Theses and Dissertations

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The rise and fall of self-esteem: a critical review, reconceptualization, and recommendations

Tamara Shawn Levy Eromo

Pepperdine University

Graduate School of Education and Psychology

THE RISE AND FALL OF SELF-ESTEEM: A CRITICAL REVIEW,

RECONCEPTUALIZATION, AND RECOMMENDATIONS

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Tamara Shawn Levy Eromo

July, 2015

David A. Levy, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Tamara Shawn Levy Eromo

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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VITA

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EDUCATION

Doctor of Psychology, Clinical Psychology, Anticipated Spring 2015
Pepperdine University, Los Angeles, CA (APA Accredited)

Comprehensive Clinical Competence Examination: Passed, June 2011
Assessment Competency Examination: Passed, June 2012

Masters of Arts, Clinical Psychology, June 2009
Pepperdine University, Los Angeles, CA

Bachelor of Arts *cum laude*, Communication Studies, June 2004
University of California, Los Angeles, Los Angeles, CA

CERTIFICATIONS

Trauma-Focused Cognitive Behavioral Therapy Certification
Lovaas Certified Behavioral Therapist

SUPERVISED CLINICAL EXPERIENCE

Learning Dynamics, Inc., Woodland Hills, CA
Doctoral Fellow, Psychological Assistant PSB37901
January 2014-Present
Supervisors: Malique Carr, Ph.D., Janice Schneider, Psy.D. and Giselle Jacinto, Ph.D.

- Administer, score and interpret psychodiagnostic, psychoeducational, and neuropsychological test instruments to an outpatient population, ranging from younger children to older adults.
- Write integrated assessment reports including DSM-5 diagnostic impressions.
- Provide both formal and informal feedback to referring clinicians, patients, and families of patients.
- Attend weekly individual supervision.
- Conduct weekly seminars designed specifically for the masters and doctoral level psychology trainees, including therapeutic intervention seminar and assessment seminar.
- Provide weekly peer supervision to both masters and doctoral level trainees.

Kaiser Permanente Los Angeles Medical Center, Los Angeles, CA
Department of Psychiatry
Predoctoral Intern
August 2012–August 2013
Training Director: Lawrence A. Levy, Ph.D. (now retired); Janice Schneider, Psy.D. (current)

- Conduct intake interviews and provide brief interventions, crisis work, and more intensive psychotherapy to outpatient Psychiatry patients who are members of the Kaiser Permanente Medical Care Program.
- Patients cover the full age range from younger children to older adults, with the typical ratio being about 30 percent child/adolescent and 70 percent adult.
- Administer, score and interpret psychodiagnostic and intelligence test instruments to an outpatient population diagnosed with complex medical problems and psychiatric disorders.
- Write integrated assessment reports including 5-Axis diagnostic impressions.
- Provide both formal and informal feedback to referring therapists, physicians, and patients.
- Attend weekly individual and group supervision and provide formal case presentations.
- Conduct comprehensive neuropsychological assessments for adults as part of a neuropsychology elective.
- Attend weekly seminars designed specifically for the clinical psychology interns, including intervention seminar, assessment seminar, professionally issues seminar, and an elective neuropsychology seminar.

Children's Hospital Los Angeles, Los Angeles, CA
Center for Cancer and Blood Diseases
Neuropsychology Extern
July 2011–July 2012
Supervisor: Sharon O'Neil, Ph.D.

- Conduct comprehensive neuropsychological and psychoeducational assessments for children, adolescents and adults (i.e., childhood cancer survivors) in hematology-oncology. Diagnoses include leukemia, brain tumors, neurofibromatosis and sickle cell anemia.
- Write integrated assessment reports and provide feedback sessions.
- Conduct neuropsychological evaluations for national Children's Oncology Group (COG) studies on long-term effects of chemotherapies and irradiation.
- Conduct neuropsychological batteries for research evaluating the effects of chemotherapy and stem cell rescue for the treatment of malignant brain tumors for children less than 10 years of age.
- Attend weekly multi-disciplinary neural tumors team meeting with physicians, nurses, social workers, nutritionists, pharmacists, and radiation oncologists.
- Attend weekly neuroscience didactics and brain cutting/autopsies with neurology fellows.
- Attend weekly didactic seminars for current APA interns at the USC/CHLA University Center for Excellence in Developmental

Disabilities (UCEDD) on topics including Special Education
Advocacy, Special Topics in Assessment, Learning Disorders,
Vicarious Traumatization, Language Development, and Evidence
Based Practices, such as Trauma-Focused Cognitive Behavioral
Therapy.
- Will provide school consultation and attend Individualized Education
Program (IEP) meetings (anticipated).

Children's Hospital, Los Angeles, Los Angeles, CA
Division of Plastic Surgery, Craniofacial and Cleft Center
Psychology Extern
September 2011–July 2012
Supervisor: Alessia Johns, Ph.D.

- Cofacilitate *Girl Talk/Yo Lo Tengo* therapy groups for children and
adolescents ages 3 to 21 years and their families, referred by plastic
surgery and craniofacial medical team members. Curriculum addresses
social and coping skills and is coordinated with an outside charity.
- Diagnoses include cleft lip/palate, craniosynostosis, microtia, vascular
anomalies, and orthognathic disorders, as well as acquired injuries
from motor vehicle accidents or burns.
- Referrals include adjustment issues related to medical diagnoses and
surgical treatment, as well as typical childhood presenting problems,
such as attentional concerns, disruptive behaviors, academic
difficulties, social issues, and familial stressors.

Harbor UCLA Medical Center, Torrance, CA
Adult Psychiatric Inpatient and Outpatient
Assessment Extern
September 2010–August 2011
Supervisor: Carol Edwards, Ph.D.

- Conducted diagnostic interviews with culturally diverse, economically
disadvantaged patients with Axis I and Axis II psychiatric disorders.
- Administered, scored and interpreted psychodiagnostic and
intelligence test instruments to an outpatient population diagnosed
with complex medical problems and psychiatric disorders.
- Administered, scored and interpreted psychodiagnostic test
instruments on an inpatient psychiatric ward.
- Wrote integrated assessment reports including 5-Axis diagnostic
impressions.
- Provided both formal and informal feedback to referring therapists,
physicians, and patients.
- Attended weekly individual and group supervision and provide formal
case presentations.

- Attended weekly Rorschach didactics using Exner's scoring and interpretation principles.
- Attended a didactic training series focused on scoring and interpretation of the MMPI-II given by the Director of Training, Dave Martin, Ph.D.

Pepperdine Community Counseling Center, Encino, CA
Psychotherapy Extern
September 2009–July 2012
Supervisors: Anat Cohen, Ph.D., Sepida Sazgar, Psy.D., and Gitu Bhatia, Psy.D.

- Extern in a university-operated community clinic setting where adults, children, families, and couples from a wide range of cultural and socioeconomic backgrounds are seen for a variety of presenting concerns.
- Conduct intake interviews and provide brief and long-term therapy for adult and adolescent clients.
- Write intake reports and progress notes, and maintain client charts in accordance with clinic guidelines.
- Administer and interpret brief assessment measures, including the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Outcome Questionnaire (OQ-45.2), Multidimensional Scale of Perceived Social Support (MSPSS), Brief Multidimensional Measurement of Religiousness/Spirituality (BMMR/S) and Working Alliance Inventory (Short Form).
- Provide adjunctive psychotherapy to *Children of the Night* residents (former child prostitutes, ages 11-17).
- Participate in weekly supervision including review of videotaped therapy sessions, collaborative diagnosis and treatment planning, and exploration of process issues.
- Serve as an on-call therapist on a rotating basis.
- Participate in didactic training sessions on a variety of topics to aid in professional development.

Lovaas Institute for Early Intervention, Los Angeles, CA
Case Manager and Behavior Therapist/Instructor
April 2008-June 2009

- Provided direct behavioral treatment to children diagnosed with autism and related disorders, utilizing the principles of applied behavior analysis.
- Worked one-on-one with children in their homes, schools, and/or in a clinic setting.

- Assisted in the development and execution of program areas, including social interaction, communication, academics, language, functional living skills, and behavioral management.
- Supervised weekly data collection, analysis, and written reporting.
- Participated in and facilitated weekly clinic meetings with treatment teams consisting of behavior therapists, parents, and the child.
- Trained new team members on the Lovaas method of early intervention.
- Conducted ongoing parent training.
- Participated in ongoing staff training and implementation of new curriculum and interventions.
- Received weekly supervision from case supervisors and the clinic director.

SUPERVISORY EXPERIENCE

Learning Dynamics, Inc., Woodland Hills, CA
Peer Supervisor
January 2014–Present
Supervisors: Sepida Sazgar, Psy.D. and Janice Schneider, Psy.D.

- Provide guidance and mentorship for second and third-year doctoral trainees, as well as masters level trainees, regarding clinical and professional issues.
- Meet with trainees for weekly one-hour supervision sessions to provide feedback and suggestions regarding clinical management cases, including legal and ethical dilemmas.
- Provide formal training to doctoral trainees in administration, scoring and interpretation of psychodiagnostic, psychoeducational, and neuropsychological test instruments.
- Provide both formal and substantive editorial feedback on doctoral trainees' comprehensive psychodiagnostic/psychoeducational assessment reports.
- Assist supervisees with articulating clear training goals for the year in terms of knowledge, skills, and competencies as a trainee therapist.
- Develop and review case conceptualizations for supervisees' clients based on various theoretical orientations, including cognitive-behavioral and psychodynamic therapy.
- Consult with supervisor during supervision-of-supervision group regarding peer supervision techniques and issues as they arise.

Pepperdine Community Counseling Center, Encino, CA
Peer Supervisor
September 2011–July 2012
Supervisor: Anat Cohen, Ph.D.

- Provide guidance and mentorship for first-year doctoral trainee therapists regarding clinical and professional issues.

- Meet with trainees for weekly one-hour supervision sessions to view videotaped therapy sessions and provide feedback and suggestions regarding clinical management of the case, including legal and ethical dilemmas.
- Assist supervisees with articulating clear training goals for the year in terms of knowledge, skills, and competencies as a trainee therapist.
- Develop and review case conceptualizations for supervisees' clients based on various theoretical orientations, including cognitive-behavioral and psychodynamic therapy.
- Consult with supervisor during supervision-of-supervision group regarding peer supervision techniques and issues as they arise.

RESEARCH EXPERIENCE

Pepperdine University, Los Angeles, CA
Research Assistant
January 2008-Present
Supervisor: David A. Levy, Ph.D.

- Assistance in the development and preparation of two published books:
  - Levy, D.A. (2010). *Tools of critical thinking: Metathoughts for psychology* (2nd ed.). Long Grove, IL: Waveland Press, Inc.
    - Received acknowledgment in Preface.
  - Shiraev, E., & Levy, D.A. (2010). *Cross-cultural psychology: Critical thinking and contemporary applications* (4th ed.). Boston: Allyn & Bacon.
    - Received acknowledgement in Preface.
- Conduct library and online research.
- Review literature.
- Provide both formal and substantive editorial assistance including editing text and updating references.
- Organize and coordinate promotion and marketing plans for textbook releases.

Clinical Dissertation
2010–Present

- Dissertation Title: The Rise and Fall of *Self-Esteem*: A Critical Review, Reconceptualization, and Recommendations.
- Final defense date: April, 2015

TEACHING EXPERIENCE

Pepperdine University, Los Angeles, CA
Teaching Assistant for Psychopathology
January 2008–July 2012
Instructor: David A. Levy, Ph.D.

- Assist tenured professor of psychology in the instruction of masters level psychopathology classes (four classes per academic year).
- Conduct in-depth review sessions for students.
- Construct, revise, and grade examinations.
- Grade papers.
- Provide tutoring services.

Pepperdine University, Los Angeles, CA
Teaching Assistant for Clinical Management of Psychopathology
September 2010–May 2011
Instructor: Anat Cohen, Ph.D.

- Provided guidance for students and answered questions regarding coursework, reading assignments, and evaluative measures.
- Participated in and evaluated student presentations aimed at expanding student intake/interviewing skills.
- Proctored midterm, final exams and oral presentations.
- Graded exams and term papers.

RELATED CLINICAL EXPERIENCE

Pepperdine University, Encino, CA
Graduate Assistant
June 2010–July 2012
Supervisor: Anat Cohen, Ph.D.

- Conduct brief phone intake assessments with potential clients and evaluate callers' needs in regards to current level of crisis, legal issues and severity of presenting problems.
- Screen callers and assign clients to clinic therapists.
- Conduct quarterly clinic orientations and provide ongoing assistance to incoming doctoral and master level students on policies, procedures, documentation and client issues.
- Train therapists on administering, scoring and interpreting clinic psychodiagnostic measures.
- Audit therapist files, ensuring accurate documentation, compliance with procedures, and quality control.

LEADERSHIP EXPERIENCE

Pepperdine University Graduate School of Education and Psychology, Doctor of Psychology Student Government Association, Los Angeles, CA
Class Steering Committee Representative
2011–2012

- The mission of the student government is to facilitate the ongoing collaborative effort of students, faculty, and staff to continually improve the Graduate School of Education and Psychology Psy.D.

Program and keep the program on the forefront of the evolving field of psychology.
- Attend monthly student government meetings, facilitate communication between the student body, student government, and steering committee faculty members to ensure discussion of proposals and decisions relevant to the Psy.D. program and curriculum.

SELECTED PROFESSIONAL ACTIVITIES & SEMINARS

Using the DSM-5
Pamela H. Harmell, Ph.D.
Pepperdine University, Continuing Education Seminar
December 2013

Trauma Focused Cognitive Behavior Therapy Training Seminar
Karen Rogers, Ph.D.
USC/CHLA University Center for Excellence in Developmental Disabilities (UCEDD)
August-September 2011–Los Angeles, CA

Children's Brain Center Conference
Alcohol and Energy Drinks: Partying Like a Rockstar
Lisa Kantz, M.D.
Children's Hospital, Los Angeles, Division of Adolescent Medicine
August 2011–Los Angeles, CA

Mindfulness as a Clinical Intervention
Matthew Brensilver, Ph.D.
UCLA Mindful Awareness Research Center (MARC)
May 2011–Los Angeles, CA

Mindfulness and Psychotherapy Workshop
Matthew Brensilver, Ph.D.
UCLA Mindful Awareness Research Center (MARC)
February 2011–Los Angeles, CA

Speech Dynamics in the Therapy Hour
David Shapiro, Ph.D.
Conference sponsored by the Center for Effective Psychotherapy
January 2010–Los Angeles, CA

HONORS/ PROFESSIONAL AFFILIATIONS

Los Angeles County Psychological Association
Student Member, 2010-Present

American Psychological Association
Student Member, 2009-Present

Psi Chi National Honor Society in Psychology
Member, 2008-Present

Phi Beta Kappa Academic Honor Society
Member, 2000-Present

Golden Key International Honor Society
Member, 2000-Present

SPEAKING ENGAGEMENTS

DSM-5 Introduction and Overview of Changes, Kaiser Permanente Medical Center, Los Angeles, CA
Invited Speaker, November 2014 (pre-doctoral interns) & December 2014 (social work interns)

Los Angeles County Psychological Association 3rd Annual Student Seminar, Tips for Success: APA Internships and Psych Assistantships, Los Angeles, CA
Invited Speaker and Panelist, Summer 2012

Psi Chi New Member Orientation at Pepperdine University,
Los Angeles, CA
Invited Panelist, Fall 2009

LANGUAGES

Working knowledge of conversational Spanish (Comprehension: moderate-high; Verbal fluency: low-moderate)

REFERENCES

David A. Levy, Ph.D., Professor of Psychology
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Practicum Supervisor

ABSTRACT

Self-esteem, viewed for decades as psychology's Holy Grail, has proved to be an elusive and surprisingly barren destination. One of the oldest concepts in psychology, self-esteem likely ranks among the top three covariates occurring in personality and social psychology research. Propelled by the self-esteem movement of the 1970s, it was popularly believed that self-esteem played a significant causal role in determining a wide range of both positive and negative social behaviors. However, the results of a 2003 large-scale literature review showed that it is actually not a major predictor of almost anything, with the exception of positive feelings (happiness) and possibly greater initiative. With over a decade passing since that publication, the current investigation sought to review, synthesize and critically analyze the more recent literature. Results confirmed a similar dearth of meaningful relationships connected to self-esteem, the only exceptions being some modest correlates to happiness, narcissism, and self-perceived attractiveness and intelligence. However, the literature continues to be plagued with myriad conceptual and methodological problems. This study utilizes specific critical thinking principles to advance understanding in this area, to address why the self-esteem obsession still persists, and to propose a new theoretical model, one that accounts for the construct's heterogeneous and multidimensional nature. Self-esteem is defined as the appraisal of one's own personal value, including both emotional components (self-worth) and cognitive components (self-efficacy). The multiple forms of self-esteem are a function of how accurately or closely it matches an individual's measureable reality, composed of the objective outcome of one's behavior (actual achievements, measurable capabilities) as well as one's interpersonal interactions (i.e., the level of congruence between how one thinks he or she is perceived and how he or she is actually perceived). Self-esteem also varies in terms of its level of stability, or the degree to which it is

influenced by evaluative events or the need to match external standards across time and situation. The permutations of these sorting variables yield eight types of self-esteem: Optimal High, Fragile High, Accurate Low, Fragile Low, Non-compensatory Narcissism, Compensatory Narcissism, Pessimal, and Disorganized. Specific recommendations for clinicians and researchers are provided.

Chapter 1: Introduction

Overview

For nearly half a century, self-esteem[1], Baumeister (2005) stated, has been viewed as the

psychologist's:

> Holy Grail: a psychological trait that would soothe most of individuals' and societies'
> woes. We thought that high self-esteem would impart not only success, health, happiness,
> and prosperity to the people who possessed it, but also stronger marriages, higher
> employment, and greater educational attainment in the communities that supported it. (p.
> 34)

In the 1970s, when the self-esteem movement emerged as a powerful social force, and even now,

many Americans believe that we suffer from a low self-esteem epidemic. However, there are

now ample data on the American population showing that is not the case. In fact, if anything, we

tend to *overvalue* ourselves (Taylor & Brown, 1988), with the average American perceiving

himself as above average[2] (Baumeister, 2005). When looking at structured scales designed to

measure global self-esteem, research has shown that the high scores on these measures are

indeed high, but the low scores are, in fact, medium, if taken at face value; relatively few people

score below any self-esteem scale's conceptual midpoint (Baumeister, Tice, & Hutton, 1989).

Therefore, the fact that most individuals in the United States score toward the high end of self-

esteem measures casts serious doubts on the basic assumption underlying the self-esteem

movement, namely that there is a widespread deficit of self-esteem. How can American society

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[1] It should be noted that, for purposes of this document, *self-esteem* will be used to refer to the
term, and self-esteem to refer to the construct.
[2] This perception is, of course, statistically impossible. Most people cannot actually be above
[2] This perception is, of course, statistically impossible. Most people cannot actually be above
average. This type of self-favoring bias is akin to the research showing that 93% of the U.S.
population consider themselves to be better than average drivers (Svenson, 1981), an example of
what social psychologists have called the *above-average effect* or *illusory superiority* (Hoorens,
1995).

be suffering from a widespread low self-esteem epidemic if the average American person regards himself as above average? Nonetheless, proponents of the self-esteem movement have embraced a positive self-view as a panacea for a remarkably wide range of social problems, from academic, occupational and interpersonal difficulties, to violence and teenage pregnancy (Dawes, 1994; Mecca, Smelser, & Vasconcellos, 1989).

In the 1980s, with this conviction as the driving force, the California State Assembly established a task force to promote self-esteem and Governor George Deukmejian signed a bill to fund its work in 1986 (Dawes, 1994). This task force, the California Task Force to Promote Self-Esteem and Personal and Social Responsibility, had high hopes of pioneering the quest to identify causes and cures of many social ills plaguing society, so much so that they actually compared their efforts to both unlocking the secrets of the atom in the 1940s *and* attempting to plumb the reaches and mysteries of outer space in the 1960s (Mecca et al., 1989). The results of their findings were published in 1989 in a book titled *The Social Importance of Self-Esteem*. In the introduction to the book, one of the editors wrote:

> The causal link is clear: low self-esteem is the causally prior factor in individuals seeking out kinds of behavior that become social problems. Thus, to work on social problems, we have to work directly on that which deals with the self-esteem of the individuals involved. Or, as we say in the trade, diminished self-esteem stands as a powerful *independent variable* (condition, cause, factor) in the genesis of major social problems. We all know this to be true, and it is really not necessary to create a special California task force on the subject to convince us. The real problem we must address—and which the contributors to this volume address—is how we can determine that it is scientifically true. (p. 7)

This statement is truly remarkable for a number of reasons, not the least of which is the fact that the editors are claiming to know something to be true, but they have yet to determine that it is scientifically true (Dawes, 1994). An even more profound problem faced by the editor and contributors, however, is that what they knew to be true turned out not to be scientifically true. In

fact, close examination of all the chapters in their book reveals a task force report that does not at all support the basic idea that self-esteem plays a major causal role in determining various social behaviors, let alone that government programs designed to enhance self-esteem will have beneficial social effects (Dawes, 1994; Mecca et al., 1989). As Dawes (1994) concluded in his book, *House of Cards: Psychology and Psychotherapy Built on Myth,* "The California task force has performed a valuable service, but not the one it intended. Rather, it created a volume of work demonstrating that the Holy Grail of pop psychology is nothing more than a mirage" (p. 243).

Nevertheless, the body of research on self-esteem has grown, and continues to grow, since the late 1980s. And, despite the lack of empirical support that self-esteem plays a direct causal role in areas like academic performance, job performance, interpersonal relationships, or healthier lifestyles, countless efforts to boost self-esteem are made by teachers, parents, and therapists alike (Baumeister, Campbell, Krueger, & Vohs, 2003). Over recent years, close analyses of the accumulated research have shaken many psychologists' faith in self-esteem. Not only has the research shown that self-esteem fails to accomplish what proponents of the movement hoped it would, efforts to raise self-esteem could in some cases backfire and contribute to some of the very problems it was thought to thwart (Baumeister et al, 2003; Blaine & Crocker, 1993; Crocker & Park, 2004; Kernis, 2003a; Raskin, Novacek, & Hogan, 1991).

Research Objective

Despite the inconsistencies in the research and regardless of the numerous studies that have shown otherwise, the pursuit of self-esteem has historically been so pervasive that many psychologists have assumed it is a universal and fundamental human need (Allport, 1955; Branden, 1969, 1994; Maslow, 1968; Rogers, 1961; Rosenberg, 1979; Satir, 1964/1983); some have even hypothesized that humans evolved as a species to pursue self-esteem (Leary &

Baumeister, 2000; Leary & Downs, 1995). With so much existing evidence to challenge these assumptions and shake the faith that many have in the construct, why is it that interest in the topic has not waned? How *should* psychologists view self-esteem and approach the topic with the populations they serve?

This study seeks to review, synthesize and critically analyze the research on self-esteem, as well as to propose a new model for conceptualizing the construct and provide a series of specific recommendations, for both clinical and research settings. This chapter provides background as an introduction to the topic and presents the research objective. Chapter 2 describes the plan of action and method by which the researcher reviews, synthesizes, and critiques the literature. Chapter 3 consists of an integration and analysis of the existing literature. Finally, Chapter 4 includes a summary of research findings and discussions of a critical thinking approach to self-esteem, a proposed new model, clinical implications and recommendations for clinicians and researchers.

Background

A brief history of self-esteem. The term self-esteem can be traced back to 1890 and the work of William James, who is generally seen as the father of modern psychology. Like many of the early theorists who came after him, James' conceptualization of self-esteem was brief, albeit insightful. In a comprehensive review of the theoretical contributions to the body of work on self-esteem, Bednar and Peterson (1995) noted that the concept self-esteem per se is not discussed in depth in the writings of the early theorists such as William James, Alfred Adler, George Herbert Mead, and Gordon Allport. Instead, it must be sifted from related ideas about the self. Although the focus was broad, a brief discussion of James' definition is included here as the first recorded description of the construct. Not only was it the first recorded definition, James'

definition is supported by a considerable amount of research (Harter, 1999). James had a very simple definition of self-esteem: successes divided by pretensions[3] (James, 1890/1983). In other words, he described self-esteem as a ratio or relationship between our achievements and our aspirations. Based on this definition, the more success we have and the lower our expectations, the higher our self-esteem. Said another way, one can raise self-esteem by either lowering expectations or increasing achievements. According to James, there are three major constituents of the self from which one chooses his pretensions: (a) the material self (i.e., objects and possessions considered to be one's personal property), (b) the social self (i.e., reputation or recognition by others), and (c) the spiritual self (i.e., the inner subjective being; Bednar & Peterson, 1995). James also recognized that self-esteem might have both general and specific elements. In other words, although fluctuations of self-esteem might occur based on daily encounters, there is an average tone that develops over time and that one's self-esteem seems to return to (Bednar & Peterson, 1995).

Early theoretical efforts, like that of James (1890/1983), were followed by years during which the concept was neglected as being unscientific and shallow (Bednar & Peterson, 1995). Martin Seligman, popular American psychologist and long-time proponent of James' definition, has written that James' work on self-esteem was largely ignored for 75 years as a result of both academic and socioeconomic factors. Economic depression and world wars did not create an environment characterized by a focus on how people felt about themselves. Moreover, schools of thought, such as Freudianism and behaviorism, dominated the field of psychology, both of which essentially shared the common belief that individuals' lives are largely determined by forces

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[3] Pretension can be defined in numerous ways. James (1890/1983) used the word to mean *aspirations*, as opposed to the common modern-day meaning (i.e., *pretentiousness* or *ostentatiousness)*.

outside of their control, either internal unconscious forces (as per Freudianism) or external forces (behaviorism). A shift occurred in the 1960s, with the rise of wealth and consumerism. Along with these social and economic changes came the ability of the individual to see himself or herself at the center of his or her own destiny (Seligman, Reivich, Jaycox, & Gillham, 2007).

Self-esteem across the major theoretical orientations. Psychodynamic[4] theory and behaviorism dominated the field from roughly the late 19th century to the 1950s, at which point humanistic psychology, sometimes called the third force in psychology, emerged as a reaction to the aforementioned schools of thoughts. While psychoanalysis focused primarily on understanding unconscious motivations that drive behavior and behaviorism primarily on conditioning processes, humanistic thinkers stressed the importance of the role of personal choice. Thus, this third force represented a shift towards focusing on each individual's potential for growth and self-actualization. It is not surprising then that most of the early writings on self-esteem came out of this movement. A brief discussion of *self-esteem* and relevant topics as they have been defined by some of the prominent theorists follows.

