fact that despite the overwhelming majority of these counselors’ belief that schools are responsible for addressing the issue of self-esteem in their students, so few of them assess levels of self-esteem? Is its manifestation assumed? Without some basis to objectively assess self-esteem levels, upon what

<table>
<thead>
<tr>
<th>Client’s Experience</th>
<th>Counselor Decision (based on perception/assumption of client’s experience)</th>
<th>Self-esteem Adequate/High</th>
<th>Self-esteem Low/False</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem Adequate/High</td>
<td>Correct Decision</td>
<td>▲ SE ≠ treatment goal</td>
<td>Incorrect Decision</td>
</tr>
<tr>
<td>Self-esteem Low/False</td>
<td>Incorrect Decision</td>
<td>▲ SE = ineffective treatment goal/False attribution of behavior/feelings/thoughts</td>
<td>Correct Decision</td>
</tr>
</tbody>
</table>

Figure 1.1 Client experience and counselor decision.
are counselors relying to develop self-esteem interventions? Surely, if addressing self-esteem is to be considered at all, assessing it is essential.

Although no shortage of instruments claiming to measure self-esteem exists, the current state of assessment is just as confusing as self-esteem’s definitional maze. Just as we found with an Internet search of the word *self-esteem* by itself, pairing it with *test* garnered over 4 million sites, and with *assessment* resulted in over 2½ million. We can safely assume that most of these sites are problematic at best.

**Standardized Assessment Instruments**

Of course, there are many well-constructed, professionally accountable assessment instruments that include a self-esteem measurement. There are well over 2,000 self-esteem-related assessment instruments in existence. Most are self-report questionnaires. They contain inherent difficulties common to all self-report measures, such as question format and social desirability and self-presentation biases, and can be misleading. Some instruments purporting to measure self-esteem in actuality are a sum of various self-descriptions that may measure concepts other than self-esteem. In a review of self-esteem assessments almost 20 years ago, Blascovich and Tomaka (1991) stated: “Neither a firm body of evidence nor a convincing definitional rationale to justify many of the ‘self-esteem’ measures exists” (p. 119). Achieving a sound degree of scientific validity is difficult. Nevertheless, the use of standardized pencil-and-paper self-report instruments is the primary and most reliable means of ascertaining self-esteem levels. Although there are limits to what clinicians can realistically expect in self-esteem instruments, the most commonly used instruments suitable for self-esteem measurements include the Self-Esteem Inventory (SEI; Coopersmith, 1981), Tennessee Self-Concept Scale (TSCS; Roid & Fitts, 1988), Piers-Harris Children’s Self-Concept Scale (P-HCSCS; Piers, 1984), Body-Esteem Scale (BES; Franzoi & Shields, 1984), and Culture-Free Self-Esteem Inventories (CFSEI-3; Battle, 2002). Arguably, the most widely used instrument is the Rosenberg Self-Esteem Scale (Rosenberg, 1965). A measure of global self-esteem, it is not published by a testing company. Used mainly for research with high face validity, it may not be suitable as an appraisal of any one individual’s self-esteem (see Wylie, 1974; Table 1.1).

Other useful assessments include the Self-Perception Profile for Children (Harter, 1985) and Self-Perception Profile for Adolescents (Harter, 1988), Self-Liking and Self-Competence Scale (Tafarodi & Swann, 2001), Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz, 1998), and Kernis and Paradise Contingent Self-Esteem Scale (Kernis & Goldman, 2006).