Psychodynamic theory. *Psychoanalysis—Sigmund Freud (1856–1939).* Psychoanalytic theory originated with the work of Sigmund Freud. The essence of Freud's theory is that sexual and aggressive energies originating in the unconscious mind are modulated by the ego, which is a set of functions that moderates between the unconscious mind and external reality. With a focus on the role of unconscious drives as the primary motivators of behavior, Freud did not specifically focus on self-esteem per se in his writings. He did, however, discuss narcissism and how it relates to one's feelings of self-regard. In his pivotal essay, *On Narcissism,* Freud (1914/1991) suggests that narcissism is actually a normal part of the human psyche. He referred

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[4] For the purposes of this document, psychodynamic refers to a wide range of both Freudian and neo-Freudian theories, including psychoanalysis.

to this as primary narcissism, or the energy that lies behind each person's survival instincts. Freud theorized that, before children are able to invest their libidinal energy in other people, they go through an adaptive period of primary narcissism in which they are egocentric and cannot take the perspective of others. Healthy development then, according to Freud (1914/1991) consists of a departure from primary narcissism, when people invest their libidinal energy into another person rather than themselves. According to his model, in which a person has a limited amount of libidinal energy, a person's own feelings of self-regard are lowered when he or she progresses from primary narcissism to object love. When viewed through the lens of more recent theoretical writings, this process may be seen as roughly equivalent to what is now considered a healthy degree of self-esteem.

Self-Psychology—Heinz Kohut (1913–1981). Of the major psychodynamic schools that stemmed from Freudianism (viz., self-psychology, ego psychology, object relations) self-psychology, which was founded by Heinz Kohut in the 1950s, focused the most directly on conceptualizing the self. Kohut asserted that the self refers to a person's perception of his or her experience, including the presence or lack of a sense of self-esteem. The self is perceived in relation to the establishment of boundaries and differentiations of self from others. For Kohut (1971), parents function as early self-objects, or persons used by the infant to organize his or her self-experiencing, by either promoting or impeding their child's self-formation along the developmental axes of (a) grandiosity, (b) idealization, and (c) twinship. Thus, Kohutian theory emphasizes the role of early self-object need gratification in initially organizing one's self-experiencing. When basic human emotional needs for affirmation, belongingness, and security are inadequately satisfied by early caregivers, the person internalizes problematic schemas unconsciously and experiences difficulties with self-esteem regulation, which subsequently

obstruct the achievement of mature interdependence in adulthood.

    Attachment Theory—John Bowlby (1907–1990). Similarly, John Bowlby's attachment theory, which also stems from psychodynamic thought, proposes that variations in relationship patterns established in the early infant-caregiver relationship give rise to stable interpersonal orientations that either promote or impair psychosocial development across the individual's lifespan (Bowlby, 1988). More specifically, the capacity of parents to satisfy their child's security-related needs determines to what degree the parent-child relationship can serve as a safe haven for containing and reducing the child's distress, which supports the child's development of healthy self-reliance. On the other hand, when parental figures are inconsistently responsive to the child's early needs for care and protection, the child becomes dysregulated, resulting in chronic hyperactivation (i.e., persistent demands for caregiver proximity) or deactivation (i.e., strong disinclinations to seek care and support from others) of the attachment system. These relational patterns are then internalized to form less favorable working models of self and other (Bowlby, 1988). According to attachment theory, self-esteem is the result of internalized self-other models for regulating one's experiences of insecurity. As prominent examples of psychodynamic theory, both self-psychology and attachment theory trace the emergence of adult emotional and interpersonal difficulties to the problematic early experiences one has with his or her parental caregiver(s). These theories anchor the development of adult interpersonal difficulties to unsatisfied early emotional needs, which then adversely impacts self-esteem regulation.

    Behaviorism, Social Cognitive Theory, and Cognitive Behavioral Theory.
Behaviorism—B. F. Skinner (1904–1990). Generally speaking, behaviorism arose in the early 20th century as a reaction against the highly speculative psychodynamic theories discussed

above. Behaviorists minimized speculation about mentalistic phenomena and focused almost

entirely on observable behavior. B.F. Skinner, perhaps the person most often associated with the

behaviorist position, devised his theories by avoiding all hypothetical constructs (e.g., ego, traits,

drives, needs). Instead, as a determinist, he asserted that human behavior does not stem from an

act of free will, but like any observable phenomenon, is lawfully determined and can be studied

scientifically (Skinner, 1953). Thus, as one would imagine, his theories and those of his fellow

radical behaviorists include very little focus on constructs like self-esteem, which by its very

nature calls for consideration of mentalistic processes such as cognition and/or subjective

emotional states.

  Social Cognitive Theory—Albert Bandura (1925-present). Nonetheless, some

behaviorists acknowledge that observable behavior does not have to be limited to external events

and can include private behaviors such as thinking, remembering, and anticipating, all of which

are observable to the person experiencing them (Bandura, 1986). Albert Bandura's social

cognitive theory stemmed from behaviorism but incorporates a cognitive component. Social

cognitive theory takes an agentic view of personality, meaning that humans have the capacity to

exercise control over their own lives (Feist & Feist, 2006). Moreover, Bandura's theory

emphasized the human capability to learn through both direct experience and vicarious

experience (Bandura, 1986). Rather than focusing on self-esteem per se, Bandura focused on

self-efficacy, which he defined as "people's beliefs in their capability to exercise some measure

of control over their own functioning and over environmental events" (Bandura, 2001, p. 10).

Self-efficacy is not a global or generalized concept, such as self-esteem or self-confidence. It

varies from situation to situation depending on one's competencies, the presence or absence of

others, the perceived competencies of those other people, and accompanying physiological states

(Feist & Feist, 2006).

Cognitive Behavioral Theory—Aaron Beck (1921-present). Aaron Beck, who is considered to be the father of cognitive therapy, deemed self-concept to consist of a number of characteristics that people ascribe to themselves and to be operationally defined by descriptors such as attractive, critical, kind, and efficient. The descriptors, in turn, are weighed by an individual with respect to how much they are valued by that person. Thus, Beck, Steer, Epstein, and Brown (1990) stated the overall self-concept reflects the,

> …summation of an individual's self-evaluations of the set of descriptors and represents how good the person feels about himself or herself. The self-concept is the product of input of self-relevant data and relatively stable structures (self-schemata) that serve as information processors. The stronger a self-schema, the greater its influence on the input of self-relevant information (i.e., data supporting the self-concept will be processed, whereas data not supporting the self-concept will be ignored). (p. 191)

From this cognitive perspective, self-esteem can be operationalized as beliefs about oneself and beliefs about how other people regard oneself (Bhar, Ghahramanlou-Holloway, Brown, & Beck, 2008).

Humanistic Theory. Humanistic psychology[5] emerged at the second half of the 20th century. Unlike psychodynamic theory and behaviorism, humanistic theory emphasized conscious human experience as opposed to unconscious processes or conditioned responses. As the focus shifted to concepts like self-determination, the power of free will, and human potential, self-esteem naturally arose as an important and popular idea. While a discussion of all the most influential humanists' work is beyond the scope of this investigation, a brief discussion of three

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[5] It should be noted that existential psychology became prominent at approximately the same time as humanistic psychology, and the two schools of thought are often considered to be one in the same. For the purposes of this investigation, the works of the major existential theorists (e.g., Rollo May, Irvin Yalom, R.D. Laing) were explored; however, writings devoted specifically to defining *self-esteem* were not found. Thus, the researcher will focus on the works of prominent humanists as a representation of what is often called the *third force movement* (aka the humanistic/existential movement).

of the most prominent theorists follows.

  Person-Centered Theory—Carl Rogers (1902–1987). Carl Rogers, perhaps the most prominent figure associated with humanistic psychology, first expressed his theory of personality, *person-centered theory*, in an APA presidential address in 1947 (Feist & Feist, 2006). According to Rogers (1959), the self-concept includes all those aspects of one's being and one's experiences that are perceived in awareness, although not always accurately, by the individual. Rogers believed that the self-concept is comprised of three different components: (a) self-image (the view one has about himself or herself), (b) the ideal self (what one wishes to be like), and (c) self-esteem or self-worth (how much value one places on himself or herself). The closer our self-image and ideal self are to each other, the more consistent or congruent we are and the higher our sense of self-worth or self-esteem. Another one of Rogers' key theoretical assumptions was that self-esteem depends on knowledge that one is genuinely understood and unconditionally accepted and loved by an important person in one's life (Feist & Feist, 2006). Generally speaking, humanistic psychologists have traced high self-esteem to a congruency between a person's real and ideal selves, suggesting that self-esteem serves as an indication to people as to when they are behaving in autonomous, self-determined ways (Leary, 1999).

  Self-actualization—Abraham Maslow (1908–1970). Abraham Maslow, whose theories first received much attention in the 1960s and 70s, assumed that human motivation is usually complex; people are continually motivated by one need or another; people are motivated by the same basic needs; and, needs can be arranged on a hierarchy (Feist & Feist, 2006; Maslow, 1970). The highest level of that hierarchy, *self-actualization*, is characterized by self-fulfillment, the realization of all one's potential, and a desire to become creative in the full sense of the word (Maslow, 1970). Based upon Maslow's theory, lower level needs must be satisfied or at least

relatively satisfied, however, before higher level needs become motivators.

The human need for self-esteem plays an important role in Maslow's hierarchy of needs. Esteem needs, which immediately precede self-actualization needs in Maslow's hierarchy, include self-respect, confidence, competence, and the knowledge that others hold them in high esteem. Maslow (1970) identified two levels of esteem needs: reputation and self-esteem. He defined reputation as the perception of the prestige or recognition a person has achieved in the eyes of others. Self-esteem, on the other hand, was defined as a person's own feelings of worth and confidence, a "desire for strength, for achievement, for adequacy, for mastery and competence, for confidence in the face of the world, and for independence and freedom" (p. 45). Maslow suggested that people need both internal self-respect and esteem from others in order to achieve self-actualization.

Humanistic Family Therapy—Virginia Satir (1916–1988). Not only is Virginia Satir widely regarded as the mother of family therapy, she was also called "the most widely known and the most high-spirited" (Mecca et al., 1989, p. xviii) of all the members of the California Task Force to Promote Self-Esteem and Personal and Social Responsibility (see above) in the 1980s. In fact, shortly before her death in September of 1988, the task force unanimously voted that its final report be dedicated to her.

Satir was a pioneer in the newly emerging field of family therapy, and she based her approach on a combination of both humanistic psychology and communications theory. The foundation of her theory was that there is a bidirectional causal relationship between self-esteem and communication. Specifically, high self-esteem and healthy communication (and conversely low self-esteem and dysfunctional communication) are both causes and effects of each other. Within the parameters of her interactional approach to family therapy, difficulty communicating

is closely linked to an individual's self-concept, including his or her self-esteem (which Satir viewed as equivalent to feelings of self-worth) and the individual's self-image (Satir, 1964/1983).

According to Satir's model of family therapy, low self-esteem comes from a person's early experiences and results in a great sense of anxiety and uncertainty about oneself. For a child to build healthy self-esteem, the parents must first recognize that their parenting is influenced by the dysfunctions in their own marital relationship and, second, must validate the child as a masterful person (a person who is able to do for himself or herself) and as a sexual person. For Satir, self-esteem, independence and individual uniqueness "go together in every way" (Satir, 1964/1983, p. 67).

Conceptual Issues Relevant to Defining Self-Esteem

One of the oldest concepts in psychology, self-esteem likely ranks among the top three covariates occurring in personality and social psychology research. In 2003, it was the subject of over 18,000 published studies (Rhodewalt & Tragakis, 2003). As of 2015, it is the subject of over 22,000 publications. Given the long history of the term, it is not surprising that many individuals, representing a wide range of theoretical perspectives, have attempted to define it. Further, each definition naturally gives rise to a different body of research findings, theories, and conclusions about the construct. With multiple active definitions of self-esteem and very little consensus, it can be difficult to keep in mind which definition is linked with which body of work, creating confusion in the field. While addressing all of the ways self-esteem has been defined would be beyond the scope of this investigation, four of the central conceptual issues and debates that are relevant to the defining of self-esteem will be explored here: (a) affective versus cognitive versus behavioral focus, (b) stable versus fluid, (c) unidimensional versus

multidimensional, and (d) self-esteem versus self-concept.

      Affective versus cognitive versus behavioral focus. According to Mruk (2006), social scientists define self-esteem in at least three very different ways, each of which has been legitimately used in the field of psychology for over a century. Generally speaking, these three different ways include: (a) self-esteem as feelings of worthiness, (b) self-esteem as a relationship between achievements and aspirations, and (c) self-esteem as a relationship between a sense of personal efficacy and a sense of personal worth.

      Feelings of worthiness. Mruk (2006) claims that the first way of defining self-esteem, as a feeling of worthiness, has numerous advantages when it comes to designing research. In particular, a one-dimensional (or single-factor) approach makes researching self-esteem relatively easy to do. For this reason, defining self-esteem in terms of worthiness, or a favorable global evaluation of oneself, seems to be the most commonly used definition by far (Baumeister, Smart, & Boden, 1996). However, conceptualizing self-esteem in terms of worthiness alone could lead to some serious problems. For example, oversimplification of the idea of self-esteem in this manner can lead to programs and interventions designed merely to make people feel good about themselves. Inherently, there does not seem to be anything wrong with making people feel good about themselves, but what if that self-perception is not warranted? As much research has shown, feeling good about oneself without earning it can lead to myriad problems, such as facilitating the development of narcissism, risking an increase in the likelihood of violence, or tolerating undesirable academic performance (Baumeister et al., 1996; Damon, 1995; Dawes, 1994).

      Achievements/aspirations ratio. Mruk (2006) also addresses the potential pitfalls of the second way researchers have defined self-esteem, as a ratio or relationship between our

achievements and our aspirations. This definition is the one that can be traced back to the

original coining of the term by William James in 1890. According to James (1890/1983):

> Our self-feeling in this world depends entirely on what we back ourselves to be and do. It is determined by the ratio of our actualities to our supposed potentialities: a fraction of which our pretensions are the denominator and the numerator our success: thus,

$$\text{Self-Esteem} = \frac{\text{Successes}}{\text{Pretensions}}$$

> Such a fraction may be increased as well by diminishing the denominator as by increasing the numerator. (p. 296)

Mruk (2006) points out that this approach to self-esteem stresses a certain type of behavior rather

than just affect, attitude, or belief. To define the term in this fashion has numerous advantages

when it comes to research. For one, competence is tied to behavior, which is observable, unlike

feelings, beliefs, or attitudes. Moreover, it is part of numerous developmental processes that have

been clearly defined (e.g., mastering age-appropriate skills). However, as Mruk (2006) cautions,

there are plenty of behaviors that one could become very good at, but that are undesirable. For

example, one could become highly skilled at violating the rights of others, but it would be

antithetical to the kinds of competencies we would associate with high (i.e., healthy) self-esteem.

Moreover, there are many people who are quite competent in a number of areas (e.g., career,

academia, athletics), but who have low self-esteem. In other words, they don't feel worthy

enough to enjoy their success.

Efficacy and worth. Finally, Mruk (2006) defines the third way, according to his

conceptualization, that self-esteem is defined, which is self-esteem as a relationship between "a

sense of personal efficacy and a sense of personal worth. It is the integrated sum of self-

confidence and self-respect. It is the conviction that one is *competent* to live and *worthy* of

living" (Branden, 1969, p. 110). In other words, self-esteem defined in this way is the

relationship between perceived competence (cognitive) and feelings of worthiness (affective). This definition has been the one most widely used and supported by Nethaniel Branden, one of the most prominent leaders of the self-esteem movement (Branden, 1969).

Stable versus fluid. In their essay on the nature of self-esteem and the ways it is defined, Brown and Marshall (2006) discuss the widespread disagreements and divisions amongst psychologists with respect to self-esteem's function and benefits. While some argue that high self-esteem is essential to human functioning (Pyszczynski & Cox, 2004; Pyszczynski, Greenberg, Solomon, Arndt, & Schimel, 2004), others argue that it is of little value and could even be a liability (Baumeister et al., 2003; Baumeister et al., 1996). According to Brown and Marshall (2006), at least part of the confusion in the field is a result of a lack of agreement and consistency with regard to the definition of the construct itself. These authors propose that self-esteem is used in at least three different ways: (a) global self-esteem (aka *trait self-esteem*), (b) feelings of self-worth (aka *state self-esteem*), and (c) self-evaluations (aka *domain-specific self-esteem*). Overall, by outlining these three ways self-esteem can be defined, Brown and Marshall assert that, regardless of the definition one chooses to use, they should not be used interchangeably.

Global self-esteem. Global self-esteem, or trait self-esteem, can be described as a personality variable that represents the general way people feel about themselves (Brown & Marshall, 2006). Whether defined through a cognitive lens (i.e., thoughts people have about their self-worth as a person) or an emotional lens (i.e., feelings of affection people have for themselves that are not derived from rational processes), global self-esteem is seen as being stable through adulthood, with a possible genetic component (Neiss, Sedikides, & Stevenson, 2002).

State self-esteem. State self-esteem, on the other hand, is typically defined as self-evaluative reactions to events or feelings of self-worth, which is more in line with William James' original definition of the term in 1890. Put plainly, trait self-esteem persists while state self-esteem can be seen as more temporary.

Domain-specific self-esteem. When self-esteem is defined in terms of self-evaluations, it refers to the way people evaluate their abilities, physical attributes, and personality characteristics within different specific domains (e.g., academically, physically, artistically). Thus, one can have different levels of self-esteem in different areas (Brown & Marshall, 2006).

Unidimensional versus multidimensional. Another way that different definitions of self-esteem can be compared is by looking at whether the definition is unidimensional or multidimensional. A unidimensional definition of self-esteem would involve a single, global domain of self-concept, whereas a multidimensional approach would focus on multiple, distinct components of self-concept. For example, a unidimensional definition might focus essentially on feelings of worthiness, whereas a multidimensional definition could include feelings of worthiness, cognitive appraisal of efficacy, and behavioral measures of success. According to an essay on the nature of self-esteem by Marsh, Craven, and Martin (2006), appropriately selected specific domains of self-concept are far more useful than a unidimensional view of self-esteem in research settings. In fact, such debates go beyond discussions of self-esteem and reverberate across different psychological disciplines. For example, researchers are increasingly recognizing the value of a multidimensional perspective when it comes to multiple intelligences versus global measures of IQ when characterizing intellectual abilities.

Self-esteem versus self-concept. Although the two terms are oftentimes used interchangeably, it is important to distinguish self-esteem from the more general term self-

concept. Self-concept can be defined as "the totality of cognitive beliefs that people have about themselves; it is everything that is known about the self, and includes things such as name, race, likes, dislikes, beliefs, values, and appearance descriptions, such as height and weight" (Heatherton & Wyland, 2003, p. 220). Self-esteem, on the other hand, regardless of how the construct is defined, involves some level of emotional response that a person experiences as he or she contemplates and evaluates things about himself or herself. Although the two terms are related, it is possible to believe objectively positive things about oneself (e.g., academic skills, athletic skills), but not necessarily like oneself. Conversely, it is possible to like oneself without objective indicators to support the positive self-views (Heatherton & Wyland, 2003).

Assessment of Self-Esteem

Not surprisingly, there are many available measures of self-esteem from which to choose, reflecting a variety of theoretical perspectives. Most self-esteem research utilizes self-report measures (Blascovich & Tomaka, 1991). In their review of measures of self-esteem, Blascovich and Tomaka (1991) identified the most frequently cited measures in the literature and then reviewed what they considered to be the 11 most common, five of which are general measures for use with adolescents and adults, two designed for use with younger children, and the remaining four cover specific aspects of self-esteem. The five most frequently cited self-report measure for adolescents and adults are: Rosenberg's (1965) Self-Esteem Scale, Coopersmith's (1967) Self-Esteem Inventory, the Tennessee Self-Concept Scale (Roid & Fitts, 1988), Janis & Field's (1959) Feelings of Inadequacy Scale, and the Texas Social Behavior Inventory (Helmreich & Stapp, 1974). The two most common measures designed for use with young children are the Piers-Harris Children's Self-Concept Scale (Piers, 1969) and the Harter Self-Perception Profile for Children (Harter, 1985/2012). The last four cited by Blascovich and

Tomaka are measures of specific aspects of self-esteem (e.g., body image), which include: The Body Esteem Scale (Mendelson, Mendelson, & White, 2001), the Ziller Social Self-Esteem Scale (Ziller, Hagey, Smith, & Long, 1969), the Shrauger Personal Evaluation Inventory (Shrauger, & Schohn, 1995), and the Marsh Self-Descriptions Questionnaire (Marsh, Martin, & Jackson, 2010). Of all the scales they reviewed, Blascovich and Tomaka found them of unequal quality and gave high marks to only a few, specifically Rosenberg's (1965) Self-Esteem Scale and a revision of Janis & Field's (1959) Feelings of Inadequacy Scale, which was revised by Fleming and Courtney (1984).

Although the vast majority of self-esteem researchers utilize self-report measures, nonreactive measures of implicit self-esteem have increased in popularity during recent years (Bosson, Swann, & Pennebaker, 2000). When completing nonreactive measures, respondents do not answer direct questions about their self-esteem. Instead, they ostensibly reveal their self-evaluations via reaction time tasks that utilize priming techniques, or projective tests in which they respond to ambiguous stimuli. The meaning behind the measure is often masked, either by subliminal presentation of stimuli or by working under time pressure or cognitive load (Bosson, 2006). Common measures of implicit self-esteem include: the Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz, 1998), cognitive priming tasks (Hetts, Sakuma, & Pelham, 1999; Spalding & Hardin, 1999), word completion tasks (Hetts et al., 1999), and people's preferences for their birthday numbers and name letters (Nuttin, 1985). Issues of validity and reliability, as well as strengths and weaknesses of different types of measures are discussed in Chapter 3.

Chapter 2: Plan of Action

Overview

This chapter outlines the method by which the published literature on self-esteem has been obtained for review and analysis. The discussion includes the following: (a) the process of identifying relevant literature; and, (b) how the literature has been synthesized and organized.

Identification of Relevant Literature

A literature search was conducted through a review of abstracts in EBSCO Host Research Database, PsycINFO. By going to the subject category in PsycINFO and searching self-esteem, a total of 21,554 articles were found. The list of articles was narrowed down using a series of criteria. First, those works that have not been published or whose sole source was *Dissertation Abstracts International* were not retained. Second, the researcher generally eliminated secondary sources in order to obtain original data. Secondary sources were only included if they presented meta-analyses or other authoritative literature reviews. In addition to the articles obtained through PsycINFO, the researcher consulted the reference pages of existing research articles and books relevant to the purposes of this endeavor. The researcher acknowledges that eliminating dissertations and works that have not been published biases the results in favor of positive effects of self-esteem, due to the fact that null results are difficult to publish. Thus, including sources cited in the articles obtained from PsycINFO was helpful for finding null effects. Worldcat was also used to locate and acquire books on the topic of self-esteem.

The search for relevant literature included, but was not limited to, the following terms independently or in combination: self-esteem, assessment/measures, definition/defining, global, trait, state, stable fluid, implicit, explicit, costs/benefits, construct validity, predictive validity, convergent validity, divergent validity, conscious, nonconscious, optimal, intervention, self-

concept, self-efficacy, happiness, depression, and initiative. Although the most current resources available were prioritized, relevant literature that dates back was considered for inclusion, particularly on the topics of defining self-esteem and assessment of self-esteem.

Organization and Synthesis of the Literature

Literature has been included or excluded based on its relevance to the study. Several factors were employed to determine inclusion and exclusion criteria. From a practical standpoint, literature has been included in this work based on its availability through electronic databases, at Pepperdine University, or through interlibrary loan. Moreover, only literature published in English was included.

The researcher sought to collect all relevant scholarly information related to self-esteem via extensive database searches for research articles and books and by perusing the references of relevant articles and texts to gather additional, influential research sources. As a result of this extensive search, the current researcher was able to identify the last major, widespread literature review conducted that sought to examine the empirical findings on the relationship between self-esteem and numerous variables of broad social relevance (e.g., health, sexual behavior, interpersonal relations, financial status, grades, intelligence, job performance and satisfaction) (Baumeister et al., 2003). On the whole, Baumeister et al. (2003) found that self-esteem is not a major predictor of almost anything. However, they did identify a couple of potential exceptions, although the findings remain somewhat speculative and are contingent on further work supporting the conclusions. According to their findings, the possible benefits of high self-esteem can be tentatively summarized in terms of two main themes: (a) high self-esteem being linked to positive feelings (i.e., happiness), and (b) high self-esteem being linked to greater initiative. Based on the findings of this seminal study, the current researcher narrowed her search criteria

and set out to extensively review the literature on self-esteem as it relates to happiness and initiative, including several additional closely related variables. The researcher then critiqued and evaluated the literature, resulting in an in-depth discussion of approaching the topic of self-esteem from a critical thinking perspective, the proposal of a new conceptual model of self-esteem, and a series of specific recommendations, for both clinical and research settings.

Limitations

There are a number of considerations that must be accounted for when conducting a critical analysis (Mertens, 1998). For example, publication bias is a potential concern, as there is a tendency for research that yields statistically significant results to be published. Moreover, research that does not yield significant results is typically discarded and not always available for review, either because authors choose not to publish or because the material gets rejected by journals (Mertens, 1998). Inclusion-exclusion decisions on the part of researchers are another concern. The current researcher has been cognizant of her inclusion and exclusion criteria during the selection process, and did not base decisions on other factors such as the researcher's interest or subjective judgment (Mertens, 1998). Additionally, because so many measurement scales are available for self-esteem, comparing results from different investigations that have used different scales is problematic, especially when the results are inconsistent.

Chapter 3: Critical Review of the Literature: Integration and Analysis

As mentioned in Chapter 2, in their analysis of the benefits of self-esteem, Baumeister et al. (2003) aimed to thoroughly review the empirical findings on the relationship between self-esteem and numerous variables of broad social relevance (e.g., health, sexual behavior, interpersonal relations, financial status, grades, intelligence, job performance and satisfaction). On the whole, the researchers found that self-esteem is not a major predictor of almost anything. However, they did identify a couple of potential exceptions. According to their findings, the possible benefits of high self-esteem can be tentatively summarized in terms of two main themes: (a) high self-esteem being linked to positive feelings (i.e., happiness), and (b) high self-esteem being linked to greater initiative. Baumeister's et al. (2003) findings are summarized below and are followed by a discussion of the more recent literature under these two broad categories.

Happiness

Baumeister et al. (2003): Summary of findings. Baumeister et al. (2003) cited five studies showing that high self-esteem is linked to happiness. Before presenting their findings, however, the authors acknowledged the fact that studies of happiness and related variables (e.g., depression) almost invariably rely on self-reports. Further, researchers obtained stronger evidence of the correlates of self-esteem when the studies relied on self-reported outcomes. For example, studies on the relationship between self-esteem and self-rated attractiveness have generally shown very strong, positive relationships between the two variables (Harter, 1993); however, once more objective measures of physical appearance (e.g., full-length pictures rated by judges) are obtained and compared to the self-report data, people with high self-esteem do not emerge as any more attractive than people with low self-esteem (Diener, Wolsic, & Fujita, 1995; Gabriel, Critelli, & Ee, 1994). Similarly, people with high self-esteem rate themselves as more

intelligent than they actually are (Gabriel, Critelli, & Ee, 1994) and more socially skilled than others rate them to be (Buhrmester, Furman, Wittenberg, & Reiss, 1988).[6]

When it comes to happiness, however, how can researchers conclude that people are less (or more) happy than they think they are with the lack of objective measures of happiness? As a result, any research investigating the link between self-esteem and happiness will necessarily have to rely on self-reports for both measures, despite the pitfalls and drawbacks associated with establishing not just the causal effects of self-esteem, but even the correlational relationships. Nonetheless, Baumeister et al. (2003) determined the strongest correlate of high self-esteem to be happiness, which also happens to be (coincidentally or not) the most subjective outcome they examined. Across a number of studies cited, self-esteem was shown to be one of, if not the, most dominant predictor of happiness when compared to other predictor variables (e.g., personality traits, recalled parental rearing styles, satisfaction in specific domains such as finances and social support; De Neve & Cooper, 1998; Diener & Diener, 1995; Furnham & Cheng, 2000).

Baumeister et al. (2003) also discussed evidence showing that people with high self-esteem are less likely to be depressed, either in general or specifically in response to stressful, traumatic events (Murrell, Meeks, & Walker, 1991; Robinson, Garber, & Hilsman, 1995; Whisman & Kwon, 1993). Thus, a review of the more recent literature on the relationship between self-esteem and happiness, as well as between self-esteem and depression, was conducted, and a summary of those findings follows.

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[6] These findings can be related to the work of Shelley E. Taylor on what she calls *positive illusions*. Taylor has explored the biological and psychological benefits of various socioemotional resources, including self-esteem, optimism, mastery, and social support. According to Taylor, under some circumstances, socioemotional resources can assume the form of positive illusions, or overly positive self-perceptions, exaggerated perceptions of control or mastery, and unrealistic optimism, which have been found to be largely beneficial and associated with criteria indicative of mental and physical health (Taylor & Brown, 1988). The research on positive illusions and its relationship to self-esteem will be discussed in more detail in Chapter 4.

More recent findings: 2003–2014. The current review was conducted in the following manner: from January 2014 through May 2014, the researcher searched the PsycINFO database and obtained a list of all articles containing self-esteem and happiness in the title. After applying the aforementioned inclusion and exclusion criteria, 9 articles published in scholarly (peer reviewed) journals, written in English, and published between 2003 and 2014 were found. The abstracts of all 9 articles were reviewed and the following studies were determined to be most directly applicable to the relationship between happiness and self-esteem. The same type of search was conducted for articles containing self-esteem and depression in the title, which yielded a list of 121 articles. The abstracts of those 121 articles were also reviewed, the same inclusion and exclusion criteria applied, and only those determined to be the most directly applicable to the relationship between the two variables are described in detail below.

Happiness. Since the 2003 Baumeister et al. review article, further research has consistently reported the link between self-esteem and happiness. In a sample of 88 young, mostly (68%) female, British, first-year undergraduate students, Cheng and Furnham (2003a) measured to what extent self-esteem predicted positive affect and self-reported happiness. Self-esteem was shown to be a significant predictor of happiness. Specifically, self-esteem, as measured by the Rosenberg Self-Esteem Scale (Rosenberg, 1965), was significantly correlated ($p < .001$) both with a single-item happiness measure[7] (Gurin, Veroff, & Feld, 1960; $r = 0.38$), the Bradburn Affect Balance Scale (Bradburn & Caplovitz, 1965; $r = 0.52$), and with the Oxford Happiness Inventory (OHI; Argyle, Martin, & Crossland, 1989; $r = 0.72$).

In another study conducted by the same authors, Cheng and Furnham (2004), a sample of 365 normal, nonclinical young people in their late teens and early 20s were administered four

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[7] This single-item scale measures respondents' general level of happiness with three choices: Very Happy; Pretty Happy; and Not too Happy.

questionnaires: the Rosenberg Self-Esteem Scale (Rosenberg, 1965), the Self-Criticism Questionnaire (Brewin, Firth-Cozens, Furnham, & McManus, 1992), the Oxford Happiness Inventory (OHI; Argyle et al., 1989), and the Parental Bonding Instrument (Parker, Tupling, & Brown, 1979). The researchers measured to what extent three recalled parental rearing styles (care, discouragement of behavioral freedom, denial of psychological autonomy), self-esteem, and self-criticism predicted self-rated happiness. The multiple regression analysis showed that self-esteem, or the aspect of self-esteem they called positive self-evaluation (measured by the positive five items of the Rosenberg Scale), was the most dominant and powerful correlate of happiness.

Lyubominsky, Tkach, and DiMatteo (2006) administered self-report questionnaires of both self-esteem and happiness (Rosenberg, 1965; Lyubominsky & Lepper, 1999) to 621 retired employees (ages 51-95) of a large Southern California utility company. The sample was 96% Caucasian, 80% male, and approximately 56% of the subjects had attended at least some college. The results of the study showed that self-esteem and happiness are highly correlated ($r = 0.58$).

Denny and Steiner (2009) examined whether happiness and satisfaction were influenced more by external or internal factors among elite collegiate athletes. Various self-report measures designed to measure internal factors (viz., locus of control, mindfulness, self-restraint, self-esteem) and external factors (viz., playtime, scholarship) were administered to 140 Stanford University athletes. The sample was 75% Caucasian and the mean socioeconomic status was upper-middle class. With regard to the factors of happiness and self-esteem specifically, various subscales of the Weinberger Adjustment Inventory (Weinberger & Schwartz, 1990), a social-emotional adjustment measure, were used to measure both variables. As predicted by Denny and

Steiner (2009), internal factors were more powerful correlates of happiness, with self-esteem being strongly associated with happiness ($r = 0.57$).

  Depression. In another study by the same pair of researchers discussed above, Cheng and Furnham (2003b) sought to examine the correlations among happiness, depression, and self-esteem among adolescents. Among a sample of 234 British youth (ages 15–35), the researchers measured self-esteem using the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and measured affect, depression, and happiness with the Bradburn Affect Balance Scale (Bradburn & Caplovitz, 1965), the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the Oxford Happiness Inventory (OHI; Argyle, Martin, & Crossland, 1989), and the Gurin Scale, a single item happiness scale (Gurin, Veroff, & Feld, 1960). They found that self-esteem was positively correlated with happiness, as measured by the OHI ($r = 0.67$) and the Gurin single-item happiness scale ($r = 0.44$). Self-esteem was inversely correlated with depression as measured by the BDI ($r = -0.59$). They reported self-esteem to be positively correlated with positive affect ($r = 0.33$) and balanced affect ($r = 0.38$) and negatively correlated with negative affect ($r = -0.23$). Based on a multiple regression analysis, the researchers also reported that self-esteem had a direct predictive effect on happiness and the opposite relationship with depression.

  In a 2003 study by Schmitz, Kugler, and Rollnik, the researchers drew upon data from the National Comorbidity Study (NCS), which was a nationally representative household survey of persons, age 15 to 54, in the noninstitutionalized civilian population of the United States. The NCS was administered between September 1990 and February 1992 in face-to-face, in-home interviews. A total of 8,098 interviews were completed and the researchers used a modified version of the World Health Organization Composite International Diagnostic Interview (CIDI;

Wittchen, 1994) to gather data about psychiatric symptoms (i.e., depression). They assessed self-esteem using an empirically abbreviated form of the Rosenberg Self-Esteem Scale (Rosenberg, 1965)[8] and found a significant inverse relationship between self-esteem and depression. Specifically, the researchers reported that those subjects determined to have very low self-esteem scores had a depression prevalence rate of 71.7%.

In an effort to account for some of the self-presentational biases inherent to using self-report measures, Steinberg, Karpinski, and Alloy (2007) incorporated implicit self-esteem techniques[9] along with the traditional self-report measures in their study of self-esteem and depression. A sample of 181 undergraduates enrolled in introduction to psychology were administered the self-other Implicit Association Test (IAT; Greenwald & Farnham, 2000), the Rosenberg Self-Esteem Scale (Rosenberg, 1965), the Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer, & Brown, 1996), and an initial-preference task (IPT; Nuttin, 1985). During the first session, participants were administered the self-other IAT, the IPT, and the Rosenberg Self-Esteem Scale, and a baseline measure of depressive symptoms (BDI-II). In the second session, approximately four months later, they completed a follow-up BDI-II and a questionnaire about life events. Implicit measures did not correlate with each other and none of the implicit measures of self-esteem correlated with depression, providing little evidence for a direct link between implicit self-esteem and depression. However, there was a significant relationship between low self-esteem and depression shown during both the initial and follow-up sessions (Time 1 $r = -0.41$; Time 2 $r = -0.24$).

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[8] This short form (5-item versus 10-item) of the Rosenberg Self-Esteem Scale was selected based on data analyses from previous studies designed to select the best subset of items to operationalize an entire scale (Mickelson, Kessler, & Shaver, 1997).
[9] Implicit measures of self-esteem are designed to assess aspects of self-esteem that operate outside of conscious awareness and control (Greenwald & Banaji, 1995).

Franck and De Raedt (2007) used samples of currently depressed inpatients (N=24), formerly depressed individuals (N=27), and never-depressed controls (N=31) to investigate the relationship between depression and unstable self-esteem, which has been defined as relatively high fluctuations and reactivity in self-esteem over time in reaction to daily stressors and boosts (Kernis, Cornell, Sun, Berry, & Harlow, 1993; Rosenberg, 1986). Franck and De Raedt (2007) measured depression with the Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer, & Brown, 1996) and the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960). They measured level of self-esteem with the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and, in order to measure self-esteem instability, the researchers used repeated assessments of self-esteem in natural contexts using an adapted version of the Rosenberg Self-Esteem Scale[10] every evening for 7 consecutive days, and then again 6 months later. Their results showed that, regarding self-esteem instability, never-depressed controls reported significantly more stable self-esteem as compared to formerly depressed individuals and the currently depressed individuals. Further, as the researchers expected, they observed significant negative correlations between self-esteem instability and level of self-esteem ($r = -0.32$), indicating that lower levels of self-esteem were associated with more unstable self-esteem. Self-esteem level was inversely correlated with average depressed mood ($r = - 0.69$) and self-esteem instability was moderately correlated with depressed mood ($r = 0.25$).

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[10] This adapted version of the Rosenberg Self-Esteem Scale includes anchor points separated by 10 dots (from totally agree to totally disagree). Participants were asked to circle the dot that best represented how they felt about themselves at the moment they completed the form. The self-esteem instability index, which represents the actual degree of short-term fluctuation in self-esteem over time (Kernis, Cornell, Sun, Berry, & Harlow, 1993; Roberts, Kassel, & Gotlib, 1995), was computed for each participant by the standard deviation of his/her repeated assessment scores.

Michalak, Teismann, Heidenreich, Strohle, and Vocks (2011) also found a significant inverse relationship between self-esteem and depression, as measured by the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and the Beck Depression Inventory (BDI; Beck & Steer, 1984). More specifically, their primary aim was to address the question of whether a non-judgmental accepting stance towards experience, as measured by the Kentucky Inventory of Mindfulness Skills—accept without judgment subscale (KIMS-A; Baer, Smith, & Allen, 2004)[11], moderates the relationship between self-esteem and depression. Results showed that non-judgmental acceptance moderates the relationship between self-esteem and depression. Among the sample of 216 German undergraduate students (age $M = 24.78$, $SD = 7.56$), high self-esteem was significantly correlated with a non-judgmental acceptance ($r = 0.61$) and inversely correlated with depression ($r = -0.71$). The sample was also divided into two groups: high mindful acceptance and low mindful acceptance individuals. In both groups, self-esteem was inversely related to depression, however, they differed quite markedly in the regression slopes obtained. Thus, the researchers suggest that an accepting, allowing, and non-judgmental stance towards experience might buffer the detrimental effects of low self-esteem on depression.

Takagishi, Sakata, and Kitamura (2011) conducted a longitudinal study with the aim of clarifying the relationships among multiple variables, including self-esteem, depression, and interpersonal dependency. Self-report measures, including the Rosenberg Self-Esteem Scale (Rosenberg, 1965) to measure self-esteem and a subscale of the Hopkins Symptom Checklist (Derogatis, 1974) to measure depression, were administered to a sample of 466 employees

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[11] The nine-item 'accepting without judgment' subscale of the KIMS was used by Michalak et al. (2011) to assess the degree to which participants have an accepting, allowing, non-judgmental or non-evaluative stance towards present-moment experience. According to Baer et al. (2004), to accept without judgment is to refrain from applying evaluative labels such as right/wrong or worthwhile/worthless and to allow present-moment experiences to be as they are without attempts to avoid, escape, or change them.

recruited in two workplaces in Japan (age $M = 41.5$). Questionnaires were administered on one occasion, and then again 10 weeks later. On both occasions, the data revealed a significant inverse correlation between self-esteem and depression (Time 1 $r = -0.51$; Time 2 $r = -0.47$). Findings also showed significant negative correlations between self-esteem and interpersonal dependency on both occasions (Time 1 $r = -0.47$; Time 2 $r = -0.36$), with interpersonal dependency being measured by the Interpersonal Dependency Scale (IDI; Hirschfeld, 1976)[12].

In a recent meta-analysis of the available longitudinal data, covering 77 studies of self-esteem and depression, with the mean age of the samples ranging from childhood to old age, Sowislo and Orth (2013) sought to explore whether data supports what the authors call the *vulnerability model*, which hypothesizes that low self-esteem contributes to depression, versus the *scar model*, which hypothesizes that depression erodes self-esteem. The researchers used a random-effects model and examined prospective effects between variables, controlling for prior levels of the predicted variables. They reported that the effect of self-esteem on depression was significantly stronger than the effect of depression on self-esteem. In other words, the relative predictive weight of self-esteem on depression was greater than the predictive weight of depression on self-esteem.

Lee, Joo, and Choi (2013) investigated the impact of perceived stress and self-esteem on work-related stress and depression. Using a sample of 284 female nurses (ages 24-38) recruited from the University Hospital in Daejeon, Korea, the researchers measured self-esteem using the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988). They found that perceived stress was inversely related to self-esteem ($r = -0.46$) and positively associated with work-related stress ($r = 0.42$) and depression (r

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[12] This scale includes 23 items designed to quantify three aspects of dependency: emotional reliance on others, lack of social self-confidence, and difficulties asserting autonomy.

= 0.28). Self-esteem was inversely associated with work-related stress (r = -0.28) and with depression (r = -0.55).

Steiger, Allemand, Robins, & Fend (2014) conducted a 23-year longitudinal study of German subjects (N = 1,527) on self-esteem and depression in which they assessed self-esteem annually from age 12 to 16, and depression at age 16 and again at 35. They measured depression with the Beck Depression Inventory (BDI; Beck et al., 1961) during adolescence and the BDI-V (Schmitt & Maes, 2000) during adulthood. They measured self-esteem using eight items of the Rosenberg Self-Esteem Scale (Rosenberg, 1965). Results demonstrated that level of self-esteem was inversely related to depression both during adolescence and also when measured almost two decades later (Time 1 r = -0.41; Time 2 r = -0.35).

Critique of the literature: Self-esteem, happiness, and depression. The current review of the literature on the relationship between self-esteem and happiness, and self-esteem and depression, reveals that the research in these areas continues to be plagued not just with the limitations addressed by Baumeister et al. (2003), but also with additional weaknesses. Specifically, although studies show that both happiness and depression appear to be strongly linked to self-esteem, the following problems and challenges present in the literature must be addressed and rectified before valid conclusions can be reached:

1. correlation versus causation;

2. directionality of causation;

3. magnitude of correlation;

4. influence of third variables;

5. methodological problems with self-report measures;

6. sample composition and generalizability;

7. instrumentation variance;

8. issues with construct validity (including discriminant and divergent factors) and overlap between measures.

Each of these issues is discussed sequentially below.

1. While the links between high self-esteem and happiness, and low self-esteem and depression, appear strong, the methodological shortcomings of the work that has been done thus far must be addressed prior to determining the exact nature of the relationships between these variables. It is important to remember the scientific tenet that the correlation between two variables is just that—a correlation, not necessarily causation. If two variables or phenomena are correlated, then the presence of one provides us with information about the other; however, cause and effect cannot be proven simply by virtue of a correlation (Levy, 2010). Nevertheless, several of the studies discussed above inappropriately imply a causal relationship between low self-esteem and depression, or high self-esteem and happiness, simply by virtue of the statistically significant relationship shown between two variables (e.g., Cheng & Furnham, 2003b; Michalak et al., 2011; Sowislo & Orth, 2013). These presumptuous inferences are reflected through unsubstantiated conclusions and wording choices such as: "…the detrimental effects of low self-esteem on depression" (Michalak et al., 2011, p. 751); "…the effect of self-esteem on depression was significantly stronger than the effect of depression on self-esteem" (Sowislo & Orth, 2013, p. 213); and, self-esteem "had a direct predictive power on happiness and the opposite relationship with depression…" (Cheng & Furnham, 2003b, p. 921).

2. One of these studies (Sowislo & Orth, 2013) not only implied a causal connection between low self-esteem and depression, but also attempted to establish the directionality of causation (i.e., *vulnerability model*, which states that low self-esteem contributes to depression,

versus the *scar model*, which states that depression erodes self-esteem). The researchers reported that the effect of self-esteem on depression was significantly stronger than the effect of depression on self-esteem. While this information is useful, it is important to note that simply demonstrating that one variable statistically *predicts* another (via multiple regression or other statistical analyses) is not equivalent to proving *cause-and-effect*.

3. A relationship that is statistically significant is not necessarily meaningful, substantive, or useful, and these concepts should not be confused. Thus, in interpreting the research, the actual numerical magnitude of the correlations (i.e., effect size) being reported must be considered, above and beyond whether it crosses the threshold of statistical significance. Throughout the literature discussed above, correlations range from $r = -0.23$ to $r = 0.72$. Even in the case of the strongest correlation ($r = 0.72$) reported by Cheng and Furnham (2003a), this finding still only accounts for approximately 52% of the variance between the two variables, thus leaving nearly half (48%) unexplained. All other reported correlations account for even less of the variance (some as low as 5%), even though they are, technically speaking, statistically significant.

4. Most of the research described above has not identified, controlled for, or ruled out potential third variable causes (i.e., covariates). While some studies imply effects of self-esteem on variables such as happiness and depression, the effects of self-esteem could be confounded with the effects of other unidentified or unknown variables; consequently, some of these apparent effects of self-esteem might diminish or even vanish when other covariates (e.g., family upbringing, peer relationships, actual successes or failures, cultural influences, physical attractiveness) are controlled for.

5. Like the studies cited by Baumeister et al. (2003), the four recent studies on self-esteem and happiness discussed here relied solely on self-report measures (Cheng & Furnham, 2003a, 2003b, 2004; Denny & Steiner, 2009; Lyubominsky et al., 2006). The same is true for seven of the nine recent studies discussed on self-esteem and depression. The two exceptions are: (a) the study that incorporated implicit measures of self-esteem, which found no correlation between implicit measures of self-esteem and depression (Steinberg, Karpinski, & Alloy, 2007), and (b) the study that used the World Health Organization Composite International Diagnostic Interview (CIDI; Wittchen, 1994) to gather data about psychiatric symptoms (i.e., depression). However, even a diagnostic interview relies on subjects' self-report responses. Although self-report measures are common, inexpensive, and easy to administer, research looking at the correspondence between reports of what people *say* they do and what they *actually* do calls into question the validity of these measures (Bellack & Hersen, 1977; Shiffman, 2000). Further, self-report is subject to a whole host of biasing factors (Stone et al., 2000), which are the product of both normal cognitive processing and psychologically motivated distortions, including: reactivity, social desirability, demand characteristics, inaccurate recollection or understanding, halo effect, response set, bias of acquiescence, bias of extreme responding, bias to the middle, random responding, faking good, and faking bad/malingering[13]. It is best, therefore, whenever possible, for researchers to consider alternatives to sole reliance on self-report measures.

6. The research appears to be plagued by a composition of samples (e.g., Stanford athletes, retired employees from one Southern California utility company, British adolescents, Korean female nurses, undergraduate students enrolled in introductory psychology courses) that are not inherently generalizable to other populations. In other words, the samples used in nearly

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[13] See Appendix A for brief definitions of these constructs.

all of these studies are not representative of a diverse population with regard to a number of important socio-cultural factors (e.g., age, level of education, ethnicity, geographic location, socioeconomic status, religion, nationality, etc.).

   7. Upon close inspection of the methods used amongst several of the studies discussed above (e.g., Cheng & Furnham, 2004; Franck & De Raedt, 2007; Schmitz et al., 2003; Steiger et al., 2014), some researchers have elected to use altered or short form versions of the Rosenberg Self-Esteem Scale and other measures. For example, Steiger et al. (2014) not only used a shortened version of the Rosenberg Self-Esteem Scale (i.e., 8 items instead of 10), they also used two different versions of the Beck Depression Inventory during the first and second sessions of their longitudinal study, without explaining the rationale for these selections. Also, in their study on self-esteem and happiness, Cheng and Furnham (2004) decided to divide self-esteem into two different variables, which they labeled, *positive self-evaluation* and *sense of self-worth*. According to the researchers, studies have shown that there are two orthogonal factors underlying the Rosenberg Self-Esteem Scale, one based on the combined positive items and one on the combined negative items. However, they only cited one outdated study (Kaplan & Pokorny, 1969) in support of this claim. A review of the literature conducted by the current researcher showed that support of this two-dimensional approach to the Rosenberg Self-Esteem Scale is mixed at best and virtually nonexistent at worst (Carmines & Zeller, 1979; Dunbar, Ford, Hunt, & Der, 2000; Greenberger, Chen, Dmitrieva, & Faruggia, 2003). Generally speaking, although the Rosenberg Self-Esteem Scale is designed to be a single-factor scale, some have suggested it should adopt a two-factor structure (with positive and negative items loading on different factors), but most argue that the two-factor structure is simply an artifact of the item

wording. Thus, with different studies electing to use altered versions of these self-report measures, such comparisons call into question the validity of their conclusions.

8. Finally, there are unanswered questions regarding self-esteem, happiness, and depression. For example, the current research does not seem to consider to what degree the specific items on these self-report measures (e.g., The Rosenberg Self-Esteem Scale, The Oxford Happiness Inventory) could be measuring the same construct. Similarly, to what degree is low self-esteem just one of the various symptoms of depression, which could account for the overlap between items on self-report measures of both constructs (e.g., The Rosenberg Self-Esteem Scale and the Beck Depression Inventory)? The construct validity of existing measures of self-esteem will be discussed in more detail later in this chapter.

Initiative [14]

Baumeister et al. (2003): Summary of findings. In addition to the research on happiness and depression, Baumeister et al. (2003) suggested that high self-esteem also appears to be linked to greater initiative. Specifically, the researchers suggested that people with high self-esteem are more prone to initiating both antisocial and prosocial actions, compared to people with low self-esteem. For example, individuals with high self-esteem have been shown to be overrepresented among both the perpetrators of bullying and the people who stand up to bullies and defend victims (Salmivalli, Kaukiainen, Kaistaniemi, & Lagerspetz, 1999). Similarly, people with high self-esteem have been shown to make up both the highest academic cheating groups

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[14] The term initiative here refers to the broad, far-reaching use of the word that was applied by Baumeister et al. (2003). In their analysis, initiative was used to refer to an extensive and heterogeneous list of situations and circumstances (e.g., initiating both antisocial and prosocial actions, initiating relationships, speaking up in groups, experimenting with sex, trying harder in response to failure). For the purpose of continuity and in an effort to build upon their findings and explore the more recent literature within this wide-ranging category, the same use of the term is being applied here.

and the lowest academic cheating groups (Lobel & Levanon, 1988). Baumeister et al. (2003) also reported that people with high self-esteem initiate interactions and relationships more than people with low self-esteem (Buhrmester et al., 1988), take more initiative in extricating themselves from unhappy relationships (Rusbult, Morrow, & Johnson, 1987) and are more likely to speak up in work groups (LePine & Van Dyne, 1998). People with high self-esteem appear to try harder in response to failure, but are willing to switch to a new line of endeavor if the present one seems unpromising. More specifically, high self-esteem has been shown to be associated with persistence in the face of failure (McFarlin, Baumeister, & Blascovich, 1984; Cruz Perez, 1973; Shrauger & Sorman, 1977).

Taking these findings into consideration, a review of the more recent literature on the relationship between self-esteem and initiative (as defined by the situations and circumstances addressed by Baumeister et al., 2003) was conducted, and a summary of those findings follows. With regard to the findings on self-esteem and persistence (McFarlin et al., 1984; Cruz Perez, 1973; Shrauger & Sorman, 1977), the recent literature related to this subject will be reviewed and addressed below. However, despite the fact that Baumeister et al. (2003) combined some of these terms (i.e., initiative and persistence) into one category, the current researcher will differentiate between the two: initiative, which involves initiating an action, is not seen as equivalent to persistence or tenacity.

More recent findings: 2003–2014. The current review was conducted in the following manner: from January 2014 through May 2014, the researcher searched the PsycINFO database for studies containing self-esteem and initiative in the title. However, that search yielded no results. The researcher therefore used more specific search terms, using the various areas

mentioned by Baumeister et al. (2013) as a guide (e.g., initiative and antisocial behavior, bullying, initiative and prosocial behavior, social/interpersonal initiative).

The researcher searched the PsycINFO database and obtained a list of all articles containing self-esteem and antisocial in the title, and, after applying the aforementioned inclusion and exclusion criteria, three articles published in scholarly (peer reviewed) journals, written in English, and published between 2003 and 2014 were found. The abstracts of all three articles were reviewed and all three studies were determined to be relevant. The same type of search was conducted for articles containing self-esteem and cheating or academic cheating in the title, which yielded no results. The search for studies containing self-esteem and bullying in the title yielded a list of 11 articles. The abstracts of these articles were reviewed, the same inclusion and exclusion criteria were applied, and only those determined to be the most directly applicable to the relationship between these two variables are described in detail below. Similarly, the researcher searched for articles containing self-esteem and prosocial in the title, which yielded one article, discussed below. In order to explore the recent literature on self-esteem and initiative in terms of group behavior, the researcher searched the PsycINFO database for studies with self-esteem and group in the title, which resulted in a list of 89 articles. The abstracts of all 89 studies were reviewed, but none of the studies were relevant to the relationship between self-esteem and taking initiative to speak up in groups. Finally, the researcher sought to explore the recent literature pertaining to self-esteem and social or interpersonal initiative. Due to the complex nature of social interaction, various search terms (viz., social initiative, social interaction, interpersonal, interpersonal initiative, social behavior, relationship initiation, starting relationships, relationship termination) were used in conjunction with self-esteem. After applying the aforementioned inclusion and exclusion criteria, numerous articles published in scholarly

(peer reviewed) journals, written in English, and published between 2003 and 2014 were found. However, after reviewing all of the abstracts, very few were found to be relevant. Only those studies determined to be the most directly applicable to the relationship between self-esteem and initiation of interpersonal relations are described in detail below.