**Other Methods of Assessing Self-Esteem**

Relying on a single form of measurement is not enough. Clinicians have several other options: interviews, behavioral observation, and ratings by others (e.g., teachers, counselors, medical professionals, parents). A responsible way to approximate self-esteem levels is through triangulation, the use of multiple methods.
### Table 1.1 Assessment Instruments Appropriate for Self-Esteem Measurement

<table>
<thead>
<tr>
<th>Instrument with Citation</th>
<th>Purpose G/S*</th>
<th>Format</th>
<th>Age Range</th>
<th>Number of Items</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Esteem Scale (SES; Rosenberg, 1965) (Also available is a 6-item SES targeted toward children below high school age, see Rosenberg &amp; Simmons, 1972)</td>
<td>G only. Unidimensional measure of global feelings of self-worth and acceptance; estimates positive or negative feelings about the self</td>
<td>4-point responses to self-descriptive statements</td>
<td>High school through adult</td>
<td>10</td>
<td>Susceptible to social desirability response. Tends to be negatively skewed for college age</td>
</tr>
<tr>
<td>Self-Esteem Inventory (SEI; Coopersmith, 1981)*</td>
<td>Form A: G and S with caution. Form B: G only. Measure “self-regard.” Form A has three subscales: Social Self-Peers, Home-Parents, School-Academic, plus a lie scale</td>
<td>Forced choice (“like me,” not like me”) responses to self-descriptive statements</td>
<td>Ages 8 through 15</td>
<td>Form A: 50 Form B: 25 (first half of Form A)</td>
<td>Susceptible to social desirability response. Tends to be negatively skewed</td>
</tr>
<tr>
<td>Tennessee Self-Concept Scale (TSCS; Roid &amp; Fitts, 1988)</td>
<td>G (total score). S (social, family, physical, moral-ethical, personal categories. Multidimensional view of the self-concept; popular as a general measure of self-esteem</td>
<td>5-point responses to self-descriptive statements</td>
<td>Ages 12 and above</td>
<td>100</td>
<td>Support only for family, physical, and social subscales (Marsh &amp; Richards, 1988)</td>
</tr>
<tr>
<td>Piers-Harris Children’s Self-Concept Scale (P-HCSCS; Piers, 1984)</td>
<td>G only. Measures self-concept; synonymous with self-esteem regard. Subscales demonstrate substantial overlap (Blascovich &amp; Tomaka, 1991)</td>
<td>Forced choice (yes/no) responses to predominantly self-descriptive statements</td>
<td>Ages 8 through 18</td>
<td>80</td>
<td>Susceptible to social desirability response; most suitable to younger groups</td>
</tr>
</tbody>
</table>

—continued
<table>
<thead>
<tr>
<th>Instrument with Citation</th>
<th>Purpose G/S</th>
<th>Format</th>
<th>Age Range</th>
<th>Number of Items</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Body-Esteem Scale (BES; Franzoi &amp; Shields, 1984)</td>
<td>S only. Measures degree of feelings with various body parts or processes</td>
<td>5-point responses rating feelings about body parts and functions including gender-specific subscales</td>
<td>College age</td>
<td>40</td>
<td>Social desirability response bias not determined but considered moderate (Blascovich &amp; Tomaka, 1991)</td>
</tr>
<tr>
<td>Culture-Free Self-Esteem Inventories, 2nd edition (CFSEI-2; Battle, 1992)</td>
<td>Measures perception of self, self-esteem independent of cultural context. Form A: (general items subscale), S with caution. Subscales are Social/Peers Related; Academic/School Related; Parents/Home Related; and lie items. Form B: G only. Form AD: G (general items subscale). S with caution. Subscales are social, personal, and lie items.</td>
<td>Forced choice (yes/no) self-report checklists</td>
<td>Grades 3–12.</td>
<td>Form A: 60 Form B: 30 Form AD: 40</td>
<td>True “culture free” status in question. Tends to be negatively skewed.</td>
</tr>
</tbody>
</table>


b Adult form adapted from Form B is also available.
In fact, just as with other issues, appraisal does not begin with administering an assessment instrument alone, but by observing and monitoring the client. Ratings by others, behavioral observations, and interview methods are subjective means of assessment. They can clarify distinctions between experienced and presented self-esteem (Demo, 1985). Experienced self-esteem is that which is evaluated by the individual, whereas presented self-esteem is that which is evident to others through observing verbal and nonverbal behaviors. Self-ratings, however good at capturing personal information unavailable to others, are inherently fallible because minor changes in questions’ wording, format, or context can result in major differences in results (Schwarz, 1999). Then again, observer ratings provide information observed by others, such as parents or teachers, but these ratings must infer information. This makes them susceptible to obscuring and distorting an individual’s self-esteem, especially given the likelihood of observers not having a sound grounding in what self-esteem actually is. Clearly, all these alternatives to standardized measurements can contribute corroborative evidence but are also susceptible to distortion.