Finally, as noted above, Baumeister et al. (2003) combined the terms initiative and persistence into one category. Since the current researcher differentiates between the two topics, a review of the more recent literature on self-esteem and persistence was conducted. The researcher searched the PsycINFO database for all articles containing self-esteem and persistence in the title, and, after applying the aforementioned inclusion and exclusion criteria, one article published in a scholarly (peer reviewed) journal, written in English, and published between 2003 and 2014 was found. However, the abstract was reviewed and the study was determined to be irrelevant to the direct relationship between the two constructs.

Antisocial behavior. Arbona and Power (2003) sought to explore the relationships between self-esteem, parental attachment, and antisocial behaviors among a diverse group of adolescents. Participants in this study were 1,583 high school students (age $M = 15.8$) from six high schools in a large metropolitan school district in the South. The sample was 42% European American, 31% African American, and 27% Mexican American. Self-esteem was measured using the Rosenberg Self-Esteem Scale (Rosenberg, 1965). Antisocial behaviors were measured by a 10-item questionnaire designed to cover five content areas (viz., aggression, stealing, lying, vandalism, and drugs), which was adapted from a 12-item self-report instrument developed by Jessor and Jessor (1977). Attachment was measured using a 38-item questionnaire regarding mother and father attachment, with items derived from three different sources: the Inventory of Parent and Peer Attachments (Armsden & Greenberg, 1987), the Emotional Autonomy Scale

(Steinberg & Silverberg, 1986), and the Children's Report of Parental Behavior Inventory (Schaefer, 1965). The researchers found a significant inverse relationship between self-esteem and antisocial behavior among the European American and African American adolescents ($r = -0.26$), as well as among Mexican American adolescents ($r = -0.22$). Overall, the researchers concluded that securely attached adolescents from the three ethnic groups had a more positive sense of self-esteem and reported less involvement in antisocial behaviors than their less securely attached peers.

Donnellan, Trzesniewski, Robins, Moffitt, and Caspi (2005) sought to explore the link between global self-esteem and externalizing problems such as aggression, antisocial behavior, and delinquency through three different studies. In the first study, self-esteem was measured with the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and the 6-item Global subscale of the Harter (1985) Self-Perception Profile for Children (SPPC). Delinquency was measured using a 12-item delinquent behaviors scale adapted by Elliot, Huizinga, and Ageton (1985). The sample consisted of 292 11 and 14 year olds (age $M = 12.66$; 55% female, 45% male; 56.5% European American, 20.5% Hispanic American, 9.2% African American, 9.0% other or not reported, and 4.8% Asian American or Pacific Islander) from two schools in Northern California. Self-esteem was consistently inversely correlated with delinquency, regardless of whether self-esteem was assessed by the Rosenberg scale ($r = -0.35$), the self-report version of the Harter SPCC ($r = -0.39$), or the teacher version of the Harter SPPC ($r = -0.29$).

In the second study conducted by Donnellan et al. (2005), self-esteem was measured among a group of youth at age 11 ($N = 812$; 48% female, 52% male) and age 13 ($N = 736$; 48% female, 52% male) using the Rosenberg Self-Esteem Scale (Rosenberg, 1965). Externalizing problems were assessed using the Rutter Child Scale (RCS; Rutter, Tizard, & Whitmore, 1970)

and the Revised Behavior Problem Checklist (RBPC; Quay & Peterson, 1987). Consistent with

the first study, self-esteem was inversely correlated with parent reports of externalizing problems

(r = -0.18 at age 11 and r = -0.28 at age 13) and with teacher reports of externalizing problems (r

= -0.16 at age 11 and r = -0.18 at age 13).

In the third study conducted by Donnellan et al. (2005), the researchers sought to explore

relationships between self-esteem, narcissism, and aggression. A sample of 3,143 undergraduate

students (68.3% female, 31.7% male; age M = 19.6) from a large research university in northern

California was administered the Rosenberg Self-Esteem Scale (Rosenberg, 1965), the

Narcissistic Personality Inventory (Raskin & Terry, 1988), and the Buss-Perry Aggression

Questionnaire (AQ; Buss & Perry, 1992). Self-esteem was inversely correlated with aggression

(r = -0.30). Self-esteem and narcissism were also moderately related (r = 0.32).[15]

Menon et al. (2007) sought to explore two hypotheses regarding self-esteem and

antisocial conduct. The first hypothesis that high self-esteem leads children to act on antisocial

cognitions (*disposition-activating hypothesis*) and the second hypothesis that high self-esteem

leads children to rationalize antisocial conduct (*disposition-rationalizing hypothesis*) were

investigated in two short-term longitudinal studies. In Study 1, antisocial behavior was defined

by level of aggression, as measured by a 3-item peer nomination scale and a 40-item

questionnaire assessing five aggression-encouraging cognitions (viz., expectation of reward,

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[15] Donnellan et al. (2005) also found that narcissism was positively correlated with aggression (r
= 0.18). The researchers conducted multiple regression analyses to test whether narcissism and
self-esteem had independent effects on aggression. The effects of self-esteem on aggression were
significantly stronger when narcissism was included in the equation than when it was not
included. Similarly, the effects of narcissism were significantly stronger when self-esteem was
included in the equations. Thus, low self-esteem and narcissism appear to contribute
independently to aggressive thoughts feelings, and behaviors, and in fact serve as mutual
suppressors. In other words, each variable, when controlled, had the effect of strengthening the
relationship between the other variables.

expectation of victim suffering, value of reward, value of victim suffering, and self-efficacy for aggression). Harter's (1985) 6-item global self-worth scale was used to measure self-esteem. The sample consisted of 189, predominately White, third- through seventh-grade boys and girls (age $M = 11.1$ years) and the children were tested in the fall and again in the spring of a school year. No direct, meaningful correlation was found between self-esteem and aggression (Time 1 $r = 0.12$; Time 2 $r = 0.00$). More specifically, to evaluate the first hypothesis, the researchers sought to determine whether high self-esteem would transform aggressive cognitions into aggressive action through conducting a hierarchical regression analysis. This study failed to yield any support for the disposition-activating hypothesis. Regarding the second hypothesis, the researchers evaluated whether high self-esteem would encourage aggressive children to rationalize their aggressive conduct. As a result of a multiple regression analysis, the researchers found that high self-esteem exacerbated the contribution of aggression to the aggressive cognition. In other words, high self-esteem children were shown to rationalize their antisocial conduct.

In Study 2 by Menon et al. (2007), antisocial behavior was defined by avoidance of the mother. Presumably, avoidant children experience the mother as aversive and are trying to exit the relationship. The disposition-rationalizing hypothesis is that "high self-esteem leads avoidant children to justify their avoidance of their mother by strengthening their perceptions of her as an inept, hostile, uncaring, blameworthy parent who deserves the avoidant treatment she is receiving" (Menon et al., 2007, p. 1632). In this study, self-esteem was assessed as it was in Study 1 and avoidant attachment was assessed using a 10-item scale adapted by Yunger, Corby, and Perry (2005) from Finnegan, Hodges, and Perry's (1996) original scale. Measures were administered once in the fourth grade and again a year later, in the fifth grade. Among the

sample of 407 children (52% girls, 48% boys; age $M = 10.8$; 52% White, 28% Black, 20% Hispanic) from five relatively small elementary schools serving middle- and lower middle-class neighborhoods in southeast Florida, self-esteem was found to be inversely, but only modestly, associated with caregiver avoidance (Time 1 $r = -0.26$; Time 2 $r = -0.09$). The results of a multiple regression analysis did not show significant support for the first hypothesis, that self-esteem motivates avoidance by children who view their mother negatively (the disposition-activating hypothesis). Regarding the disposition-rationalizing hypothesis, multiple regression analysis showed that high self-esteem magnified the contribution of avoidant attachment to a negative view of the mother, leading avoidant children to view their mother more negatively. Thus, according to the researchers, aggressive children with high self-esteem increasingly valued the rewards that aggression offers and belittled their victims, and avoidant children with high self-esteem increasingly viewed their mother as harassing and uninvolved. The researchers concluded that, for antisocial children, high self-esteem carries costs.

Bullying. Seals and Young (2003) explored the relationship of bullying and victimization to gender, grade level, ethnicity, self-esteem, and depression. The sample consisted of 454 students (59% female, 41% male) from Mississippi, who were between the ages of 12 to 17 years. The sample was 79% African American and 18% Caucasian. Bullying and victimization were measured using the Peer Relations Questionnaire (Rigby & Slee, 1995) and self-esteem was measured using the Rosenberg Self-Esteem Scale (Rosenberg, 1965). Three groups (bullies, victims, and nonbullies-nonvictims) were compared in terms of self-esteem. Although bullies and nonbullies-nonvictims scored higher in self-esteem than victims, the differences were minimal and a one-way analysis of variance was not significant ($p < .50$).

Fox and Farrow (2009) collected self-report data from a sample of British 11- to 14-year-olds ($N = 376$) about their weight status, their experiences of three different types of bullying (verbal, physical and social), their global self-worth, self-esteem for physical appearance, and body dissatisfaction. Global self-worth and self-esteem for physical appearance were measured using the Harter's Self-Perception Profile for Children/Adolescents (Harter, 1985) and 16 items were written by the researchers to reflect "a complete range of current bullying experiences" (i.e., verbal, physical, and social; Fox & Farrow, 2009, p. 1290). Global self-worth and self-esteem for physical appearance were highly correlated ($r = 0.63$). Global self-esteem was also moderately inversely correlated with body dissatisfaction ($r = -0.32$), verbal bullying ($r = -0.32$), physical bullying ($r = -0.23$), and social bullying ($r = -0.37$).

Gendron, Williams, and Guerra (2011) examined the relations between self-esteem, approving normative beliefs about bullying, school climate, and bullying perpetration using a large, longitudinal sample of children from elementary, middle, and high school. Self-esteem was measured with a four-item scale adapted from the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and bullying was measured with an eight-item scale adapted from Espelage, Holt, and Henkel (2003). Data were collected as part of a 3-year bullying prevention initiative in Colorado and a total of 7,299 fifth-, eighth-, and 11th-grade students participated in the study. Self-esteem was inversely correlated with bullying (Time 1 $r = -0.22$; Time 2 $r = -0.14$). The results of a multiple regression analysis suggested that self-esteem is positively associated with bullying when school climate is perceived as non-supportive but negatively associated with bullying when it is perceived as supportive.

Prosocial behavior. Lindsey, Colwell, Frabutt, Campbell, and MacKinnon-Lewis (2008) aimed to examine mother-child synchrony, characterized by a mutually responsive and

interconnected interaction style, and its link to early adolescents' self-esteem and prosocial behavior. Data were collected from 268 early adolescents (49% girls, 51% boys) and their mothers, from both European American (56%) and African American (44%) families. All children in the study were transitioning into middle school and ranged from 11 to 13 years old (age $M = 12.34$). Self-esteem was measured by the global self-worth scale from Harter's (1982) Perceived Competence Scale for Children (PCSC) and prosocial behavior was measured by the Ratings of Children's Social Behavior Scale (CSBS; Crick, 1996), which includes such items as says supportive things to peers and tries to cheer up peers when sad or upset. The researchers found a positive correlation between self-esteem and prosocial behavior ($r = 0.30$).

Social-interpersonal initiative. Ethier et al. (2006) attempted to clarify the relationship between psychological factors (e.g., self-esteem, emotional distress) and sexual behavior (e.g., sexual history, future risky sexual behavior). On a sample of 155 sexually active adolescent females (46% African American, 37% Latina, 17% other), aged 14-19 years (age $M = 17.2$), the Rosenberg Self-Esteem Scale (Rosenberg, 1965) was used to measure self-esteem. Among the various variables they measured, the researchers reported a statistically significant, but small, relationship between level of self-esteem and age at first intercourse ($r = 0.18$), which led the researchers to conclude that adolescent females who initiate sex earlier have lower self-esteem. Additionally, self-esteem was inversely correlated with having a history of a risky partner ($r = -0.22$) and inversely, but weakly, correlated with number of partners per year ($r = -0.05$) and sexually transmitted disease (STD) history ($r = -0.02$).

Eryilmaz and Atak (2011) sought to investigate the level at which self-esteem and gender roles predict the ability to start romantic intimacy in emerging adulthood. Using a sample of 256 university students (ages 19–25 years), the researchers measured self-esteem using the

Rosenberg Self-Esteem Scale (Rosenberg, 1965). They measured perceptions of starting romantic intimacy with the Markers of Starting Romantic Intimacy Scale (Eryilmaz & Atak, 2009) and gender role tendencies with the Bem Gender Roles Inventory (Bem, 1974). The results of a multiple regression analysis showed that level of self-esteem was a significant predictor variable when it came to starting of romantic intimacy among emerging adults. More specifically, self-esteem, gender, and also gender roles were the most important factors for starting romantic intimacy.

Cameron, Stinson, and Wood (2013) aimed to explore the interactions between self-esteem, gender, and relationship initiation with two studies. In Study 1, a sample of 48 introductory psychology students (56% female, 44% male; age $M = 18.7$ years) were administered the Rosenberg (1965) Self-Esteem Scale and a questionnaire regarding recent romantic relationship interactions (e.g., most recent romantic attraction, relationship initiation attempts, romantic involvement) and perceived social risk (e.g., importance of becoming romantically involved with the target, the importance and significance of this event in their life, how much it bothered them if they did not become involved with the target). The results of a multiple regression analysis indicated that, when perceived social risk was present, lower self-esteem individuals were less likely to use direct initiation behaviors than higher self-esteem individuals. However, if perceived social risk was not present, these self-esteem differences in behavior were no longer significant.

In Study 2 by Cameron et al. (2013), a sample of 60 introductory psychology students (52% female, 48% male; age $M = 19.2$ years) were administered the Rosenberg Self-Esteem Scale (1965). Subjects were placed in a situation where they believed that there was a second, opposite-sex participant in the lab room next to their own, and that they would be

communicating with their interaction partner via video camera. Some subjects were then assigned to a risk condition (i.e., believing that there was a possibility they could meet the other participant, if and only if the other participant wanted to meet them) and some to a no risk condition (i.e., believing that they were unable to meet their interaction partner face-to-face, even if they wanted to, due to ethical regulations). A behavioral coding method was used to assess actual initiation behavior. The results of a hierarchical regression analysis indicated that gender moderated the links between self-esteem, risk, and initiation behavior in a manner consistent with traditional gender roles. In other words, the researchers sought to examine the two-way and three-way interactions between self-esteem, gender, and risk condition in predicting directness of cues conveying liking. Women tended to display more direct cues conveying liking in the risky condition and less in the no risk condition, but there was no interaction between self-esteem and risk condition for women. For men, an interaction between self-esteem and condition emerged. In the high-risk condition, men with high self-esteem displayed greater liking cues than those with low self-esteem. Self-esteem was unrelated to the directness of cues conveying liking in the no-risk condition. Thus, self-esteem predicted men's, but not women's, use of direct initiation strategies as a function of risk.

Critique of the literature: Self-esteem and initiative. Similar to the studies on the relationship between self-esteem, happiness, and depression, the recent literature on the relationship between self-esteem and initiative reveals that the research in this area continues to display not just the limitations addressed by Baumeister et al. (2003), but also additional weaknesses. Moreover, although Baumeister et al. did conclude that the potential benefits of high self-esteem could be tentatively summarized in terms of two main themes (i.e., happiness and greater initiative), they also clearly stated that, with the exception of the link to happiness, most

other effects were weak to modest. Thus, even the findings they cited on initiative in 2003 were not considered particularly strong. Further, the current review of the initiative literature did not yield any more robust support for the tentative conclusions of Baumeister et al. (2003) than they themselves found over a decade ago. Specifically, the following problems and challenges present in the research, many of which plagued the literature on happiness and depression as well, must be addressed and rectified before valid conclusions can be reached:

1. correlation versus causation;

2. magnitude of correlation;

3. influence of third variables;

4. methodological problems with self-report measures;

5. sample composition and generalizability;

6. instrumentation variance;

7. issues with construct validity (including discriminant and divergent factors).

Each of these issues is discussed sequentially below.

1. While the links between self-esteem and initiative appear notable in some cases, the methodological shortcomings of the work that has been done must be addressed prior to determining the exact nature of the relationships between these variables. As mentioned above in the critique of the literature on self-esteem, happiness, and depression, a correlation between two variables does not prove causation. Nevertheless, several of the studies discussed above (e.g., Donnellan et al., 2005; Eryilmaz & Atak, 2011; Gendron et al., 2011) inappropriately imply a causal relationship between self-esteem and initiative across a number of situations, simply by virtue of the statistically significant relationship shown between two variables. These inferences are reflected through unsupported conclusions and misleading wording choices such as: "…the

effect of self-esteem on aggression was independent of narcissism" (Donnellan et al., 2005, p. 328); "…the effect of self-esteem on bullying perpetration was moderated by perceptions of school climate" (Gendron et al., 2011, p. 150); and, "…self-esteem has a positive effect on starting romantic intimacy" (Eryilmaz & Atak, 2011, p. 599).

2. A relationship that is statistically significant is not necessarily meaningful, substantive, or useful, and the actual numerical magnitude of the correlations (i.e., effect size) being reported must be considered, above and beyond whether it crosses the threshold of statistical significance. Throughout the literature discussed above, correlations range from $r = -0.09$ to $r = 0.63$. Even in the case of the strongest correlation ($r = 0.63$) reported by Fox and Farrow (2009), this finding still only accounts for approximately 40% of the variance between the two variables (viz., self-esteem and physical appearance), thus leaving over half (60%) unexplained. Moreover, this correlation, albeit the highest reported, is not even directly related to initiative. The next highest correlation reported here was between self-esteem (measured by the Harter SPCC) and delinquent behavior ($r = -0.39$), which accounts for approximately 15% of the variance, leaving 85% unexplained (Donnellan et al., 2005). All other reported correlations account for even less of the variance (some as low as < 1%), even though they are, technically speaking, statistically significant.

3. Most of the research described above has not identified, controlled for, or ruled out potential third variable causes (i.e., covariates). While some studies imply effects of self-esteem on variables such as bullying or prosocial behavior, the effects of self-esteem could be confounded with the effects of other unidentified or unknown variables; consequently, some of these apparent effects of self-esteem might diminish or even vanish when other covariates (e.g., family upbringing, peer relationships, cultural influences) are controlled for.

4. Like the studies cited by Baumeister et al. (2003), the three recent studies on self-esteem and antisocial behavior discussed here (Arbona & Power, 2003; Donnellan et al., 2005; Menon et al., 2007) relied solely on self-report measures, as did the three recent studies on self-esteem and bullying (Seals & Young, 2003; Fox & Farrow, 2009; Gendron et al., 2011), the study on self-esteem and prosocial behavior (Lindsey et al., 2008), and two of the studies on self-esteem and social initiative (Ethier et al., 2006; Eryilmaz & Atak, 2011). Only one study discussed here on self-esteem and social initiative (Cameron et al., 2013) used both self-report measures and observational data gathered while the researchers attempted to experimentally manipulate certain conditions. As discussed above, self-report measures are common, inexpensive, and easy to administer; however, they are subject to a whole host of validity issues (Bellack & Hersen, 1977; Shiffman, 2000) and biasing factors (Stone et al., 2000)[16].

5. Compared to the literature discussed above regarding the relationships between self-esteem, happiness, and depression, much of the research on self-esteem and initiative includes more ethnically diverse samples. Nonetheless, it is important to note that many of the studies discussed here used samples that are not inherently generalizable to other populations for a variety of other reasons. Most notably, almost every study described above involved samples of children and adolescents (Arbona & Power, 2003; Donnellan et al., 2005; Menon et al., 2007; Seals & Young, 2003; Fox & Farrow, 2009; Gendron et al., 2011; Lindsey et al., 2008; Ethier et al., 2006), limiting the generalizability of these findings to other age groups. Additionally, many of the samples are quite limited with regard to being truly representative of a diverse population because of a number of other important socio-cultural factors (e.g., gender, level of education, geographic location, socioeconomic status, religion, nationality, ethnicity, etc.).

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[16] See Appendix A for a list and brief descriptions of biasing factors associated with self-report measures.

6. Upon close inspection of the methods used amongst a couple of the studies discussed above (e.g., Arbona & Power, 2003; Gendron et al., 2011), some researchers have elected to use shortened versions (e.g., seven of ten items; four of ten items) of the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and other measures. Thus, with different studies electing to use altered versions of these self-report measures, such comparisons call into question the validity of their conclusions. Moreover, several of the studies discussed above relied upon Harter's (1982) Perceived Competence Scale for Children as the sole measure for self-esteem (Fox & Farrow, 2009; Lindsey et al., 2008; Menon et al., 2007), versus the Rosenberg (1965) scale that is used across all the other studies. While there is no inherent, notable problem with using Harter's (1982) scale as a measure of self-esteem, caution must be taken when making comparisons and drawing conclusions with various studies electing to use different self-report measures of self-esteem.

7. Finally, before legitimate conclusions can be made, the construct validity of the measures used within this research must be considered. For example, in Study 2 by Menon et al. (2007), the researchers operationalized antisocial behavior by the degree to which the youth engaged in avoidance behavior with their mothers. Avoidance behavior was assessed by a scale designed to measure avoidant attachment, a 10-item scale adapted by Yunger et al. (2005) from Finnegan et al.'s (1996) original scale. The researchers concluded that self-esteem was found to be inversely associated with caregiver avoidance (Time 1 $r = -0.26$; Time 2 $r = -0.09$); however, not only were the correlations weak to modest at best, how can we be sure that an avoidant attachment style predicts antisocial behavior? If we cannot even be sure that a test measures what it claims, or purports, to be measuring, how can we make valid conclusions about that construct and its relation to self-esteem?

More broadly, this entire portion of the current investigation (i.e., self-esteem and initiative) was guided by the tentative conclusions of Baumesiter et al. (2003) and their particular operationalization of the term initiative. According to the Merriam-Webster Online Dictionary, initiative can be defined as "the power or opportunity to do something before others do" (Initiative, 2014, para. 3) "the energy and desire that is needed to do something" (para. 3), "an introductory step" (para. 4), or "energy or aptitude displayed in initiation of action" (para. 4). Baumeister et al. (2003) defined initiative so broadly, applying it to such a wide-ranging list of situations and circumstances (e.g., performing both antisocial and prosocial actions, initiating relationships, speaking up in groups, experimenting with sex, trying harder in response to failure, etc.), it is difficult to say with certainty that even the findings discussed here can contribute to conclusions about initiative as it is defined colloquially or by the dictionary.

Last, as mentioned in the critique of the literature on self-esteem, happiness, and depression (above), the construct validity of existing measures of self-esteem will be discussed in more detail below.

Measures of Self-Esteem

As discussed in Chapter 1, the vast majority of self-esteem research utilizes self-report measures. In their review of measures of self-esteem, Blascovich and Tomaka (1991) identified the most frequently cited measures in the literature and then reviewed what they considered to be the 11 most common, five of which are general measures for use with adolescents and adults, two of which are designed for use with younger children, and the remaining four which cover specific aspects of self-esteem. Of all the scales they reviewed, Blascovich and Tomaka found them of vastly unequal quality and gave high marks to only a few, specifically Rosenberg's (1965) Self-Esteem Scale (SES) and a revision of Janis and Field's (1959) Feelings of

Inadequacy Scale, which was revised by Fleming and Courtney (1984). In the current review of

the literature, over 80% of the research studies cited utilized the Rosenberg (1965) SES to

measure self-esteem. Harter's (1985) Self-Perception Profile for Children (SPPC), which was

included on Blascovich and Tomaka's list as one of the most common measures for children,

was used in the vast majority of the remaining research reviewed. Therefore, the following

sections include summaries and reviews of these two measures (viz., SES and SPPC), which

were essentially the only two self-esteem instruments cited by the research in the current study[17].

Immediately below is a discussion of the key psychometric properties used to summarize and

critically analyze these two measures, followed by a review of each instrument.

     Psychometrics. For interpretations of data to be useful, the measuring instruments used

to collect those data must be both reliable and valid. The following section provides a brief

overview of both reliability and validity.

     Reliability. Reliability is the degree to which a test is a consistent measure. Thus, the

more reliable a measuring instrument is, the more likely it is that items within the test are

internally consistent, or that the scores obtained from the test will be the same if the test is re-

administered at another time by the same or by a different examiner (Gay, Mills, & Airasian,

2009). Although a valid test is always reliable, a reliable test is not always valid. Reliability

provides information about the consistency of scores produced by an instrument whereas validity

provides information about the appropriateness or usefulness of an instrument (Gay et al., 2009).

     Reliability is expressed numerically, usually as a reliability coefficient, which is obtained

by using correlation ranging from 0 to 1, with higher values reflecting greater reliability (Gay et

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[17] For a complete list of measures used in the literature reviewed, see Appendix B. This list
includes measures of self-esteem, happiness, depression, and other variables associated with
initiative.

al., 2009). For example, Cronbach's α is an index of internal consistency, which tells us how closely related a set of items are as a group (Cronbach, 1951). In other words, it estimates internal consistency by determining how all items on a test relate to all other test items and to the total test. Other types of reliability include stability (or test-retest reliability), which refers to the degree to which scores on the same test are consistent over time. Inter-rater reliability and intra-rater reliability refer, respectively, to the consistency of two or more independent scorers or to the consistency of one individual's scoring over time (Gay et al., 2009).

　　　　Validity. Validity refers to the degree to which a test measures what it is supposed to measure, which allows for appropriate interpretation of scores. Like reliability, validity is typically expressed numerically, usually as a validity coefficient, which is also obtained by using correlation. However, in the case of a validity coefficient, the value can range from -1 to +1. A coefficient of 0 indicates that the variables are orthogonal (i.e., statistically independent or uncorrelated). Generally speaking, there are three main types of test validity: content validity, criterion-related validity, and construct validity (Gay et al., 2009). Content validity refers to the extent to which a test represents the general domain or content area of interest. Criterion-related validity refers to the extent to which a test correlates with another test designed to measure the same content area of interest. Criterion-related validity has two forms: concurrent validity (i.e., the degree to which scores on one test are related to scores on a similar test administered in the same time frame) and predictive validity (i.e., the degree to which a test can predict how well an individual will perform in a future situation). Construct validity refers to what extent a test reflects the construct it is intended to measure (Gay et al., 2009). Convergent and discriminant validity can be considered subcategories of construct validity and both must be demonstrated in order to establish construct validity. In other words, one must show a correspondence or

convergence between similar constructs (i.e., constructs that theoretically should be related to each other are observed, in fact, to be related) and one must be able to discriminate between dissimilar constructs (i.e., constructs that theoretically should *not* be related are observed, in fact, not to be related to each other; see Campbell & Fiske, 1959, for a comprehensive discussion of the multitrait-multimethod matrix). For instance, one might expect self-esteem to be correlated with mood (e.g., high self-esteem with happiness and low self-esteem with depression), whereas one would expect no correlation or meaningful relationship at all between self-esteem and psychosis, IQ, or birthdate.