Although necessary, regrettably, assessing self-esteem is an imprecise activity. No one alternative method can accurately pinpoint self-esteem levels or consistently make accurate judgments on any one client. Practitioners should therefore take advantage of one or more standardized assessment instruments and supplement the information with one or more of the alternative methods whenever possible.

**SELF-ESTEEM CHARACTERISTICS**

Self-esteem exists on a continuum and can be high, medium, low, or defensive. When considering optimal self-esteem, the curvilinear model seems to be most apt, with too low and too high self-esteem being less adaptive than medium self-esteem. Too strong a belief in one’s competence, for example, may actually make one more vulnerable to life’s pitfalls because the individual does not recognize realistic limitations. Extreme high self-esteem can be indicative of narcissism and destructiveness (Baumeister, Smart, & Boden, 1996). On the other hand, some people who exhibit signs of high self-esteem may actually be experiencing feelings of low self-esteem through the mechanism of defensive, pseudo-high, or false self-esteem. The person with false high self-esteem is characterized by an overinflated sense of self (Hoyle, Kernis, Leary, & Baldwin, 1999), which in actuality covers up a sense of low self-worth. This person lacks self-awareness and may be defensive, destructive, and aggressive, all the while professing a strong evaluative sense of self. The combination of self-esteem level and instability may result in hostility; self-esteem reactivity may be one characteristic of childhood aggression. Those with unstable high self-esteem may be more likely to act angry and hostile than those with high stable self-esteem (Esposito, Kobak, & Little, 2005). Baumeister et al. (1996) have proposed that the combination of high self-esteem (associated with narcissism), low empathy, excessive need for approval, and unstable self-esteem results in a tendency toward violence. Others disagree, saying that those with low self-esteem are more likely to report violent thoughts (Harter, Low, & Whitesell,
The person with healthy and genuine high or medium self-esteem will be assertive rather than aggressive. Those with genuinely low self-esteem tend to be avoidant, rather than aggressive.

Low self-esteem is highly correlated with depression (Beck, Brown, Steer, & Kuyken, 2001; Silverstone & Salsali, 2003), and a significant relationship exists between suicidal ideation and self-esteem. Self-esteem is also correlated with locus of control (Brockner, 1979; Judge, Erez, Bono, & Thoresen, 2002). Many studies support the fact that high-self-esteem individuals seem to be more self-directed and independent than low-self-esteem individuals. High-self-esteem people are more open to feedback and can perceive situations more realistically. Lower-self-esteem individuals tend to be more cautious, self-protective, and conservative than higher-self-esteem people. Self-esteem stability seems to play a role. Stability is “the magnitude of short-term fluctuations that people experience in their current, contextually based feelings of self-worth” (Kernis, 2005, p. 1). Instability may be associated with greater sensitivity to feedback. When highly unstable-self-esteem people receive negative feedback, their self-esteem declines in reaction to this feedback more than that of stable-self-esteem people (Kernis, Cornell, Sun, Berry, & Harlow, 1993).

Rosenberg and Owens (2001) have provided us with a portrait of low-self-esteem people drawn from surveys and experimental studies. Those with low self-esteem are more sensitive than others to experiences that threaten to damage their self-esteem. They are more troubled by criticism and have more severe emotional reactions to failure. Additionally, they are more likely to magnify events as negative or perceive noncritical remarks as critical. Those with low self-esteem are more likely than others to experience social anxiety, exhibiting high levels of public self-consciousness. Low-self-esteem people have low interpersonal confidence. They feel “awkward, shy, conspicuous, and unable to adequately express themselves when interacting with others” (p. 409). This lack of interpersonal confidence lowers interpersonal success, which then results in damaged global self-esteem. Although not necessarily obvious to an observer, high- and low-self-esteem individuals vary greatly in their motives for personal growth and improvement. High-self-esteem people seek growth, whereas low-self-esteem people seek to protect the self and focus on not making mistakes. Moreover, those with low self-esteem experience substantially less happiness and more emotional distress, including depression and anxiety. Low-self-esteem individuals tend to be pessimistic, cynical, and have negative attitudes toward institutions as well as toward people and groups. Low-self-esteem people exhibit unconstructive thinking such as rigidity and inflexibility. They are more likely to be indecisive and slower to respond when they need to make decisions. They experience greater depersonalization, experiencing themselves as detached onlookers. However, Rosenberg and Owens (2001) point out that this type of depersonalization is distinct from the DSM disorder.