Separate but related types of validity that are important to the evaluation of research methods include: internal validity, external validity, and incremental validity. Internal validity refers to the degree to which changes observed in a dependent variable are due to the effect of the independent variable, and not other extraneous variables. External validity refers to the extent to which the results of a research study can be generalized to other situations or to other populations. Incremental validity refers to whether a new psychometric assessment will increase predictive ability beyond what would be provided or obtained with an already existing method (Mertens, 2010).

Rosenberg's self-esteem scale. [18] The Self-Esteem Scale (SES; Rosenberg, 1965) is a 10-item self-report questionnaire that was originally designed to measure adolescents' global feelings of self-worth or self-acceptance. The original sample was a group of 5,024 high school juniors and seniors from 10 randomly selected New York State high schools. The Self-Esteem Scale consists of five positively worded (e.g., I feel that I have a number of good qualities) and five negatively worded (e.g., All in all, I am inclined to feel that I am a failure) items, which

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[18] Refer to Appendix C for the Self-Esteem Scale test items, along with scoring instructions.

require the respondent to report feelings about the self directly. It is typically scored using a four-point response format (i.e., strongly agree, agree, disagree, strongly disagree), resulting in a scale range of 0-30 with higher scores representing higher self-esteem.

The Self-Esteem Scale is considered to be a unidimensional measure of self-esteem. Rosenberg (1979) focused on global self-esteem as the target of measurement. Although he did not dispute the fact that people evaluate themselves differently in different domains of their lives, he took the stance that these discriminations are difficult to accurately assess. Rather, an overall assessment of one's feeling of self-worth as a person, the form of global judgment of self-esteem, was seen as sufficient as a predictor of other important life outcomes.

According to a review by Blascovich and Tomaka (1991), the scale's brevity, ease of administration, and simple scoring are some of the reasons it has been used so prevalently. As mentioned above, using the publications reviewed in the current study as a benchmark, over 80% utilized the Rosenberg Self-Esteem Scale. The SES is often viewed as the standard against which new measures are evaluated. Overall, the scale is considered to be a straightforward estimate of positive or negative feelings about the self; however, some items may be susceptible to socially desirable responding (Blascovich & Tomaka, 1991).

The Rosenberg SES is both internally consistent and temporally stable. Dobson, Goudy, Keith, & Powers (1979) obtained a Cronbach's α of 0.77 for their sample and Fleming and Courtney (1984) reported a Cronbach's α of 0.88 (Blascovich & Tomaka, 1991). Silber and Tippett (1965) reported a test-retest correlation of 0.85 for 28 subjects after a 2-week interval. Fleming and Courtney (1984) reported a test-retest correlation of 0.82 for 259 subjects with a 1-week interval (Blascovich & Tomaka, 1991).

Convergent and discriminant validity of the Rosenberg SES have been demonstrated across a number of studies. The measure has been shown to be associated with many self-esteem-related constructs. For example, correlations have been shown between Rosenberg SES scores and confidence ($r = 0.65$; Lorr & Wunderlich, 1986), popularity ($r = 0.39$; Lorr & Wunderlich, 1986), overall academic self-concept ($r = 0.38$; Reynolds, 1988), and social confidence (0.51). Fleming and Courtney (1984) also demonstrated the Rosenberg SES to be correlated with school abilities ($r = 0.35$) and physical appearance ($r = 0.42$). Two studies have shown the relationship between SES scores and peer ratings of self-esteem ($r = 0.27$; Savin-Williams & Jaquish, 1981; $r = 0.32$; Demo, 1985). Correlations with social desirability range from 0.10 (Reynolds, 1988) to 0.33 (Fleming & Courtney, 1984). Regarding other measures of self-esteem, Rosenberg SES scores are correlated with Lerner Self-Esteem Scale scores ($r = 0.72$; Savin-Williams & Jaquish, 1981), the Janis and Field Scale scores ($r = 0.66$; Fleming & Courtney, 1984), and the Coopersmith SEI ($r = 0.55$; Demo, 1985). Inverse relationships have been demonstrated between the Rosenberg SES and concepts associated with low self-regard. For example, SES scores are negatively correlated with anxiety ($r = -0.64$), anomie ($r = -0.43$), and depression ($r = -0.54$[19]; Fleming & Courtney, 1984).

Significant discriminant validity has also been demonstrated for the Rosenberg SES. Reynolds (1988) found no significant correlations between Rosenberg SES scores and grade point averages ($r = 0.10$), locus of control ($r = -0.04$), Scholastic Aptitude Test verbal scores ($r = -0.06$) or quantitative scores ($r = 0.10$). Fleming and Courtney (1984) found no significant correlations between SES scores and gender ($r = 0.10$), age ($r = 0.13$), work experience ($r = -$

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[19] For a detailed review of the relationship between self-esteem and depression, see the review of the literature earlier in this chapter.

0.07), marital status ($r = 0.17$), birth order ($r = 0.02$), grade point average ($r = 0.01$), or vocabulary ($r = -0.04$).

Harter's self-perception profile for children. [20] The Self-Perception Profile for Children (SPPC) is a 36-item self-report scale that measures several aspects of a child's general sense of self-worth and self-concept that are related primarily to competence and acceptance (Harter, 1985/2012). The original standardization sample was composed of 1553 third through eighth grade boys and girls (Blascovich & Tomaka, 1991). This tool taps five specific domains of self-concept (viz., scholastic competence, social competence, athletic competence, physical appearance, and behavioral conduct), as well as global self-worth. Although the original scale was designed just for children, Harter has since developed six different versions of her Self-Perception Profile to correspond with different developmental stages: the original Self-Perception Profile for Children, ages 8-13 (Harter, 1985/2012), the Self-Perception Profile for Adolescents, ages 14-19 (Harter, 1988/2012), Profile for Learning Disabled Students, ages 8-18 (Renick & Harter, 1988/2012), the Self-Perception Profile for College Students (Neemann & Harter, 1986/2012), the Self-Perception Profile for Adults, ages 20-60 (Messer & Harter, 1986/2012), and the Self-Perception Profile for Older Adults, ages 60+ (Harter & Kreinik, 2012).

According to Harter (1999), self-perceptions, beginning in childhood, are more complex than what can be captured by measures that take a unidimensional, single score approach (e.g., the global self-esteem score of the Rosenberg Self-Esteem Scale). Thus, Harter (1985/2012) sought to develop assessment tools that would tap into the differentiation between an individual's self-evaluations across multiple domains. Based on Harter's approach, however,

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[20] Refer to Appendix D for the Self-Perception Profile for Children test items, along with scoring instructions.

these domain-specific evaluations do not preclude an individual from having an overall sense of self-worth as a person, which she labels global self-worth (analogous to overall self-esteem), and these two categories of self-evaluations can coexist (Harter, 1985/2012). Therefore, the SPPC contains subscales tapping domain-specific concepts and a separate subscale titled Global Self-Worth, namely how much one likes oneself as a person, overall. This scale is not the sum of the domain-specific scores, but is rated by its own set of items and scored separately (Harter, 1985/2012).

Regarding the contents of the Global Self-Worth scale, Harter (1985/2012) identifies these items as tapping directly into how much one likes oneself as a person, is happy with the way one is leading one's life, is generally happy with the way one is, as a human being. Within the items designed to measure global self-worth, there are no references to specific skills or competencies. According to Harter (1985/2012), this subscale is similar to Rosenberg's (1965) notion of self-esteem; however, the wording is more appropriate for children and the question format differs. Harter advises that the global self-worth scores of children under 8 years of age be interpreted with caution, since younger children are less able to make abstract judgments (Blascovich & Tomaka, 1991).

Briefly, with regard to the other domains, the Scholastic Competence items refer specifically to the child's perceived cognitive competence, as applied to schoolwork. The Social Competence items refer to knowing how to make friends, having the skills to get others to like oneself, knowing what to do to have others like or accept you, and understanding what it takes to become popular. The items included on the Athletic Competence subscale refer to one's ability to do well at sports, including outdoor games, and items included on the Physical Appearance subscale tap into the extent to which one feels one is good looking (e.g., happy with one's looks,

face, hair, etc.). Finally, the Behavioral Conduct subscale taps the degree to which one likes the way one behaves, avoids getting in trouble, and acts the way he or she is supposed to act.

Regarding question format, Harter (1985/2012) designed the format with the aim of offsetting the tendency to give socially desirable response and to provide participants with a range of response choices. Specifically, the child is first asked to decide which kind of kids he or she is most like (i.e., those described on the left side of the test form or those described on the right side) in each statement. After having made this decision, the child then decides whether the description on the side he/she chose is Really True for Me or Sort of True for Me. Each of the six subscales is based on six items and items are scored from one to four, with the most positive answers receiving a four (positive picture, really true) and negative responses receiving a one (negative picture, really true). Domain scores can range from 6 to 24 and total scores range from 36 to 144, with higher scores indicating a more positive self-concept (Blascovich & Tomaka, 1991).

The Global Self-Worth Scale of the SPPC is internally consistent, with Cronbach's α values ranging from 0.71 to 0.85 across four samples (Blascovich & Tomaka, 1991). With regard to temporal stability, the test author does not recommend test-retest statistics as an index of reliability, namely due to self-perceptions changing over time interventions designed to impact change, natural events in a child's life, school transitions, various stressors, changing family constellations, age-related developmental factors, etc. (Harter, 1999). Further, no test-retest correlations were found from outside sources (Blascovich & Tomaka, 1991).

Regarding test validity, some convergent evidence comes from unpublished data reported by Harter (1985/2012) in which 96% of first and second grade children were readily able to give specific reasons why they felt competent or not and why they felt accepted or not. Also, a

correlation of 0.42 was reportedly obtained between perceived competence and preferred level of difficulty in puzzle tasks (Blascovich & Tomaka, 1991). Regarding other measures, scores on the Global Self-Worth subscale of the Harter SPPC (1985/2012) have been shown to correlate with scores on the General Self-Concept Subscale of the Marsh Self-Description Questionnaire (Marsh, 1991; $r = 0.56$; Harter, 1985/2012). No discriminant validity data were found (Blascovich & Tomaka, 1991).

   Critique of measures: The Rosenberg SES and the Harter SPPC. Both methodological and conceptual problems combine to make valid, useful measurement of self-esteem difficult. Conceptual confusion is exacerbated by the fact that self-esteem, like many important constructs in the field of psychology, is used both colloquially as well as within the realms of academic and clinical psychology. Thus, although research would benefit from a strong, standardized measure of self-esteem, common-language notions of self-esteem are sometimes substituted for more explicit, scientific definitions, which creates an illusion of a universally accepted, well-defined entity (Wells & Marwell, 1976). Moreover, given the ultimately subjective nature of self-esteem, it has been measured almost exclusively by self-report[21]. As discussed in Chapter 1, considering all the different theoretical approaches to defining self-esteem and the enormous number of research studies that have sought to measure the construct, it is no surprise that different measuring instruments have evolved over time. Nonetheless, the use of simple self-report measures in research appears to be the method that has prevailed and been deemed to be the most pragmatic (Blaskovich & Tomaka, 1991). The pragmatic approach, however, is not without its methodological shortcomings. For example, the

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[21] For a discussion of problems associated with self-report measures, see critiques of the literature on self-esteem, happiness, and depression, as well as the critique of the literature on self-esteem and initiative (above). Also, see Appendix A for a list of biasing factors associated with self-report measures.

social desirability of high self-esteem in North American culture generally leads subjects to respond to face-valid (i.e., subjectively transparent or viewed as explicitly covering the concept it purports to measure) items accordingly, thereby inflating self-esteem scores on self-report measures (Blaskovich & Tomaka, 1991). Taking these conceptual and methodological issues into consideration, as well as the psychometric properties discussed above, below are critiques of some of the specific problems with the Rosenberg (1965) Self-Esteem Scale and the Harter (1985) Self-Perception Profile for Children.

Rosenberg SES: A critique. As mentioned previously, the Rosenberg SES has enjoyed widespread use as a unidimensional measure of self-esteem and is often the standard against which new measures are evaluated. However, it is not without methodological problems. For example, according to Blascovich and Tomaka (1991), the test items are susceptible to socially desirable responding. Regarding test reliability, although studies have shown the measure to be both internally consistent and temporally stable, the test-retest reliability coefficients reported were measured over such short periods of time (i.e., 1 week and 2 weeks), it is unclear whether the measure is actually reliable over longer periods of time. Similarly, with regard to validity, the data do not suggest the predictive validity of the measure. In other words, with such limited data on temporal stability, how can one be sure that the test predicts level of self-esteem in future situations? Studies have shown both convergent validity (i.e., positive correlations between the SES and confidence, popularity, overall academic self-concept, social confidence, school abilities, physical appearance, and peer ratings of self-esteem, as well as inverse relationships between SES scores and anxiety, depression and anomie) and discriminant validity (i.e., no significant correlations between SES scores and grade point averages, locus of control, Scholastic Aptitude Test verbal or quantitative scores, gender, age, work experience, marital

status, birth order, grade point average, or vocabulary). Concurrent validity has been shown through correlations between the SES and Lerner Self-Esteem Scale scores, the Janis and Field Scale scores, and the Coopersmith SEI. However, the external validity of the Rosenberg SES is questionable. For example, with the original standardization sample being composed of adolescents from 10 New York State high schools, how can one be certain that the norms generated from that sample are generalizable to other populations (e.g., anyone who is not an adolescent in a New York state public school)?

Finally, from a conceptual standpoint, although Rosenberg did not dispute that people evaluate themselves differently in different domains, he took the stance that this heterogeneity is difficult to accurately assess and an overall assessment of one's feeling of self-worth as a person (i.e., global self-esteem), was seen as sufficient as a predictor of other important life outcomes. The question still stands as to whether or not this conceptualization of self-esteem is truly valid or useful. Not only can self-evaluations vary in different domains of functioning, high self-esteem has repeatedly been shown to be a heterogeneous construct (Baumeister et al., 2003). Thus, a unidimensional measure of global self-esteem, like the Rosenberg SES, might not capture the distinction between being conceited, narcissistic, or defensive, on one hand, as opposed to accepting oneself with accurate appreciation of one's strengths and worth, on the other.

Harter's SPPC: A critique. In their 1991 review article, Blaskovich and Tomaka noted that, while most work using the SPPC has been performed by Harter and her colleagues, the scale is promising as a useful and stable instrument for assessing children's self-concept. However, the authors also stated that additional work is necessary to establish the validity of the instrument. Over 20 years later, it appears as though the use of the Harter SPPC is more

widespread, but the lack of research showing the reliability and validity of the instrument is still a significant problem.

For example, while the measure has been shown to be internally consistent, there are virtually no data available pointing to the temporal stability of the test. As mentioned above, the test author does not recommend test-retest statistics as an index of reliability, namely due to self-perceptions changing over time and no test-retest correlations were found from outside sources. Is self-esteem so fragile and context-specific that scores on this measure would not remain consistent even over short periods of time? If so, then should researchers actually be using the SPPC as a measure of global self-esteem? Moreover, research showing the validity of the instrument (e.g., construct, convergent, discriminant, concurrent, or predictive validity) is essentially nonexistent. As noted above, the only evidence of convergent validity is in the form of unpublished data, which happens to be reported by the test author herself, rather than from a more objective, independent source. Regarding concurrent and construct validity, the current researcher personally contacted and corresponded with Harter via email and she responded to inquiries about the direct correlation between the SPPC and the Rosenberg SES by stating that she has come across some work correlating her Global Self-Worth scale with Rosenberg's instrument, but she does "not recall who did this work or where it was published" (S. Harter, personal communication, July 15, 2014). The current researcher found no such work. Given that Rosenberg's SES is the most commonly used—and accepted—self-report measure of self-esteem, the lack of research validating the SPPC against even the SES is a strong indication of the remarkable absence of established validity of this instrument.

Further, the external validity (i.e., generalizability) of the SPPC is questionable. Although the original standardization sample was large ($n = 1,553$ third- through eighth-grade boys and

girls), the diversity of the sample, with regard to a number of important socio-cultural factors

(e.g., geographic location, socioeconomic status, religion, nationality, ethnicity, etc.), is

unknown. Thus, it is unclear whether results drawn from that sample are truly generalizable to

other populations.

Chapter 4: Discussion

The primary goal of the current study was to survey the recent research literature in order to assess whether self-esteem, as it has been conceptualized historically, has important implications, both from clinical and social perspectives. Additionally, the current researcher set out to examine and evaluate the manner in which self-esteem has been defined and measured in the recent literature. These objectives were complicated by several factors: (a) the vast multitude of studies that discussed self-esteem; (b) imprecise and varied definitions and operationalizations of self-esteem; (c) widespread reliance on unreliable and poorly validated self-report measures; and (d) a variety of other methodological shortcomings identified within the literature.

Of particular interest to the current researcher were the following questions:

1. Despite the fact that the construct has been in existence for over 120 years, why does there continue to be a lack of consensus when it comes to defining and understanding self-esteem?

2. What have been some of the most salient problems with the existing research?

3. In light of the striking lack of empirical support for self-esteem being psychology's Holy Grail, why does our obsession with self-esteem persist?

4. Assuming that the construct of self-esteem is heterogeneous, where do the distinctions lie?

5. What are the clinical implications if we continue to misunderstand and misuse self-esteem?

The discussion begins with a summary of findings from the critical review of the literature and is followed by a detailed exploration of the aforementioned questions, applying a critical thinking perspective to the subject of self-esteem.

Summary of Findings and Critical Analysis

- Since the emergence of the self-esteem movement as a powerful social force in the 1970s, many Americans have come to believe that we suffer from a widespread low self-esteem epidemic.

- However, research clearly shows that we do not suffer from a low self-esteem epidemic. If anything we tend to overvalue ourselves, with the average American perceiving himself or herself as above average.

- The California Task Force to Promote Self-Esteem and Personal and Social Responsibility did not find the support they sought for their assumption that self-esteem plays a major causal role in determining a wide range of both positive and negative social behaviors. They also failed to conclude that programs designed to enhance self-esteem would have beneficial social effects.

- Despite the lack of empirical support that self-esteem plays a direct causal role in areas like academic and job performance, interpersonal relationships, or healthier lifestyles, countless efforts to boost self-esteem continue to be made by teachers, parents, and therapists alike.

- Moreover, some researchers have suggested that these efforts to raise self-esteem could potentially backfire and contribute to some of the very problems they were thought to thwart.

- One of the oldest concepts in psychology and ranking among the top three covariates occurring in personality and social psychology research, self-esteem has been conceptualized and defined in numerous ways (e.g., affective vs. cognitive vs. behavioral; stable vs. fluid; unidimensional vs. multidimensional) and by numerous individuals, representing a wide range of theoretical orientations.

- With multiple active definitions of self-esteem and very little consensus, it can be difficult to link definitions, theories, and research, creating confusion in the field.

- There are many available measures of self-esteem, the vast majority of which are self-report inventories, reflecting a variety of theoretical perspectives.

- Both methodological and conceptual problems combine to make valid, useful measurement of self-esteem difficult.

- Even the Rosenberg (1965) Self-Esteem Scale, which is by far the most commonly used and highly regarded instrument, has a number of flaws, including: susceptibility to socially desirable responding; overly simplifying the heterogeneity of self-esteem; and questionable long-term reliability, predictive validity, and external validity.

- In their seminal review, Baumeister et al. (2003) concluded that self-esteem is not a major predictor of most anything, with the exception of two main themes: (1) high self-esteem is linked to positive feelings (i.e., happiness), and (2) high self-esteem is linked to greater initiative.

- The current review of the literature since 2003 revealed similar findings on self-esteem and happiness, self-esteem and depression, and self-esteem and initiative:

    o Self-esteem and happiness are significantly, positively correlated. More specifically, self-esteem has been shown to be a significant predictor of happiness when compared to other predictor variables.

    o Self-esteem and depression are significantly, inversely correlated. Further, the relative predictive weight of self-esteem on depression has been shown to be greater than the predictive weight of depression on self-esteem.

    o With the exception of the relationship between high self-esteem and initiation of social interactions (e.g., romantic intimacy), the findings on the link between self-esteem and *initiative* were mixed at best, and virtually nonexistent at worst.

- The current review also yielded the following results:

    o Self-esteem has been linked to self-rated physical attractiveness; however, when more objective measures of physical appearance are compared to self-report data, people with high self-esteem do not emerge as any more attractive than people with low self-esteem. There is an inverse relationship between global self-esteem and body dissatisfaction.

    o People with high self-esteem rate themselves as more intelligent than they actually are and more socially skilled than others rate them to be.

    o Some research has shown a positive correlation between self-esteem and narcissism. The same researchers also found that narcissism was positively correlated with aggression.

- The research repeatedly attests to the heterogeneity of high self-esteem, and many researchers have invoked some distinction between being conceited, narcissistic, and defensive on the one hand, versus accepting oneself with an accurate appreciation of one's strengths and worth on the other.

- Overall, the research on self-esteem is plagued with a variety of conceptual and methodological problems. Some of these include: imprecise definitions and operationalizations, lack of external validity, reliance on unreliable and poorly validated self-report measures, haphazard instrumentation variance, failure to rule out the influence of third variables, concluding causal relationships based on research that

is primarily correlational, and claiming significant findings based on correlations that are not necessarily meaningful, substantive, or useful.

Applying a Critical Thinking Approach to Self-Esteem

Our judgment and decision making, although reasonably accurate much of the time, are frequently clouded by a vast array of cognitive biases and heuristics[22]. Further, there is widespread consensus that these biases and heuristics reflect the workings of basically adaptive processes that are misapplied in specific circumstances (Gigerenzer & Todd, 2002; Lilienfeld, Ammirati, & Landfield, 2009; Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2014; Shepperd & Koch, 2005; Tversky & Kahneman, 1974). Despite the considerable amount of psychological research that exists concerning the impact of these biases and heuristics on human judgment, psychologists have made far more progress cataloguing these biases than they have in finding ways to correct or prevent them (Lilienfeld et al., 2009). Moreover, although the field seems to be teeming with pleas to teach and disseminate critical thinking, which some researchers define as thinking intended to identify and overcome cognitive biases, relatively little research demonstrates that learned critical thinking skills generalize beyond the tasks or domains within which they are taught (Halpern, 2014; Lilienfeld et al., 2009). In fact, even among extraordinarily intelligent scholars, the capacity to think critically is surprisingly non-generalizable across disciples (see Feynman, 1985; Lykken, 1991). Could it be that the

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[22] It should be noted that, although biases and heuristics are closely related terms that are often confused with one another, they are distinct and separate concepts. A bias is a "prejudicial inclination or predisposition that inhibits, deters, or prevents impartial judgment" (e.g., cognitive bias, motivational bias; Levy, 2010, p. 264). A heuristic is a "mental shortcut or rule-of-thumb strategy for problem solving that reduces complex information and time-consuming tasks to more simple, rapid, and efficient judgmental operations, particularly in reaching decisions under timed conditions of uncertainty" (e.g., availability heuristic, representativeness heuristic; Levy, 2010, p. 270).

widespread epidemic from which we suffer is not of low self-esteem, but rather of insufficient critical thinking?

When reviewing the Summary of Findings and Critical Analysis above, one thing is certain: the body of existing work on self-esteem is undeniably characterized by its overwhelming deficiency in critical thinking. In his book, *Tools of Critical Thinking: Metathoughts for Psychology,* Levy (2010) defines and applies cognitive tools, which he calls metathoughts (literally, thoughts about thought), in order to provide readers with specific strategies for inquiry and problem solving.

The findings of the current investigation, as well as the findings of past scholars who have uncovered the problems and contradictions within the research, lead to a plethora of unanswered questions about self-esteem. In an effort to address and answer some of these fundamental questions, Levy's (2010) tools of critical thinking (*metathoughts*) are applied in a detailed discussion below.

1. Despite the fact that the construct has been in existence for over 120 years, why does there continue to be a lack of consensus when it comes to defining and understanding self-esteem? As discussed in Chapter 1, the term self-esteem can be traced back to 1890 and the work of William James (1983/1890). Following his early theoretical efforts, while the term was largely ignored for 75 years as a result of both academic and socioeconomic factors, a shift occurred in the 1960s, with the rise of wealth and consumerism. Along with these social and economic changes came the ability of the individual to see himself or herself at the center of his or her own destiny (Seligman et al., 2007), and thus what some call the self-esteem movement was born.

Not only did self-esteem grow to be one of the most prominent individual concerns in Western civilization, it has become a household word and even a widespread societal concern. North American culture in particular has come to embrace the idea that high self-esteem is not only desirable in and of itself, but also one of the central psychological sources from which all positive behaviors spring, and that low self-esteem, conversely, lies at the root of countless individual and societal problems (Baumeister et al., 2003). For nearly half a century, self-esteem has been viewed as the psychologist's Holy Grail (Baumeister, 2005).

Given the long history of the term, it is not surprising that many individuals have attempted to define it, creating confusion in the field. But if this term has been viewed as not only the psychologists' Holy Grail, but as a prominent concern of American individuals, educators, mental health professionals, and Westernized civilizations at large, why is it still so misunderstood? Why is there still a lack of consensus in the field about the very definition and nature of self-esteem? We have named it and we have certainly decided as a society that it is very important, but do we actually understand it? These questions will be addressed and discussed below from a critical thinking perspective.

The nominal fallacy and tautologous reasoning. In a world where descriptive labels are a fundamental and indispensable part of science and everyday life, it is important to remember that to name something does not necessarily mean to explain it. This error in thinking, called the nominal fallacy, typically involves circular or tautological reasoning. A tautology is a needless repetition of an idea or statement, using different words that essentially say the same thing twice (Levy, 2010). For example, People who like themselves have self-esteem; therefore, people who have self-esteem like themselves. When it comes to self-esteem and the field of psychology,

examples of the nominal fallacy and tautological reasoning are rampant in the daily conversations of clinicians, educators, and researchers alike. For example:

Why does that man not think well of himself?

Because he has low self-esteem.

How do you know he has low self-esteem?

Can't you see that he doesn't think well of himself?

For another example:

Why is that woman happy with who she is?

Because she has high self-esteem.

How do you know she has high self-esteem?

Look at how happy she is with herself!

It is important to remember, however, that these kinds of circular explanations are not explanations at all. To label someone as having high self-esteem or low self-esteem does not explain why they are happy or sad, why their interpersonal relationships are functional or dysfunctional, why they engage in healthy or unhealthy behaviors, or why they are successful or unsuccessful.

Consider the opposite. As mentioned previously, self-esteem has been conceptualized and defined in numerous ways (e.g., affective vs. cognitive vs. behavioral; stable vs. fluid; unidimensional vs. multidimensional) and by numerous individuals, representing a wide range of theoretical orientations. However, in order to truly define or understand any given phenomenon, its theoretical opposite should be addressed and explored (Levy, 2010). How can we understand what it means to have self-esteem if we don't know what the absence of self-esteem is? If we have not come to a consensus on the definition of self-esteem, how can we consider its

theoretical opposite? As these questions illustrate, Levy (2010) stated:

> To contrast a phenomenon with its polar opposite is to give definition to both terms. Just as thesis and antithesis can't be understood in isolation from each other, all the polar opposites are dependent upon one another for their very conceptual existence. (p. 31)

Conceptually speaking, just as we cannot understand good without bad, or light without dark, we cannot thoroughly define or understand self-esteem without addressing or grasping its theoretical opposite.