People with low self-esteem also tend to have lower self-efficacy and confidence in their own judgments and opinions. Self-efficacy and self-confidence are related parts of the self-concept. Self-efficacy refers to people’s assessments of their effectiveness and competency and causal agency (Bandura, 1977; Gecas, 1989). However, high self-esteem does not necessarily reflect strong feelings of efficacy, nor does a good sense of self-efficacy ensure high self-esteem. Self-confidence is
defined as the “anticipation of successfully mastering challenges or overcoming obstacles…” (Rosenberg, 1979, p. 31). High-self-esteem individuals are confident in the accuracy of their perceptions and judgments and believe that they can favorably resolve their efforts (Coopersmith, 1967). Yet global self-esteem seems to be distinct from social confidence.

Baumeister et al. (2003) found that self-esteem and happiness are strongly interrelated: Enhanced initiative, pleasant feelings, and better physical health and longevity are positive outcomes of high self-esteem. Those with high self-esteem are less likely to be depressed in response to stressful, traumatic events. They seem to perform better in the workplace and experience more occupational success, persist following failure, sometimes perform better in groups, and perceive themselves as well liked and popular. Low self-esteem is linked to depression, may be a risk factor for it, and is associated with victimization.

Perhaps the most overriding and important difference between low- and high-self-esteem people identified by Rosenberg and Owens (2001) is in their approach to life. Low-self-esteem people engage in self-protective behaviors, whereas high-self-esteem people engage in self-enhancing behaviors. Low-self-esteem people avoid risk taking, especially in their interpersonal encounters. They tend to restrict their interactions with others, are less likely to express their opinions and views, keep their emotions private, and conceal their thoughts, which are often hostile and suspicious of others. Consequently, those with low self-esteem are less spontaneous, more passive, lonelier, more interpersonally inept, and more alienated than those with high self-esteem. Overall, low-self-esteem people are most concerned with safety and protection of the self. Rosenberg and Owens (2001) sound one cautionary note: “The features of the LSE [low-self-esteem] personality are generally not qualitatively different from those of most other people; they are largely an accentuation of characteristics that appear among many people…. Many people with self-esteem problems are able to function reasonably well in life, even while their self-esteem problems cause pain, difficulty, failure, and worry…. It would be no exaggeration to say that it damages their lives in many ways” (p. 431).

Crocker and Park (2004) have suggested that when perceiving threats to the self-concept, both high- and low-self-esteem people act to enhance self-esteem, but do so differently. Those with high self-esteem are concerned with presenting their abilities; they discount negative feedback and seek feedback on competence. Low-self-esteem people pursue self-esteem by seeking acceptance. Kaplan (2001) states, “People characteristically behave so as to minimize the experience of self-rejecting attitudes and maximize the experience of positive self-attitudes.”

How aware are helping professionals of these self-esteem characteristics? In the survey of school counselors discussed earlier in this chapter, participants were asked to list five characteristics each that best describe students with high self-esteem and students with low self-esteem (Table 1.2).

A majority of the participants in this study (63.9%) saw students with high self-esteem, first and foremost, as confident. The second most frequent characteristic was friendly/outgoing (43.8%), with the third most frequent being happy (36.6%). Other characteristics included positive/optimistic and motivated. The most frequent characteristics of low-self-esteem students were withdrawn/shy/quiet and