The evaluative bias of language. Two of the most salient functions that language serves are to help people describe various phenomena and to evaluate those phenomena. While most people assume that descriptions are objective and evaluations are subjective, whenever we attempt to describe something or someone, the words we use are almost always value laden, in that they reflect our own personal values and preferences. Therefore, our use of any particular term serves not only to describe, but also to prescribe what is desirable or undesirable to us (Levy, 2010). In the vast majority of cases, the distinction between objective description and subjective evaluation is far from clear, which can be illustrated through different uses of the term self-esteem. For example, one person might perceive another as having high self-esteem, connoting that he or she is confident, self-assured, and assertive, while another—with a different set of values and preferences, or from a different culture—might view that same person as pushy, narcissistic and overly ambitious. On the other hand, one might label someone as having low self-esteem, as being self-doubting, insecure, and anxious, while another person might label that very same person as deferential, humble, and respectful of authority. Therefore, the very use of the labels high self-esteem or low self-esteem are value laden, depending on one's own set of perspectives and beliefs.

2. What have been some of the most salient problems with the existing research? As summarized above, the research on self-esteem is plagued with a variety of conceptual and methodological problems. Some of these include: imprecise definitions and operationalizations, lack of external validity, reliance on unreliable and poorly validated self-report measures, haphazard instrumentation variance, failure to rule out the influence of third variables, concluding causal relationships based on research that is primarily correlational, and claiming significant findings based on correlations that are not necessarily meaningful, substantive, or useful. But, why, from a broader, conceptual standpoint, do we continue to make these same mistakes? With countless studies on self-esteem being performed and published in professional journals for over half a century, why do we continue to see some of the same problems with the research?

Whether we are setting out to solve problems, to control our environments, or simply to satisfy our curiosity, our need for understanding is a primary motivator in life. Unfortunately, however, because we tend to prefer explanations that are simple and easy to understand, we often settle for simple and uncomplicated at the cost of comprehensive and accurate (Levy, 2010). Below is a discussion of some of the broad, overarching problems that are salient in the existing studies that have sought to investigate and explain self-esteem.

Reactivity. As discussed in Chapter 3, given the ultimately subjective nature of self-esteem, the vast majority of research on self-esteem relies solely on self-report measures (Blascovich & Tomaka, 1991). While self-report may, in fact, be an efficient method of measuring self-esteem, self-report measures are associated with a whole host of potential biasing factors[23]. One of those biasing factors is reactivity, a phenomenon in which the conduct of

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[23] For a list of biasing factors associated with self-report measures, see Appendix A.

research or measurement, in itself, affects the very entity that is being studied. In other words, reactivity refers to the extent to which measuring something causes it to change (Levy, 2010). How much are subjects' responses to self-report measures of self-esteem altered by the biasing factor of reactivity?

Almost without exception, the moment subjects become aware that they are being studied, they develop expectations and hypotheses about the purpose of the study and how they may be expected to behave (Levy, 2010). Thus, once subjects are aware of being observed, they may be prompted to behave in ways that they believe to be socially desirable. For example, in an individualistic, Western culture where it is desirable to present oneself as high rather than low in self-esteem, one might be likely to—even unintentionally—respond to face-valid items accordingly, thereby inflating self-esteem scores. Alternatively, under some circumstances, sociocultural variables or variables such as the subject's level of cooperativeness, trust, or submissiveness, might affect the subject by responding to test items in a manner that deflates his or her self-esteem score. Moreover, simply asking subjects to think about self-esteem (e.g., by administering the Rosenberg Self-Esteem Scale) may stimulate them to consider the topic in a new way, or even prompt them to formulate an opinion when they previously had none. Therefore, due to the effects of reactivity, researchers using self-report measures of self-esteem are never really ever able to measure natural, authentic feelings or behavior, which invariably compromises the validity of their observations.

Correlation does not prove causation. As discussed at length in the critique sections of Chapter 3, while the links between self-esteem and a few other variables (e.g., happiness, depression) appear strong, the methodological shortcomings of the work that has been done thus far must be addressed prior to determining the exact nature of these relationships. With all of the

available research being based on correlational data, we must remember that the correlation between two variables is just that—a correlation, not necessarily causation. In other words, cause and effect cannot be proved simply by virtue of a correlation (Levy, 2010).

For example, low self-esteem is often considered to be an associated feature of eating disorders (e.g., anorexia and bulimia nervosa), along with negative or distorted body image. In fact, evaluation of body appearance has been shown to be significantly correlated with global self-esteem amongst both normal (Harter, 1999) and clinical populations (O'Brien & Epstein, 1988). However, these relationships do not prove the causal link (or links) between these two variables. A negative evaluation of body appearance might cause low self-esteem. Conversely, low self-esteem might cause a negative evaluation of body appearance. Further, low self-esteem and negative evaluations of body appearance may cause each other. Or, some other variables, such as family upbringing, environmental factors, or emotional variables (e.g., anxiety, depression) might cause both low self-esteem and poor evaluation of body appearance. Thus, while a high percentage of the studies discussed in Chapter 3 inappropriately imply a causal relationship between self-esteem and other variables, simply because of the statistically significant relationship shown between two variables, correlation does not necessarily establish a causal relationship between two variables.

Bi-directional causation. Typically, a causal relationship is thought of as being uni-directional, while oftentimes the causal relationship between two variables is bi-directional (Levy, 2010). Take, for example, certain popular beliefs about the relationship between self-esteem and popularity, namely that people with high-esteem are more popular than people with low-esteem. It is certainly plausible that high self-esteem might improve interpersonal relationships. Assuming that, perhaps, high self-esteem does cause a person to be more likeable

or attractive insofar as people might prefer to be around confident, outgoing individuals and avoid interacting with people who are insecure, the reverse causal relationship could also be possible, which is illustrated by Leary's *sociometer theory* of self-esteem. According to this theory, self-esteem evolved in order to monitor social acceptance and avoid social rejection. In other words, self-esteem is an internal measure of one's interpersonal appeal and success and virtually all influences on self-esteem involve factors that have real, potential or imagined implications for the individual's acceptability to other people (Leary, 2006; Leary & Baumeister, 2000; Leary, Tambor, Terdal, & Downs, 1995; Leary & Downs, 1995). Therefore, popularity, according to this model, would cause self-esteem to rise, while social rejection would cause it to decrease. It is important to remember that cause and effect are relative terms, with cause in one instance becoming effect in another. In other words, it is not a question of whether popularity causes self-esteem or self-esteem causes popularity because both statements are likely true. Therefore, from this perspective, attempting to understand which phenomenon came first, in many instances, may be irrelevant and unanswerable (Levy, 2010).

Multiple causation. Practically every behavior has multiple determinants. Any single explanation is almost invariably an oversimplification (Levy, 2010). For example, what causes overeating? Is it feelings of stress and tension? Or early childhood trauma? Or growing up with critical parents? Or depression? Or a malfunctioning hypothalamus? Or low levels of serotonin? Or loneliness? Or body dissatisfaction? Or—of course, always a favorite—low self-esteem? The reality is that any given effect may be—and typically is—the result of not just one single cause, but numerous causes that are functioning together. Oftentimes, the question of what's the cause of a particular phenomenon can be misleading in that it suggests that there is a single cause of

that event. Rather than a matter of *either-or,* the question of causation is usually a matter of *both-and*.

Taking into account the principle of multiple causation might help to explain why the California Task Force to Promote Self-Esteem and Personal and Social Responsibility failed to confirm their hypothesis that low self-esteem is "*the* [emphasis added] causally prior factor in individuals seeking out kinds of behavior that become social problems" (Mecca et al., 1989, p. 8). Not only has research shown that self-esteem does not have a direct causal effect on almost anything (Baumeister et al., 2003), the lack of conceptual clarity and consensus in the field on a definition of self-esteem suggest that the findings on *what causes self-esteem* are about as unclear as the findings on *what self-esteem causes*.

What does cause low self-esteem? Is it an unhappy childhood? Or critical parents? Or poor academic performance? Or ongoing relationship problems? Conversely, what causes high self-esteem? Is it the result of one's supportive upbringing? Or loving parents? Or is it genetic resiliency? Or is it the result of one's life successes—academic, occupational, financial, or interpersonal success? The existing research findings that have sought to answer these questions are hazy at best, likely because no single cause alone produces the effects in question. Instead, they are a result of multiple factors interacting with one another, a principle that many researchers of self-esteem have failed to explicitly address.

3. In light of the striking lack of empirical support for self-esteem being psychology's Holy Grail, why does our obsession with self-esteem persist? Despite the lack of empirical support that self-esteem plays a direct causal role in any objective outcomes, and in spite of the weaknesses of the correlational data, countless efforts to boost self-esteem continue to be made by teachers, parents, and therapists alike. What is more, our culture still seems to be

characterized by this self-esteem obsession, as the quest to raise self-esteem continues to be both an individual fixation and a national preoccupation, as evidenced by the multitude of self-help books, the popular psychology articles, talk shows, and advertisements that continue to center around boosting self-esteem. But why does this pervasive fascination with self-esteem continue? The following is a discussion of various metathoughts, which might help to explain, in part, why the fascination and obsession with self-esteem persist.

The Barnum effect. The famous circus master P. T. Barnum was reputed to have said: A good circus should have a little something for everybody. This infamous saying led to the term Barnum statement, which can be defined as a description or interpretation of personality about one particular person or group that is true of practically all human beings. In other words, the statement is vague and general enough to apply to a wide range of people, and subsequently, has a little something for everyone. The Barnum Effect can be described as one's willingness to accept the validity of such wide-ranging, generic interpretations (Levy, 2010). This error in thinking is often cited as a partial explanation for the widespread acceptance of such practices such as astrological horoscopes, fortune telling, and some types of personality tests.

In his book on critical thinking, Levy (2010) provides a number of examples of Barnum statements that are all too often used by psychotherapists and other mental health professionals, one of which is My client's problem is that he has self-esteem issues. (Who *doesn't?*) Although such Barnum statements might, and usually do, have prima facie validity, they are not typically useful in describing anything distinctive about a particular individual or group. This point is especially important to remember when it comes to clinical diagnosis and treatment planning. In other words, part of the reason that the fascination and focus on self-esteem persists, regardless of how widely the term is misunderstood in the field, is that statements about individuals' self-

esteem issues are often so generic and overly inclusive that they can be true of practically all human beings. Thus, at first glance, they seem to be valid, resulting in people continuing to accept them uncritically and clinicians continuing to "delude themselves into believing the veracity of their own pseudo-incisive personality interpretations" (p. 61).

The fundamental attribution error. Nearly all significant behaviors can be attributed to multiple determinants (see discussion of multiple causation above) that vary in the degree to which they are responsible for causing a person's actions (Levy, 2010). However, in arriving at causal attributions, we have a tendency to weigh internal determinants (i.e., personality traits, characteristics, attitudes) too heavily, and external determinants (i.e., one's circumstances, surroundings, environment) too lightly. This attributional bias leads us to minimize or ignore the importance of the particular situations within which people find themselves and to explain the behavior of others as resulting predominately from their personalities.

For instance, we attribute people's behavior to his or her level of self-esteem while overlooking a number of situational factors that also could account for his or her behavior. Consider a person who goes to a job interview and comes across as lacking confidence. Due to the fundamental attribution error, the interviewer might be likely to label the interviewee as having low self-esteem. But the circumstance itself may have been very stressful, resulting in the observed behavior. Conversely, a person who generally struggles with low self-esteem might be judged as being confident and outgoing at a party while under the influence of alcohol. As observers, we might be inclined to attribute such behavior to an inherent disposition, essentially disregarding situational factors that could be responsible for producing these behaviors (i.e., social setting and inebriation). This tendency to weigh internal determinants too heavily, and external determinants too lightly—which can be especially problematic when it leads us to

ignore important sociocultural factors that shape behavior—is likely another reason that the self-esteem obsession persists.

      The if I feel it, it must be true fallacy. Oftentimes, we rely on our subjective experiences of emotional comfort or discomfort, which are largely based on knee-jerk reactions to somatic or physiological sensations, as gauges for differentiating what is true from what is false. In other words, we tend to use our feelings as the basis on which we formulate subjective judgments of events surrounding us. But are our feelings about events valid gauges of veracity? In point of fact, what feels good is not necessarily true or correct, and what feels bad is not necessarily incorrect (Levy, 2010).

      Might these points shed some light as to why the pervasive quest to boost self-esteem persists in our society? The research has shown time and again that having self-esteem will not necessarily make people perform better in school or at work, nor will it bring about better relationships with others, nor will it end problems associated with violence and aggression, nor will it ensure that people engage in healthier lifestyle behaviors. However, the research also shows that high self-esteem is linked to happiness and, therefore, it feels good. So, why does the quest to boost self-esteem persist in the field of psychology and in Western society at large? Could it just be that self-esteem happens to feel good? Is high self-esteem such a feel-good phenomenon that we are willing to overlook the astounding lack of support for the notion that we should continue to boost self-esteem indiscriminately amongst our patients, our students, our children, and our peers? More broadly, is it possible that the very existence of the construct and just believing in self-esteem makes us feel good? As a construct, in and of itself, self-esteem is simple, easy for nearly everyone to understand, and internally based (see discussion of fundamental attribution error above). Thus, it is something that seems manageable and

controllable, which holds out the hope (false or otherwise) that we can actually *do* something about it.

  The assimilation bias. As human beings, we have an innate tendency to classify, organize, group, type, or otherwise structure the world around us into categories, which we conceptualize as mental representations or *schemas*. While this inclination does have helpful attributes in terms of organizing information and processing data, it can also become a problem because we tend to overlook, misconstrue or even reject valid information when it is not consistent with our existing schemas (Levy, 2010). With the self-esteem movement having found its way into mainstream psychotherapeutic, educational, and occupational practices, is it possible that we all so accustomed to viewing things through the self-esteem lens that we simply do not question whether or not it is valid? If we are inclined to make data fit into our schemas (*assimilation*) versus modifying them in order to fit new data (*accommodation*), this common cognitive bias could have a lot to do with our propensity to overlook the tremendous amount of evidence that contradicts our common assumptions about self-esteem. Moreover, because of the remarkable pervasiveness of the term in our culture, we may have become accustomed to viewing the world through self-esteem colored glasses, making it easier to view every problem, irrespective of its nature or cause, as a self-esteem issue, versus modifying our existing schemas to account for contradicting data.

  The belief perseverance effect. Over the course of a lifetime, we develop a wide range of different beliefs, the content of which ranges from the most ordinary to the most profound. One of the most significant characteristics of our beliefs is the degree to which we become emotionally attached or invested in them. The more personally invested we are in our beliefs, the more likely we are to cling to them, even in the face of contrary evidence, a bias in thinking that

is referred to as the belief perseverance effect (Levy, 2010). But what happens when our beliefs are challenged? Particularly those beliefs we happen to like or those we have come to accept as truths? The more emotionally attached we are to our beliefs, the more we are prone to feel personally criticized, and even threatened, when our beliefs are being challenged. In our Western, individualistic society, beliefs about the importance of high self-esteem are not only widely accepted, but as research has shown, high self-esteem feels good. Therefore, it is highly likely that our emotional investment in these beliefs about self-esteem contributes significantly to our tendency to discount, deny, or simply ignore any information that runs counter to them.

The availability bias. In everyday life, we are consistently called upon to make rapid judgments and draw conclusions under circumstances that may not lend themselves to thoroughness or accuracy. Thus, while the ideal strategy to make certain judgments might involve a complete systematic analysis of the issue at hand, we typically do not have the luxury of conducting such analyses and must rely on the use of a variety of mental shortcuts or heuristics. Because we are limited in our capacity to process complex information accurately, we often draw on instances that are easily accessible or available from our memory, a specific cognitive strategy that has been termed the availability heuristic (Tversky & Kahneman, 1973).

If examples are readily available in our memories, we tend to overestimate the frequency of those phenomena. Conversely, if we are unable to quickly recall examples of a particular phenomenon, we are quick to assume that it is uncommon. However, there are numerous biasing factors that affect the availability of particular events in our memories (e.g., life experience, cultural background, level of education). When the use of the availability heuristic to make judgments results in systematic errors, we may refer to this phenomenon as the availability bias (Levy, 2010).

In his book, *House of Cards: Psychology and Psychotherapy Built on Myth*, Dawes (1994) strongly criticizes New Age psychology for the widespread belief that all human distress can be traced to deficient self-esteem. As part of his discussion, he mentions how the availability bias affects psychotherapists in reaching conclusions about self-esteem. Namely, if psychotherapists are seeing people who have psychological problems everyday and many of those people do not feel good about themselves (a common motivation to seek therapy), therapists might be quick to link psychological problems to poor self-esteem simply because of the availability of such examples in their memories[24]. Of course many people who behave in personally or socially destructive ways may suffer from low self-esteem, and low self-esteem can be considered a psychological problem in and of itself. However, that does not necessarily mean that poor behavior is necessarily traceable to low self-esteem or that good behavior is traceable to high self-esteem. Further, the term self-esteem pervades our culture. Information and endorsements of high self-esteem are so accessible to us at any given moment—on our news programs, within our literature, on our television shows, in movies, in our classrooms, and within clinical settings—the availability bias may lead us to overestimate the ubiquity and importance of self-esteem simply because we are inundated with it.

The confirmation bias. As discussed above, we are constantly faced with a multitude of obstacles that can obstruct our ability to reach valid and trustworthy conclusions when attempting to explain complex phenomena. Unfortunately, because we are consistently faced with such an overabundance of information, the manner in which we actually gather information is far from unbiased. Specifically, we tend to selectively gather information consistent with our

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[24] In addition to the availability bias, this example is also an illustration of *illusory correlation,* a cognitive bias that can be defined as a bias in which one's judgments are based on the relation one expects to see even when no such relationship exists (Chapman & Chapman, 1967; Hilbert, 2012).

prior expectations, or evidence that will confirm our own beliefs, and we are much less likely to seek evidence that will refute them. Our propensity to gather information in this way is called the confirmation bias (Levy, 2010). Confirmation bias can lead us to draw distorted conclusions regarding evidence that runs counter to our views and lead us to seek out evidence in a self-fulfilling manner (Lilienfeld et al., 2009).

In a recent article on why ineffective psychotherapies appear to work, Lilienfeld et al. (2014) assert that confirmation bias can predispose clinicians to attend to hits and forget the misses, thereby overestimating the extent to which their interventions are associated with ensuing improvement. Further, confirmation bias can foster a propensity toward illusory correlation, which can be defined as the perception of a statistical association in its absence (Chapman & Chapman, 1967). Therefore, with regard to the persistence and survival of our popular assumptions about self-esteem, part of the reason for our continual disregard of contradictory evidence may very well be a result of this common cognitive bias. As researchers and clinicians, we may be unknowingly gathering data and eliciting information that affirms our common misconceptions about self-esteem, causing us to cling to the same conclusions that have been refuted by the evidence time and again.

4. Assuming that the construct of self-esteem is heterogeneous, where do the distinctions lie? What constitutes self-esteem is a fundamental question that has concerned personality and clinical psychologists for decades. The research repeatedly attests to the heterogeneity of self-esteem, and many theorists have invoked some distinction between being conceited, narcissistic, and defensive on the one hand, versus accepting oneself with an accurate appreciation of one's strengths and worth on the other. Generally speaking, high self-esteem has been viewed as involving positive feelings of self-worth, self-liking, and acceptance, while low

self-esteem is typically seen as reflecting negative feelings of self-worth, self-dislike, and lack of self-acceptance. The current consensus is that self-esteem falls along a continuum, from true or optimal to unauthentic or contingent (Crocker & Wolfe, 2001; Deci & Ryan, 1995; Kernis, 2003a).

The heterogeneity of self-esteem has been conceptualized in a number of different ways over time. For example, Schneider and Turkat (1975) hypothesized that high self-esteem can either be genuine or defensive and concluded that individuals with defensive high self-esteem can be identified if they score high on the Marlowe-Crowne Social Desirability Scale, in addition to scoring high on the Rosenberg Self-Esteem Scale (Crowne & Marlowe, 1960). Approaching the heterogeneity of self-esteem from a different standpoint, Kernis and Waschull (1995) provide evidence that a full understanding of self-esteem requires consideration of both the level and temporal stability of self-esteem. As an example of a theory that has sought to explain the heterogeneous nature of the construct, *self-determination theory* distinguishes between two different types of high self-esteem: contingent self-esteem (i.e., sense of self-worth based on the introjection of externally defined standards) and true self-esteem (i.e., sense of self-worth experienced as inherent or given), with the latter being considered more optimal (Deci & Ryan, 1995).

Kernis and Goldman (1999) described self-esteem in terms of fragile versus secure forms that vary along four theoretical components: stability, contingency, congruence, and defensiveness. In other words, secure self-esteem is characterized by positive feelings of self-worth that: (a) show minimal short-term variability (stable), (b) arise from satisfying core psychological needs versus attaining specific outcomes (true), (c) are consistent with positive implicit feelings of self-worth (congruent), and (d) are open to recognizing negative aspects of

the self (genuine). On the other hand, fragile self-esteem is characterized by feelings of self-worth that: (a) exhibit significant short-term fluctuations from day-to-day (unstable); (b) depend upon achieving specific outcomes (contingent); (c) are conflicting with implicit feelings of self-worth (incongruent); and (d) reflect an unwillingness to admit to negative feelings of self-worth (defensive; Kernis & Goldman, 1999).

Another approach to examining the heterogeneity of self-esteem is to consider the construct of narcissism or narcissistic personality disorder, which is associated with a highly favorable, even grandiose sense of self-importance, need for admiration, sense of entitlement, fantasies of personal brilliance or beauty, arrogance, and lack of empathy (see American Psychiatric Association, 2013). The heterogeneity of self-esteem is indicated by the finding that some people who score high on measures of self-esteem are narcissistic, whereas others are not, but the reverse is not true (i.e., narcissists typically do not score low on measures of self-esteem) (Baumeister et al., 2003). Further, research has shown that the high self-esteem of narcissists' tends to be unstable (Rhodewalt &, Madrian, & Cheney, 1998) and self-defensive (Paulhus, 1998).

Taken together, these lines of research imply that the category of people with high self-esteem is a mixed bag of individuals whose self-concepts and feelings of self-worth differ in important ways (Baumesiter et al., 2003). Below is a discussion of three metathoughts that should be considered in understanding the heterogeneous nature of the construct and determining where the distinctions lie within this mixed bag.

The evaluative bias of language. As noted above, the words we use are almost always value laden, in that they reflect our own personal values and preferences. Thus, our use of any particular term serves not only to describe, but also to prescribe what is desirable or undesirable

to us (Levy, 2010). This concept, referred to as the evaluative bias of language, should be considered not only in terms of how we define self-esteem, but also in examining the heterogeneity of the term. As discussed above, the research repeatedly attests to the heterogeneity of high self-esteem, but where do the distinctions lie and how much of the distinctions are in the eye of the perceiver? Regardless of the descriptive words one chooses, whether it be narcissistic, arrogant, optimal, defensive, fragile, or true, it is imperative that we be aware of our own personal values and communicate these values as openly and fairly as possible, as opposed to presenting our value judgments as objective reflections truth.

Further, many believe that concerns about self-esteem are idiosyncratic features of Western individualistic cultures. Therefore, the quest for high self-esteem is not a universal human motive, according to this perspective, but differs based on socio-cultural factors. For example, in collectivistic cultures (e.g., Japanese, South American, or some African cultures), this motivation to have high self-esteem is virtually nonexistent (Heine, Lehman, Markus, & Kitayama, 1999). Even within Western civilization, cultural differences exist based on a number of socio-cultural factors (e.g., gender, ethnicity, sexual orientation, age). Moreover, some research has focused on the fact that the need for high self-esteem seems to be a relatively recent development in Western culture. For example, the Judeo-Christian tradition, which has long reigned supreme in Western society, has historically considered excessive self-love to be suspect because it leads to sentiments of self-importance and arrogance, as opposed to modesty and humility, which are virtues believed to be conducive to spiritual growth. These examples are a reflection of the fact that, regardless of intent, the descriptive words we choose—especially regarding people—are invariably value laden. In coming to a consensus on where the distinctions lie within the heterogeneous category of self-esteem, we must be aware of this evaluative bias.

Differentiating dichotomous variables and continuous variables. Dichotomous variables can be divided into two mutually exclusive or contradictory categories, whereas continuous variables consist of a theoretically infinite number of points lying between two polar opposites (Levy, 2010). Self-esteem is a pertinent example of a continuous variable that is often confused as being dichotomous. How often are psychotherapists and social science researchers guilty of referring to individuals as either having self-esteem or not having self-esteem? Most person-related phenomena, especially psychological constructs, are frequently presumed to fit into dichotomous categories or types, when they actually belong on a continuum (Levy, 2010). For example, having self-esteem is not the same as being pregnant or being alive. A person is either pregnant or not pregnant, dead or alive. Self-esteem, however, as the research has repeatedly suggested, is a heterogeneous construct and a variable that is more appropriately represented on a continuum as opposed to in two separate categories.

Their conceptual and methodological shortcomings notwithstanding, the most widely used assessments of self-esteem rightfully do, in fact, depict self-esteem as a continuous variable. For example, although the Rosenberg (1965) Self-Esteem Scale is a unidimensional scale of self-esteem (i.e., a measure of global self-esteem), it is scored using a four-point response format, resulting in a scale range of 0–30, with higher scores representing higher self-esteem. The subject's self-esteem score subsequently lies somewhere on a continuum rather than falling within one of two distinct categories. However, regardless of the fact that such scales are typically used to measure self-esteem in formal research settings, it continues to be regarded as a dichotomous variable across a number of contexts, including popular psychology and clinical settings. In the vast majority of situations, continuous variables are more accurate and therefore more useful representations of the phenomena we are attempting to describe and explain (Levy,

2010). Thus, as we move towards conceptualizing self-esteem more accurately, it is important that we remember that it is not a dichotomous (black or white) variable, but rather it is continuous, representing countless shades of gray.

The similarity-uniqueness paradox. Determining the similarities and differences between any set of events depends almost entirely upon the perspectives from which one chooses to view them. In other words, all phenomena are both similar to and different from each other depending on the variables or dimensions that have been selected to compare and contrast (Levy, 2010). For example, astronomy and astrology are similar in that they both involve the study of celestial objects such as stars, planets, and moons. However, if we look at the two constructs from a scientific perspective, they are also very different. Astronomy is a well-respected branch of the natural sciences, whereas astrology has largely been rejected by scientific communities and categorized as a pseudoscience. To look at another example, methamphetamines are similar to caffeine in that they are both addictive, stimulant drugs. However, from a legal perspective, they are different because meth is illegal and caffeine is not.

Keeping these principles in mind, how are self-esteem, self-efficacy, and narcissism the same? How are they different? All three constructs are similar in that they involve some sort of positive self-appraisal, they can all be considered parts of one's self-concept, and, moreover, they can all be represented on a continuum versus in dichotomous categories. However, self-esteem and self-efficacy are typically judged positively in Western society, whereas narcissism is looked down upon. Narcissism, from a clinical standpoint, is pathological, while many people aspire to obtain self-esteem and self-efficacy. Conceptually, self-esteem is, more often than not, defined with a focus on affect (i.e., how one feels about himself or herself), whereas self-efficacy is typically defined with a focus on thoughts and cognition (i.e., one's beliefs about his or her

ability to complete tasks or reach goals). Thus, as we attempt to determine, describe, and explain where the distinctions lie within the heterogeneous concept of self-esteem, it is important to keep this principle in mind: the dimensions or variables selected for the purposes of evaluation will determine just how similar or unique the various types or categories of self-esteem turn out to be.

5. What are the clinical implications if we continue to misunderstand and misuse self-esteem? Despite the striking lack of empirical support that self-esteem plays a direct role in any outcomes other than feeling good, the pursuit of self-esteem continues to be a central preoccupation of North American culture. Thousands of books offer strategies to increase self-esteem, childrearing manuals coach parents on how to raise children high in self-esteem, and schools across the United States continue to implement programs aimed at raising self-esteem, all in hopes of reducing an array of problematic feelings and behaviors. Even since the publication of the widely cited review article by Baumeister et al. in 2003, which was the first large scale study to assert that the objective benefits of high self-esteem are small and limited, well over 8,000 journal articles on the subject of self-esteem have been published.

Some might be inclined to ask, *why not* continue to boost self-esteem? If it feels good and it appears to be linked to happiness, what do we have to lose by continuing to strive for it? In addition to the immediate emotional benefits of validating people's self-worth, striving for the recognition and acknowledgement that enhance self-esteem might even result in people accomplishing great things. What could be the harm in that?

While there is some validity to these points, we must not ignore the ever-increasing amount of recent literature that has focused on the ensuing costs of having or even pursuing high self-esteem. A general discussion of some of these potential costs is below, followed by a discussion of six tools of critical thinking associated with these clinical implications.

Having high self-esteem: Potential costs[25]. While having high self-esteem has at least short-term emotional benefits (e.g., positive emotions and certain self-concepts), some research has shown that it also has both immediate and long-term costs (Crocker, 2006). For example, some studies have shown that people with high self-esteem are more likely to persist in the face of failure, which could be seen as a positive quality under some circumstances (Baumeister et al., 2003). However, when failure is unavoidable, does persistence always pay? Baumeister, Heatherton, and Tice (1993) showed that, under ego threat (i.e., any event or communication that has unfavorable implications for the self), individuals with high self-esteem are overconfident and take unwarranted risks, sometimes losing money as a result. Also, while having high self-esteem might have emotional benefits for the self (i.e., feeling good), it might not be as beneficial for other people. For example, under conditions involving ego threat, individuals with high self-esteem become less likeable, while those with low self-esteem have been shown to become more likeable (Heatherton & Vohs, 2000; Vohs & Heatherton, 2001). Further, the positive self-concepts of individuals with high self-esteem can lead them to become hostile, defensive, and blaming when things go badly (Blaine & Crocker, 1993).

As discussed above, people with high self-esteem also tend to overestimate their intelligence, likeability, and attractiveness. Therefore, they may be less realistic about their strengths and weaknesses than people who score lower on measures of self-esteem (Taylor & Brown, 1988). These *positive illusions,* which were mentioned briefly in a footnote in Chapter 3, can be defined as overly positive self-perceptions or exaggerated perceptions of control or mastery. Depending on circumstance, positive illusions can be helpful or unhelpful. For example,

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[25] In her essay on the costs and benefits of self-esteem, Crocker (2006) makes the distinction between having self-esteem (i.e., measuring high in trait self-esteem) and pursuing self-esteem (i.e., taking steps to boost the magnitude of self-esteem). This same useful and important distinction is made in the current study.

the overly positive self-views of a person with high self-esteem might be helpful when it comes to someone asking his or her boss for a raise, but might be unhelpful and interfere with receiving and understanding feedback about areas one needs to improve when a raise is pending. In other words, these positive illusions (e.g., focusing on one's strengths and minimizing one's weaknesses) often foster positive mood, optimism, and perseverance. However, when one's weaknesses are interfering with accomplishing a goal and could be addressed, the overly certain self-views related to high self-esteem might obscure addressing the weakness and, subsequently, impair accomplishing the goal (Crocker, 2006). Thus, perhaps the self-serving illusions that bolster self-esteem and produce a positive mood in the short run ultimately set people up for disappointment and failure in the long run, due to negative feedback being largely ignored when it comes to setting goals, making decisions, and planning (see Janoff-Bulman & Brickman, 1982; Weinstein, 1984). Moreover, mildly depressed people and those low in self-esteem have been shown to make more balanced and unbiased assessments about the future than normal (i.e., non-depressed) individuals (Ruehlman, West, & Pasahow, 1985; Taylor & Brown, 1988). Thus, although in some cases, such patterns may reflect the pessimism, which is characteristic of depressed people, it appears that those who are high, not low, in subjective well being have more biased perceptions of the future (Taylor & Brown, 1988).

Regarding self-esteem predicting behavioral outcomes, Baumeister and his colleagues (e.g., Baumeister, 1993; Baumeister et al., 2003; Baumeister et al., 1996) found that behaviors are often more variable for people high in self-esteem than for people low in self-esteem. For example, high self-esteem is associated with both the presence *and* absence of aggression or violence. On the other hand, the assumption that low self-esteem is linked to violence has not been supported by evidence. In fact, signs of low self-esteem, such as modesty, self-deprecation,

and self-effacing mannerisms, seem to be rare (underrepresented) among violent criminals and aggressors (Baumeister et al., 1996).

Kernis, Grannemann, and Barclay (1989) found that people with high but unstable self-esteem score higher on measures of hostility than people with low self-esteem (whether stable or unstable). People with high but stable self-esteem were shown to be the least hostile. Thus, with regard to the question of possessing high self-esteem, it seems evident that secure or stable high self-esteem is preferable to fragile or unstable self-esteem. Nonetheless, while having high self-esteem feels good to the individual, it has been shown to be associated with potential negative outcomes as well.

Pursuing high self-esteem: Potential costs. According to much of the research that has been discussed, many of us (at least here in the United States) seem to be stuck in a relentless pursuit of self-esteem, regardless of whether it has been empirically shown to be useful. What might be some of the benefits and costs of this relentless pursuit? When the quest is successful, boosting self-esteem has been shown to have immediate emotional and motivational benefits (Crocker, 2006). However, the pursuit of self-esteem itself may paradoxically lower self-esteem more than it raises it. In other words, when people seek self-esteem, they often create the opposite of what they intend to, and inflict costs on others around them as well. When some people pursue self-esteem, success can mean not only I succeeded, but also, I am worthy. Therefore, failure does not just mean I failed, but also, I am worthless. Thus, when people succeed in a particular domain, one in which their self-worth is invested, they experience intense positive emotions, but when they fail they experience intense negative emotions (Crocker & Park, 2004).

Outside of the inherent negative emotions that can ensue, the pursuit of high self-esteem has been shown to interfere in several other areas of functioning, such as learning and mastery (Covington, 1984; Deci & Ryan, 2000; Dweck, 1999). For example, when self-worth is at stake, people typically want to avoid failure, even if doing so undermines learning. Covington (1984) showed that students with contingent self-worth in the academic domain reported that they would be willing to cheat if they were unable to succeed at a task, a reaction entirely focused on maintaining or pursuing self-esteem, rather than learning from experience. When the primary goal is self-validation, then mistakes, failures, or any negative feedback are perceived as self-threats versus opportunities to learn and improve.

The pursuit of self-esteem has also been shown to have detrimental effects on relationships. From an interpersonal perspective, when people pursue self-esteem, relatedness can be hindered because they are focused more on themselves at the expense of others' needs and feelings. Some people pursuing self-esteem tend to want to be superior to others (Brown, 1986; Taylor & Brown, 1988). According to Crocker and Park (2004), when self-esteem is the goal, life becomes a zero-sum game, with other people being perceived as competitors and enemies rather than supports and resources. Responding to self-esteem threats with avoidance, distancing, and withdrawal, or with blame, excuses, anger, antagonism, and aggression is incompatible with relatedness (i.e., caring for or being cared for by others; Baumeister, Bushman, & Campbell, 2000; Baumeister et al., 1996; Crocker & Park, 2003; Heatherton & Vohs, 2000; Kernis & Wachull, 1995; Tice, 1993). Studies have shown that the pursuit of self-esteem can cause people to be less attuned to the needs and feelings of others (Crocker & Park, 2003; Crocker, Lee, & Park, 2004) and that people with high self-esteem sacrifice mutually caring relationships with others for the sake of maintaining, enhancing, and protecting self-

esteem through achievement (Baumesiter et al., 1996; Heatherton & Vohs, 2000; Vohs & Heatherton, 2001).

Some people pursue high self-esteem through avenues such as being accepted, included, and liked by others, a pattern ironically considered more characteristic of people with low self-esteem. At first glance, this strategy for pursuing high self-esteem might seem congruent with successful interpersonal relationships. However, research has shown that people who base their self-esteem mainly on the approval and regard of others tend to have poor relationships and behave in ways that make their relationships worse over time (e.g., excessive reassurance seeking; Murray, Holmes, Griffin, Bellavia, & Rose, 2001). Rhodewalt and Tragakis (2002) have coined the term *self-solicitation* to refer to the strategic behaviors involved in seeking the social feedback with the goals of maintaining, boosting, or protecting self-esteem. Such strategies often accomplish the intended goal in the short-term. However, because the self-solicitor is aware, at some level, that the feedback was solicited, it serves to sustain his or her own uncertainty, resulting in the person being caught in an unending cycle of self-evaluation and self-esteem regulation (Morf & Rhodewalt, 2001; Rhodewalt, 2006; Rhodewalt & Tragakis, 2002).

Moreover, according to a review of methods for boosting self-esteem by Wood, Anthony, and Foddis (2006), not all techniques of striving for high self-esteem are created equal. The authors concluded that methods empirically demonstrated to raise self-esteem are scarce and it is unclear whether they have a lasting impact. However, one feature that methods shown to be effective in raising self-esteem (at least short-term) have in common, is that they do not automatically instigate self-evaluation processes. Despite the popular North American belief that people benefit from positive self-statements (e.g., self-help books encouraging the use of positive self-affirmations), when people with low self-esteem repeat highly positive self-statements, their

moods, their feelings about themselves, and their self-related thoughts actually become *worse*, not better (Wood et al., 2006). Because methods involving self-evaluation involve focusing attention on the self (Crocker & Park, 2004; Leary 2004), this self-focused attention often results in intensification of one's emotional state, disruption of social functioning, and intensification of attention to one's standards, all of which can actually have opposite than the desired effect (e.g., for an individual with low self-esteem). Therefore, with regard to the actual pursuit of high self-esteem itself, self-evaluative methods (i.e., those involving focusing attention on the self) for boosting self-esteem can actually backfire and make a situation worse.

While further research is needed to explore the aforementioned potential costs of having and pursuing high self-esteem, the existing research has shown enough evidence to warrant some serious concerns when it comes to indiscriminately boosting self-esteem. The following is a discussion of the tools of critical thinking that are most pertinent to understanding the clinical implications associated with misunderstanding or overlooking what research has revealed about self-esteem.

The reification error. The reification error is a common error in thinking that occurs when conceptualizing phenomena. To reify is to invent a concept (or construct), name it, and then treat the concept as though it objectively exists in the world. Levy (2010) used self-esteem as a primary example of an abstract concept that is frequently regarded as if it were a concrete thing. He wrote that it is easy to forget that self-esteem is not something that someone actually has (although many people regard it has such). Rather, it is a concept that we have created to help us organize and make sense out of other people's (as well as our own) behavior. Unfortunately, however, many persist in reifying this construct, for instance, by advising others, "'Your self-esteem is too low, you need to get more of it'—as if self-esteem were some kind of

commodity that can be purchased at your local automotive supply store" (p. 9). Countless

clinicians and educators within the field of psychology are guilty of committing this common

error in thinking when it comes to discussions on self-esteem, as well as a myriad of other

popular constructs (e.g., the mind, the unconscious, personality, motivation, ego strength, etc.).

Outside of sparking an interesting semantic discussion, why is it important to clearly

distinguish between self-esteem being a concrete thing versus an abstract concept? As mentioned

above, in the pursuit of self-esteem, if success means not only I succeeded, but also, I am worthy,

and, therefore, failure does not just mean I failed, but also, I am worthless, this error in thinking

could be more costly to the individual than one might assume at first glance. In other words, if

we continue to understand and treat self-esteem as though it is a thing that objectively exists in

the world, people will continue to pursue the attainment of self-esteem to no avail. Being stuck in

a relentless pursuit of something that does not objectively exist is likely to be experienced as

failure, which paradoxically could lead to even lower levels of self-esteem. On the other hand,

understanding self-esteem for exactly what it is, a human-made construct—fragile and

imperfect—is likely more conducive to an appropriate, manageable understanding of one's self-

directed feelings. As Levy (2010) notes, in the final analysis, the construct of self-esteem should

be evaluated not in terms of whether it is true, but rather to what extent it is *useful*.

The naturalistic fallacy. As mentioned above, our perceptions and, therefore, our

descriptions of the world are inescapably affected by our personal beliefs. We tend to equate our

descriptions of what is with our prescriptions of what ought to be. We typically consider what is

typical to be normal and good, while what is atypical to be abnormal and bad. The converse can

also be true: idealizing someone for being different from the crowd or condemning someone

solely for doing as most others do. This error in thinking is called the naturalistic fallacy (Levy,

2010; see also Hume, 1978). As responsible clinicians, educators, and researchers, it is important to be aware of this common error in thinking and to avoid presenting our value judgments as objective reflections of truth. Examining self-esteem through a cross-cultural lens highlights the importance of acknowledging how our perceptions are inevitably influenced by our own personal beliefs and biases. For example, just because the quest for high self-esteem is common in North American society does not make it good or right. The pursuit of high self-esteem is not necessarily a universal human motive.

For example, from the perspective of European-American culture, the self is defined primarily in terms of its internal attributes, such as personality traits, competence, and abilities. Thus, from this cultural context, self-enhancing perceptions are positively sanctioned, reinforced, and therefore internalized as a highly automatized response tendency. One can then assume that individuals within this type of culture are highly motivated to confirm the positivity of their internal attributes of the self (Paulhus & Levitt, 1987). On the other hand, Asian cultures adhere to a very different model of the self as interdependent, in which the self is defined primarily in terms of its relationship to others. Within this collectivistic cultural context, self-esteem, as a positive appraisal of the self, is often antithetical to the objective of interdependence. Therefore, in Asian interdependent cultures, an expression of the Westernized concept of high self-esteem is typically perceived as a sign of insecurity, incompetence (Yoshida, Kojo, & Kaku, 1982), and psychological vulnerabilities (Miller, Wang, Sandel, & Cho, 2002). Further, self-critical or self-effacing self-perceptions—the very attributes that Western cultures might view as low self-esteem—are often encouraged, reinforced and eventually internalized as a habitual response tendency (Kitayama, 2006).

Therefore, as this example illustrates, the quest to obtain high self-esteem is not universal. Nonetheless, in the United States and other Westernized societies, countless psychotherapists, mental health providers, educators, and parents behave as if it is. From a clinical perspective, what might be the consequences of a psychotherapist consistently encouraging a client to strive for higher self-esteem if, in fact, that client does not share the therapist's Westernized belief system? How might a psychotherapist in training be affected by a professor or supervisor who regularly instructs him or her to work towards increasing a client's self-esteem, or his or her own self-esteem for that matter, if that therapist in training does not adhere to the same cultural beliefs? In other words, as clinicians, how often are we confusing what *is* with what *should* be? By confusing what is with what should be, clinicians and educators are not only failing to uphold a commitment to cultural awareness and sensitivity, but could also be contributing to or even creating the clinical problems they are seeking to alleviate.

The intervention-causation fallacy. The intervention-causation fallacy refers to the common misattribution of determining the cause of an event simply on the basis of its response to a particular intervention. In point of fact, however, the solution to a problem does not necessarily determine its cause (Levy, 2010). For example, suppose a psychotherapist implements an intervention designed to boost self-esteem and it results in immediate favorable outcomes. Does that mean that we have determined that low self-esteem was the cause of that client's original distress? Not necessarily.

There are numerous possible explanations for the immediate favorable outcomes in this hypothetical scenario. The outcomes could have been a result, at least in part, to the placebo effect, or to the fact that the intervention simply caused the person feel good momentarily, or that the intervention happened to ameliorate another separate but related symptom (e.g., mood

dysphoria). Regardless, a favorable response to an intervention does not necessarily determine the original cause of the person's original distress. Incorrectly assuming that low self-esteem is the cause simply by virtue of one's response to an intervention could seriously undermine the efforts of clinicians, parents, and educators to accurately understand and treat an individual's issues. As discussed above, having high self-esteem, and even just the pursuit of self-esteem, are not without potential negative implications. Therefore, to assume that an immediate favorable response to an intervention designed to boost self-esteem means that low self-esteem is the original cause of distress could lead not only to continuing the relentless—and potentially costly—pursuit of self-esteem, but also to the clinician overlooking the real causal factors at play.

Differentiating dichotomous variables and continuous variables. As discussed above, self-esteem is an example of a continuous variable, consisting of a theoretically infinite number of points lying between two polar opposites, but it is often confused as being a dichotomous variable, which can be divided into two mutually exclusive categories (Levy, 2010). Why does it matter if we continue to treat self-esteem as a dichotomous variable when it more appropriately belongs on a continuum? For one, as Levy discusses in his book, false dichotomization can lead to psychological distress across a number of theoretical orientations and clinical presentations. Psychodynamic theorists refer to the ego defense mechanism of *splitting*, or falsely categorizing the world into good versus bad components and treating them in an all-or-none fashion, as a fixation at a more primitive level of psychological development (e.g., Klein, 1937; Mahler, Pine, & Bergman, 1975). Along these lines, a common goal of cognitive therapy, is to help clients modify their black-or-white thinking into seeing more shades of grey (see Beck, 1995; Ellis, 1984).

Through learning to view their situations in less absolute terms, clients diagnosed with a wide range of psychopathological disorders (from eating disorders and depression, to anxiety, paranoia, or obsessive-compulsive personality disorder), can gain a greater sense of acceptance and control over their situations. Just as there are potential negative effects for an individual with an eating disorder viewing life through a dichotomous lens (e.g., perfect or imperfect, fat or thin) or a depressed person viewing the world through a dichotomous lens (e.g., success or failure, fair or unfair), viewing self-esteem through an all-or-nothing lens might have equally undesirable consequences. For example, if we view self-esteem as something we either have or do not have, what might be the effects on a person who is consistently seeking the attainment of high self-esteem to no avail? That person is much more likely to view himself or herself as unsuccessful, imperfect, and a failure. In contrast, by learning to view self-esteem in less absolute (and therefore more realistic) terms, an individual can gain a greater sense of acceptance, flexibility, and control over his or her life (Levy, 2010).

The insight fallacy. One of our most widespread and enduring societal myths, especially in the field of psychology, is that insight alone produces meaningful change. Nowhere within the field of psychology is the insight fallacy more apparent than in the practice of psychotherapy. Therapists and clients alike cling to the belief that understanding a psychological problem will somehow spontaneously cause the problem to solve itself (Levy, 2010). Understanding the roots of a problem, however, is rarely, if ever, the sole key to solving the problem.

Acknowledging this common error in thinking should not suggest that there are no benefits to insight. There are numerous potential values to insight in psychotherapy: providing a sense of relief or comfort by helping the client to grasp an unexplained phenomenon, acting as a critical initial step towards the client adopting specific problem-solving strategies, and providing

greater understanding, which could subsequently lead to therapeutic gains being generalized to other situations or challenges (Levy, 2010). These advantages notwithstanding, the problem lies in us failing to recognize that insight alone has significant limitations.

All too often, clinicians attribute problems to low self-esteem and stop there. Low self-esteem is regularly identified and documented as a root cause of almost every pathological condition: depression, suicide, eating disorders, narcissism, inattention, substance abuse, self-injurious behavior, oppositional behavior, violence, hypersexuality, anxiety, sleep disturbance, gender dysphoria, preoccupation with perceived flaws in physical appearance, relational problems, educational problems, acculturation problems, physically or sexually abusing others, and even staying in an abusive relationship, to list but a few.

But what are we accomplishing by identifying low self-esteem as a cause of people's problems or by guiding clients to gain insight into their feelings of self-worth, or lack thereof? For one, as this study has shown repeatedly, the research does not support a causal relationship between self-esteem and almost anything. But let us assume that we were to continue to assist clients in gaining insight into their feelings of self-worth simply because of the association between high self-esteem and short-term emotional benefits (i.e., positive feelings or happiness). We must remember that insight alone into one's feelings about himself or herself will not necessarily change those feelings. In fact, some critics have gone so far to argue that emphasizing insight can be detrimental to the therapeutic process in that focusing on cognitive insight allows both clients and therapists to avoid unpleasant emotions (see A. Freud, 1936; Holland, 2003). To summarize, insight might be useful in some ways, but we must continually remember to recognize its numerous limitations, and therefore seek to explore alternative avenues of change (Levy, 2010).

The self-fulfilling prophecy. The self-fulfilling prophecy can be described as a phenomenon whereby a perceiver's assumptions about another person actually lead that person to adopt those attributes (Levy, 2010). In perhaps the most famous study of the self-fulfilling prophecy (Rosenthal & Jacobson, 1968), the researchers found that by simply informing elementary school teachers that some of their pupils would show dramatic improvement in academic performance during the upcoming school year, the children who had been identified as bloomers (students who were actually chosen at random) did in fact show an improvement in their academic skills and even their IQ scores. Thus, their teachers had unknowingly created the very behaviors they expected (Levy, 2010).

While the expectations of the teachers in this study were positive (i.e., expecting improvement in academic performance), the self-fulfilling prophecy has been demonstrated with a wide range of both positive and negative perceiver expectancies. To consider some clinical examples, suppose that a therapist expects his or her new client to be fragile, resistant, seductive, or manipulative? Similarly, what might occur if a therapist expects a new client is low in self-esteem? If we continue to view clients through the self-esteem lens, how can we be sure that our beliefs that we hold towards them are not producing the very behaviors we expect to find? Similar to the example of the elementary school students above, expecting that a client or a supervisee is high in self-esteem (perhaps based on reviewing past records or recommendations) could have potentially positive effects, if the therapist's or supervisor's assumptions unknowingly create the behaviors they expect. But, what about the expectation that one is low in self-esteem? Regardless of our intent, continuing to assume that people are suffering from a widespread epidemic of low self-esteem might be more detrimental than we might think. Our assumptions could actually be contributing to people adopting these expected traits.

Summary of Critical Thinking Applications

In a detailed discussion above, the current researcher has taken a critical thinking approach to addressing some of the fundamental questions about self-esteem. Below is a summary of the metathought tools (denoted in italics within parentheses) of critical thinking used to answer those questions, followed by concluding reflections and an introduction of a new model of self-esteem:

Understanding self-esteem. Despite the fact that the term has been in existence for over 120 years, at least part of the reason for the continued lack of consensus when it comes to defining and understanding *self-esteem* is our failure to think about it critically. More specifically, despite the plethora of research dedicated to understanding self-esteem, we have failed to realize and acknowledge that: (a) to label people as having high self-esteem or low self-esteem does not explain their behavior (*the nominal fallacy and tautologous reasoning*); (b) if we are to understand what it means to have self-esteem, we will likely need to define its theoretical opposite (*consider the opposite*); and (c) the very use of the labels self-esteem, high self-esteem and low self-esteem are value laden depending on one's own set of individual and cultural perspectives and beliefs (*the evaluative bias of language*).

Problems with the existing research. In seeking to explain self-esteem, it is important to remember that: (a) while self-report may be an efficient method of measuring self-esteem, self-report measures are associated with a whole host of potential biasing factors, including reactivity, which will invariably compromise the validity of researchers' observations (*reactivity*); (b) cause and effect cannot be proven simply by virtue of a statistically significant correlation (*correlation does not prove causation*); (c) cause and effect are relative terms, with cause in one instance becoming effect in another, resulting in the question of which phenomenon

came first being potentially irrelevant and unanswerable (*bi-directional causation*); and (d) the majority of effects are likely to be the result of not just one but multiple causes, which are operating together (*multiple causation*).

The self-esteem obsession. Why does our fixation and obsession with self-esteem persist? The answers to this question can be summarized at least in part by the following: (a) statements about individuals' self-esteem are often so generic and overly inclusive that they can be true of practically all human beings, resulting in people continuing to accept them uncritically (*the Barnum effect*); (b) we have a tendency to weigh internal determinants (e.g., self-esteem) more heavily than external determinants (e.g., environmental or sociocultural factors) (*the fundamental attribution error*); (c) self-esteem feels good, which might lead us to overlook the lack of empirical evidence for its grave importance in shaping behavior and psychological well-being (*the if I feel it, it must be true fallacy*); (d) we are inclined to make data fit into our existing schemas about self-esteem versus modifying them (*assimilation bias*); (e) we are emotionally invested in beliefs about self-esteem, which makes us more likely to cling to them (*belief perseverance effect*); (f) we tend to draw conclusions based on information that is readily available in our memories, thereby assuming a causal connection between self-esteem and other variables simply by virtue of relying on easily recalled, vivid examples (*availability bias*); and (g) we have a propensity towards selectively gathering information consistent with our popular beliefs about self-esteem, while ignoring evidence that refutes them (*confirmation bias*).

The heterogeneity of self-esteem. Research supports the heterogeneity of high self-esteem, but very little success has been achieved at determining where the distinctions lie. If we are to attempt to delineate these distinctions, it is important to remember that: (a) regardless of the descriptive words one chooses to describe self-esteem, it is imperative that we acknowledge

that our words are value laden and that we not present our value judgments as objective reflections truth (*the evaluative bias of language*); (b) self-esteem is often regarded as if it fits into dichotomous categories, when it rightfully belongs on a continuum (*dichotomous versus continuous variables*); and (c) all phenomena (e.g., self-esteem, self-efficacy and narcissism) are both similar to and different from each other depending on the variables or dimensions that have been selected to compare and contrast (*the similarity-uniqueness paradox*).

     Clinical implications. If self-esteem has been shown to feel good and it is linked to happiness, what do we have to lose by continuing to strive for it? What is the harm?

     As discussed above, there is an ever-increasing amount of recent literature that has focused on the ensuing costs of both having and pursuing high self-esteem. As we move towards a more in-depth understanding of the clinical implications that go along with these resulting costs, the following are some of the most essential and relevant critical thinking concepts: (a) if we continue to understand and treat self-esteem as though it is a thing that objectively exists in the world versus a fragile and imperfect human-made construct, people will continue to pursue the attainment of self-esteem to no avail, which could paradoxically lead to even lower levels of self-esteem (*the reification error*); (b) by confusing what is with what should be, clinicians and educators are not only failing to uphold a commitment to cultural awareness and sensitivity, but could also be contributing to or even creating the clinical problems they are seeking to alleviate (*the naturalistic fallacy*); (c) incorrectly assuming that low self-esteem is the cause of an individual's distress simply by virtue of one's response to an intervention intended to boost self-esteem could seriously undermine efforts to accurately understand and treat an individual's issues (*the intervention-causation fallacy*); (d) by learning to view self-esteem in less absolute (and therefore more realistic) terms, individuals can gain a greater sense of acceptance,

flexibility, and control over their lives (*differentiating dichotomous and continuous variables*); (e) insight alone into one's feelings about himself or herself will not necessarily change those feelings (*the insight fallacy*); and (f) regardless of our intent, continuing to assume that people are suffering from a widespread epidemic of low self-esteem might be more detrimental than we might think because our assumptions could actually be contributing to people adopting these expected traits (*the self-fulfilling prophecy*).

Reconceptualizing Self-Esteem

Despite the fact that the body of work on self-esteem has been plagued with a variety of conceptual and methodological shortcomings, the term did not become one of the top covariates occurring in personality and social psychology research and the subject of more than 20,000 publications without reason. Most social science researchers, clinicians, and educators would agree that one's feelings of self-worth, beliefs about oneself, and one's accomplishments are certainly fundamental factors affecting his or her psychological well-being. However, as the current study and a multitude of other studies have suggested, self-esteem is a complex concept, multifaceted and heterogeneous in nature. To fully understand its role in psychological functioning, we must go beyond whether it is simply high or low. Moreover, until relatively recently, the notion that to have high self-esteem is unmistakably a good thing has gone unchallenged, but recent theory and evidence has suggested that this characterization is not necessarily true. There appear to be numerous forms of high self-esteem that vary widely in terms of how closely they mirror healthy or optimal psychological functioning (Kernis & Paradise, 2002). Whether one's self-esteem is considered optimal or whether it contributes to the healthy psychological functioning depends on a consideration of not just its level, but also its characteristics (e.g., Crocker & Wolfe, 2001; Kernis & Paradise, 2002).

As discussed in Chapter 1, given the long history of the term, the self-esteem research has given rise to a number of different definitions, all of which have yielded diverse assumptions, theories, and findings. The lack of consensus in the field about a definition and the numerous conceptual debates that have arisen are, therefore, not surprising. Three of the central conceptual issues discussed in Chapter 1 are summarized here. First, existing definitions of self-esteem have differed in terms of whether they center around affective factors (e.g., feelings of worthiness), cognitive factors (e.g., perceived competence), or behavioral factors (e.g., one's achievements). Second, definitions of self-esteem have differed historically in terms of the degree to which the construct is viewed as relatively stable or fluid. Specifically, self-esteem has been defined as a global construct (i.e., *trait self-esteem*), as being based primarily on variable feelings of self-worth (i.e., *state self-esteem*), and as particular self-evaluations (i.e., *domain specific self-esteem*). Third, definitions vary in terms of whether they are unidimensional (i.e., involving a single global domain of self-concept) or multidimensional (i.e., involving multiple, distinct components of self-concept).

Overall, attempts to resolve the conflicting views of what exactly constitutes self-esteem have resulted in many researchers suggesting that self-esteem is a multifaceted construct (Baumeister et al., 2003; Kernis, 2003b; Goldman, 2006). From this standpoint, based upon the various conceptual issues described above, what we have come to think of as self-esteem is a highly complex, dynamic concept that cannot be summarized or confined to a simple definition that is unidimensional and fixed, focusing on just one aspect of human experience (e.g., feelings of worthiness). As the research has shown, oversimplification of the idea of self-esteem contributes not only to continued confusion in the field, but also can lead to significant problems. For example, oversimplification can lead to programs and interventions designed merely to make

people feel good about themselves. As discussed in previous chapters, making people feel good about themselves does not appear to be problematic inherently, but what if those feelings and self-perceptions are not warranted? As much research has shown, feeling good about oneself without earning it can lead to a myriad of problems, such as facilitating the development of narcissism, risking an increase in the likelihood of violence, or tolerating undesirable academic performance (Baumeister et al., 1996; Damon, 1995; Dawes, 1994).

Therefore, the current researcher proposes a new model for conceptualizing self-esteem, one that captures the heterogeneous nature of the term. This model seeks to integrate the various facets of self-esteem and account for the different dimensions on which self-esteem can vary, taking into account the existing research findings, addressing and resolving some of the flaws in critical thinking, and bearing in mind the fundamental conceptual issues discussed above. In sum, the model seeks to go beyond conceptualizing self-esteem as high or low and provide an organized system for determining various types of self-esteem, and the degree to which they relate to optimal psychological functioning.

A new model of self-esteem: Background and rationale. In conceptualizing and introducing a new model of self-esteem, the very use of the term itself must first be addressed. As the current research shows, despite the appeal, ubiquity and importance of the concepts it represents, the term and its ensuing research are plagued with confusion, discrepancies and disagreements. Nonetheless, self-esteem is far too embedded in the literature and the concept is far too important to discard all together. Thus, the current researcher proposes a broader approach, involving taking a step back to examine the more fundamental concept of self-appraisal and the various forms it can take. Whether the numerous existing definitions of self-esteem are unidimensional or multidimensional; stable or fluid; focused primarily on cognitive

factors, affective factors, behavioral factors, or some combination thereof, they all attempt to describe a process or an aspect of self-appraisal. In other words, virtually every existing definition of self-esteem involves some act of a person judging the value, condition, or importance of himself or herself. Therefore, as can be seen in Figure 1, the current researcher has chosen to use self-appraisal as the foundation and primary sorting variable from which the various manifestations or types of self-esteem stem.

SELF-APPRAISAL

ACCURATE

POSITIVE

STABLE → OPTIMAL HIGH SELF-ESTEEM

UNSTABLE → FRAGILE HIGH SELF-ESTEEM

NEGATIVE

STABLE → ACCURATE LOW SELF-ESTEEM

UNSTABLE → FRAGILE LOW SELF-ESTEEM

DISTORTED

INFLATED

STABLE → NON-COMPENSATORY NARCISSISM

UNSTABLE → COMPENSATORY NARCISSISM

DEFLATED

STABLE → PESSIMAL SELF-ESTEEM
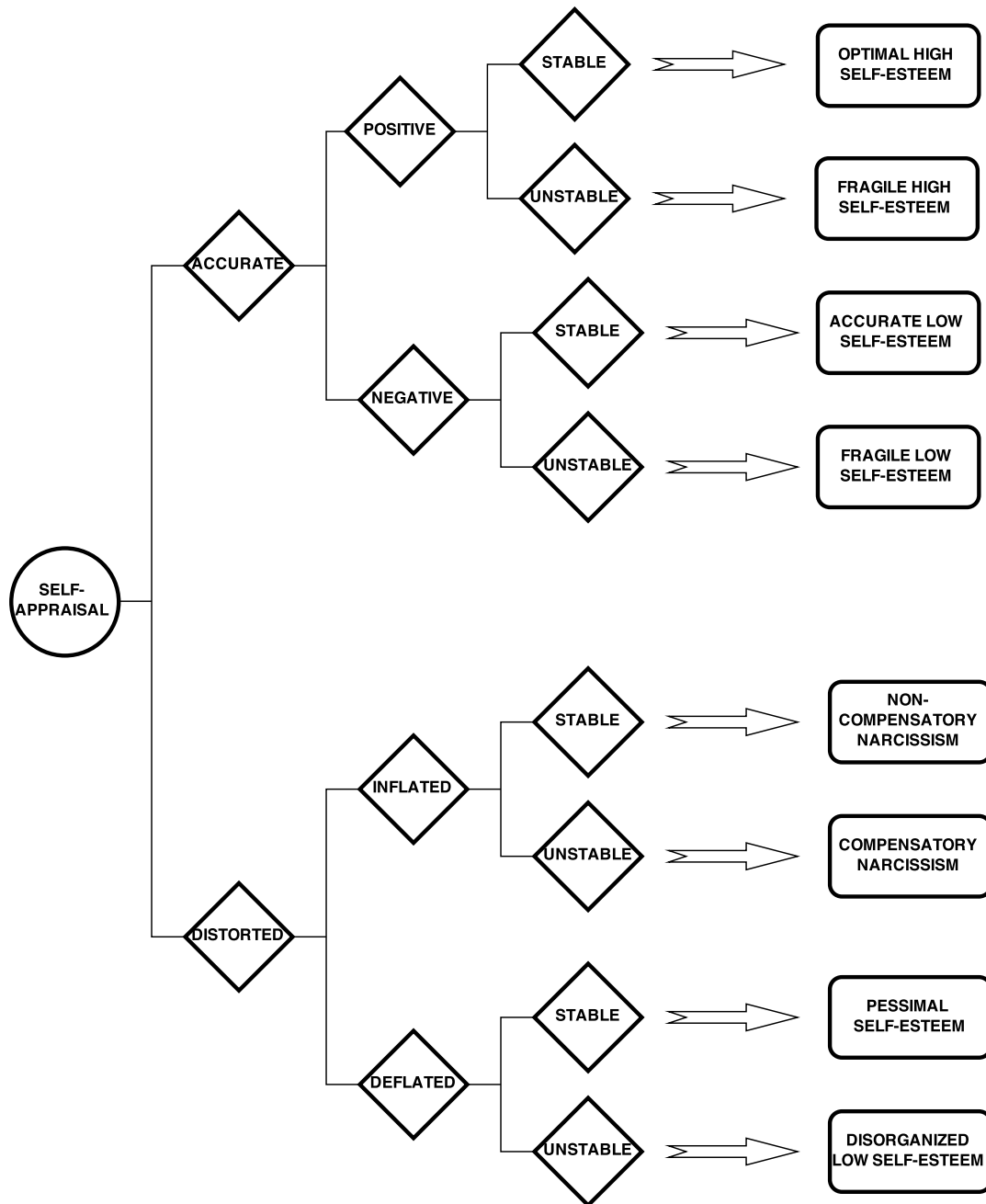
UNSTABLE → DISORGANIZED LOW SELF-ESTEEM

Figure 1. A new model of self-esteem. This figure illustrates a new model for conceptualizing self-esteem, one that captures the heterogeneous nature of the term.

Accuracy. From this starting point, the model depicts self-appraisal as branching off into two pathways: *accurate* self-appraisal and *distorted* self-appraisal[26]. Although this distinction has been virtually absent from existing models of self-esteem, the current researcher asserts that it is a fundamental one. In order to truly capture the heterogeneous nature of the concept— including everything from grandiosity to self-loathing to an accurate appreciation of one's strengths and worth—a consideration of accurate versus distorted is essential. Without consideration of this distinction, the differences between such terms as high self-esteem and narcissism, for example, are largely indistinguishable. Moreover, as discussed in Chapter 1, the very first known definition of self-esteem by William James may have been simple, but it has been supported by a considerable amount of research (Harter, 1999). To review, James (1890/1983) defined self-esteem as successes divided by pretensions[27], or a ratio between achievements and aspirations. Based on this definition, by its very nature, level of self-esteem depends, in part, on actual objective behaviors and outcomes (i.e., successes). Therefore, the more success we have and the lower our expectations, the higher our self-esteem. Said another way, one can raise self-esteem by either lowering expectations and/or increasing achievements. Generally speaking, many of the definitions that followed that of James, especially those that came out of the more recent self-esteem movement, focused primarily on the cognitive and/or affective factors influencing self-esteem, without any consideration of behavior, successes or objective outcomes. For example, Nathaniel Branden (1969), one of the most prominent figures

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[26] For the purposes of simplicity and clarity, the sorting variables in the current model are presented as categorical in nature. However, with the aforementioned principles of critical thinking in mind (specifically, dichotomous versus continuous variables), it should be noted that all of the constructs included in the current model are, in fact, continuous variables.

[27] Although *pretension* can be defined in numerous ways, James (1890/1983) used the word to mean *aspirations*, as opposed to the common modern-day meaning (i.e., *pretentiousness* or *ostentatiousness)*.

of the self-esteem movement, defined self-esteem as the result of two interrelated aspects: "It entails a sense of personal efficacy and a sense of personal worth. It is the integrated sum of self-confidence and self-respect. It is the conviction that one is competent to live and worthy of living" (p. 110).

While the cognitive and affective facets of self-esteem are certainly vital to understanding the nature of the construct, the current researcher asserts that one's external, measurable reality is equally important. In other words, self-esteem is shaped not only by one's thoughts and feelings, but also by the objective outcome of one's behavior (e.g., actual achievements, measurable capabilities), as well as by one's interpersonal interactions (i.e., the level of congruence between how one thinks he or she is perceived and how he or she is actually perceived). In this model, *accurate self-appraisal* refers to one's judgment of the value, condition, or importance of oneself that is accurately based upon his or her measurable reality (as just described). For example, a woman might consider herself to be highly likeable with strong social skills and, based upon reports of individuals in her social circle, she is in fact well liked by others (*accurate self-appraisal*). In this instance, there is congruence between her self-appraisal and the manner in which others appraise her. Conversely, *distorted self-appraisal* refers to one's judgment of the value, condition, or importance of oneself that is incongruent with his or her measurable reality. For example, a man might consider himself to be highly intelligent, but based upon an objective measure of intelligence (scores on a measure of cognitive abilities) his level of intelligence is actually below average.

Directionality. As these examples indicate, both accurate self-appraisal and distorted self-appraisal can be skewed in opposing directions, leading to the secondary sorting variable of directionality. Therefore, the second sequence of the model gives rise to the following

conditions: *accurate positive self-appraisal* (self-appraisal that is positive and congruent with measurable factors and/or the interpersonal perceptions of others), *accurate negative self-appraisal* (self-appraisal that is negative and congruent with measurable factors and/or the interpersonal perceptions of others), *distorted inflated self-appraisal* (self-appraisal that is more positive than is reflected by measurable factors and/or the interpersonal perceptions of others), and *distorted deflated self-appraisal* (self-appraisal that is more negative than is reflected by measurable factors and/or the interpersonal perceptions of others).

  Stability. Each of these four categories (*accurate positive, accurate negative, distorted inflated*, and *distorted deflated*) is then further divided by a third sorting variable of stability. Considerable research supports the usefulness of distinguishing between stable versus unstable feelings of self-worth (e.g., Kernis et al., 1993). According to Kernis and Paradise (2002), for example, the stability of self-esteem is determined based on the extent to which the individual's current feelings of self-worth fluctuate across time and situations. More specifically, feelings of self-worth that are stable are minimally affected by specific evaluative events, whereas feelings of self-worth that are unstable are highly influenced by evaluative events, both internally generated (e.g., reflecting on an earlier interpersonal interaction) and externally generated (e.g., an evaluation from a teacher). Along similar lines, other research and theory (Crocker & Wolfe, 2001; Kernis & Paradise, 2002) have shown promising support for the construct of *contingent self-esteem* and its assessment. Based upon Self-Determination Theory (SDT), for example, self-esteem can either be contingent (i.e., dependent upon matching some external standards or expectations and requiring continual validation) or non-contingent (i.e., not dependent upon matching some external standards and not requiring continual validation; Deci & Ryan, 1995). While these two variables, stability and contingency, have often been treated as separate

constructs, the current researcher asserts that, by definition, if self-esteem is contingent, it is also unstable. Conversely, if self-esteem is non-contingent, it is naturally stable. Therefore, the current model defines *stable* as minimally influenced by evaluative events (both externally and internally generated) and low need to match external standards across time and situation, and *unstable* as highly influenced by evaluative events (both externally and internally generated) and high need to match external standards or expectations across time and situation.

It should be noted that Kernis and Goldman (1999) and Kernis and Paradise (2002), whose research has focused primarily upon distinguishing between fragile versus secure forms of self-esteem, argue that self-esteem varies along four theoretical components: stability, contingency, congruence, and defensiveness. Specifically, fragile high self-esteem is defined by these researchers as positive feelings of self-worth that are unstable (i.e., fluctuates based on contextually based feelings of self-worth), contingent (i.e., depends on the achievement of specific outcomes), incongruent (i.e., are discrepant when compared to implicit feelings of self-worth), and defensive (i.e., exhibit an unwillingness to admit to negative feelings of self-worth). Conversely, the authors conceptualize secure high self-esteem as positive feelings of self-worth that are stable (i.e., vary minimally across experiences), noncontingent (i.e., result from the satisfaction of core psychological needs versus the attainment of specific outcomes), congruent (i.e., are in line with implicit feelings of self-worth), and genuine (i.e., open to recognizing negative aspects of one's self). Although the current researcher generally supports this depiction of self-esteem as a heterogeneous and multifaceted construct, the proposed model does not include a discussion of either the congruent versus incongruent variable, or the defensive versus genuine variable, for the following reasons:

First, the distinction between congruent and incongruent, which refers to the level of congruence between explicit and implicit self-esteem, has been made by theories such as Cognitive Experiential Self Theory (CEST; Epstein & Morling, 1995). CEST is an example of one theory that centers around the assumption that self-esteem should be understood as an interaction between two separate but related systems, essentially conscious (i.e., explicit) self-esteem and unconscious (i.e., implicit) self-esteem. Thus, theoretically, high explicit self- esteem coupled with low implicit self-esteem would represent fragile self-esteem, while high explicit self-esteem coupled with high implicit self-esteem would represent more secure self-esteem. Explicit self-esteem has traditionally been measured by self-report measures such as the Rosenberg (1965) Self-Esteem Scale, whereas implicit self-esteem, as discussed in Chapter 1, is measured more indirectly through nonreactive measures such as projective tests, cognitive priming tasks, and implicit association tasks. However, although nonreactive measures of implicit self-esteem have increased in popularity during recent years (Bosson, Swann, & Pennebaker, 2000), they have been shown to have weak and/or inconsistent psychometric properties and the understanding of how to interpret these measures is cloudy at best (Bosson, 2006). Therefore, given the lack of empirical support for the reliability or validity of implicit measures of self-esteem, these variables were not included in the proposed model.

Second, although the distinction between defensive and genuine high self-esteem dates back as early as 65 years ago (Horney, 1950), it has not generated a large body of empirical support (Kernis & Paradise, 2002). In the research that has been done, defensive has traditionally been distinguished from genuine through measures of socially desirable responding, such as the Crowne-Marlowe Social Desirability Scale (e.g., Crowne & Marlow, 1960). In other words, if one measures high in self-esteem and high in social desirability, he or she presumably possesses

defensive high self-esteem due to being unwilling to admit to the undesirable qualities he or she is likely to possess. Conversely, if one measures high in self-esteem and low on a social desirability measure, the person is presumably less likely to conceal negative characteristics from others and, therefore, is thought to possess genuine self-esteem. This idea notwithstanding, however, the current researcher would argue that there are numerous ways of defining defensive, which leads to undesirable ambiguity and confusion surrounding the term. Colloquially, defensive is typically used to describe argumentative behavior (e.g., when one person accuses another of being quarrelsome in response to feedback). However, in the realm of psychological assessment, it is used to refer to a tendency to respond in a deliberately socially desirable fashion (e.g., as measured by the Crowne-Marlowe Social Desirability Scale), or to respond relatively unintentionally in a manner reflecting social poise or reserve (e.g., as measured by the K scale on the MMPI-2, termed subtle defensiveness). In a different context, some psychotherapists use defensive to refer to a client's resistance or denial in therapy. Due to this conceptual ambiguity, defensive and genuine are not necessarily theoretical opposites: in contrast, stable versus unstable (the third sorting variable of the current model) are. Moreover, the current researcher would argue that a consideration of whether one's self-appraisal is accurate or distorted, and the direction in which it is skewed, encompasses the distinction made by Kernis and Goldman (1999) and Kernis and Paradise (2002) when they describe the difference between one who exhibits an unwillingness to admit to negative feelings of self-worth versus one who is open to recognizing negative aspects of oneself. In other words, if one's self-appraisal is defensive, regardless of which definition is being used, it is (by its very nature) distorted. Therefore, for these reasons, defensive versus genuine is not specifically included as a sorting variable in the proposed model.

A comprehensive definition of self-esteem. Based on the current research and model, the following is a proposed comprehensive definition of self-esteem:

Self-esteem is the appraisal of one's own personal value, including both emotional components (self-worth) and cognitive components (self-efficacy). More specifically, self-esteem is a multifaceted and heterogeneous construct, the multiple forms of which are a function of how accurately or closely it matches an individual's measureable reality, comprised of the objective outcome of one's behavior (actual achievements, measurable capabilities) as well as one's interpersonal interactions (i.e., the level of congruence between how one thinks he or she is perceived and how he or she is actually perceived). Self-esteem also varies in terms of its level of stability, or the degree to which it is influenced by evaluative events or the need to match external standards across time and situation. The permutations of these sorting variables yield eight types of self-esteem: Optimal High, Fragile High, Accurate Low, Fragile Low, Noncompensatory Narcissism, Compensatory Narcissism, Pessimal, and Disorganized. A detailed description of each of these eight types, including examples, follows.

Optimal high self-esteem. Optimal High Self-Esteem consists of self-appraisal that is accurately based upon the objective outcome of one's behavior and one's interpersonal interactions and is skewed in a positive direction (*accurate, positive*). Further, one's judgment of the value, condition or importance of oneself is minimally influenced by evaluative events (both externally and internally generated) and/or by the need to match external standards or expectations across time and situation (*stable*). The self-appraisal of individuals placed within this category is based upon their measurable reality (e.g., actual achievements, measurable capabilities), as well as a high level of congruence between how they think they are perceived and how they are actually perceived by others. Regardless of experiences or information that

might threaten, contradict or challenge the individual's overall positive self-appraisal, it remains relatively consistent across time and situation.

For example, a woman in the Optimal High Self-Esteem category, regardless of the fact that she is unhappy about recently gaining some weight and being passed up for a promotion at work, maintains an overall positive and accurate self-appraisal that is not significantly influenced by a desire to match external standards of success or physical attractiveness. She may experience a variety of emotions and she may even take steps to better her situation, but the manner in which she judges her own value and importance remains relatively consistent.

Fragile high self-esteem. Fragile High Self-Esteem consists of self-appraisal that is accurately based on the objective outcome of one's behavior and one's interpersonal interactions and is skewed in a positive direction (*accurate, positive*). However, one's judgment of the value, condition or importance of oneself is highly susceptible to being influenced by evaluative events (both externally and internally generated) and/or by the need to match external standards or expectations across time and situation (*unstable*). The self-appraisal of individuals placed within this category is based upon their measurable reality (e.g., actual achievements, measurable capabilities), as well as a high level of congruence between how they think they are perceived and how they are actually perceived by others. Despite these individuals' susceptibility to adverse experiences or information, they demonstrate high resilience in their ability to recover relatively quickly from setbacks and return to their high baseline level of functioning.

For example, a graduate student with Fragile High Self-Esteem might react to mild criticism from her dissertation chairperson by experiencing sadness, discouragement, and self-doubt. However, after a brief period of time, she is able to recover from her negative emotions

and get back to rewriting her research without significant or lasting impact on her self-appraisal, which is relatively high overall.

Accurate low self-esteem. Accurate Low Self-Esteem consists of self-appraisal that is accurately based on the objective outcome of one's behavior and one's interpersonal interactions but is skewed in a negative direction (*accurate, negative*). Further, one's judgment of the value, condition or importance of oneself is minimally influenced by evaluative events (both externally and internally generated) and/or by the need to match external standards across time and situation (*stable*). The self-appraisal of individuals placed within this category is based upon their measurable reality (e.g., actual achievements, measurable capabilities), as well as a high level of congruence between how they think they are perceived and how they are actually perceived by others. Their self-appraisal remains skewed in a negative direction consistently across time and situation and is minimally influenced by self-reflection or external feedback.

For example, a man with Accurate Low Self-Esteem who has been highly unsuccessful in school, extracurricular activities, the workforce, and his interpersonal relationships, may receive a call from his father telling him he is proud of him for recently obtaining a job. However, with his overall self-appraisal being negative and accurately based upon his actual history, his self-appraisal remains unaffected by getting a job or by his father's feedback.

Fragile low self-esteem. Fragile Low Self-Esteem consists of self-appraisal that is accurately based on the objective outcome of one's behavior and one's interpersonal interactions and is skewed in a negative direction (*accurate, negative*). However, one's judgment of the value, condition or importance of oneself is highly susceptible to being influenced by evaluative events (both externally and internally generated) and/or the need to match external standards or expectations across time and situation (*unstable*). The self-appraisal of individuals placed within

this category is based upon their measureable realities (e.g., actual achievements, measurable capabilities), as well as a high level of congruence between how they think they are perceived and how they are actually perceived by others. However, due to their self-appraisal being skewed in a negative direction, they demonstrate low resilience in their ability to recover from setbacks and return to their low baseline level of functioning.

For example, the same graduate student described above who receives mild criticism from her dissertation chairperson, but is instead placed within the Fragile Low Self-Esteem category, would experience much more difficulty recovering from this setback. She is likely to take a prolonged period of time to get back to rewriting her dissertation, taking her chairperson's feedback as disapproval of her global abilities and struggling to return to her level of baseline functioning and self-appraisal.

Non-compensatory narcissism. Non-compensatory Narcissism consists of self-appraisal that is more positive than is reflected by measurable factors and/or the interpersonal perceptions of others (*distorted, inflated*). Further, one's judgment of the value, condition or importance of oneself is minimally influenced by evaluative events (both externally and internally generated) and/or the need to match external standards across time and situation (*stable*). Included within this category are individuals who meet a clinical description of narcissism, which is characterized by an excessive self-admiration of one's own attributes, and includes features of grandiosity, arrogance, entitlement, and a lack of perceived need for personal change (Pincus, 2013; Stolorow, 1975; Wrzos, 1987). In its more extreme form, individuals may meet criteria for a diagnosis of narcissistic personality disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). As noted in DSM, this disorder involves a pattern that is inflexible and pervasive across a broad range of

interpersonal and social situations, and is also marked by a lack of empathy for others. Because individuals placed in the category of Non-Compensatory Narcissism are minimally influenced by evaluative events or the need to match external standards, this type of self-appraisal can sometimes involve delusional thinking. The individuals' firmly held, distorted beliefs and feelings of superiority are stable across time and situation and, thus, are essentially immune to criticisms, threats or contradictory evidence. The current researcher asserts that, in contrast to Compensatory Narcissism (see below), individuals in this category do not appear to be covering deficits in self-perceptions; they are, in fact, secure in their beliefs.

For example, an attorney with Non-compensatory Narcissism who receives harsh criticism from a judge is likely to respond unflappably, leaving the courtroom with a smirk on her face, thinking that the judge is incompetent and inferior. Regardless of how accurate the judge's criticism might be, she blithely dismisses it as being worthless and invalid. Her self-appraisal is consistently more positive than is reflected by her actual courtroom trial outcomes or many other judges' perceptions of her. As another example, a Non-compensatory Narcissist whose long-time girlfriend tells him she is breaking up with him would likely be unfazed and react arrogantly by condescendingly and smugly informing her that the loss is all hers, without even the slightest consideration that he might need to examine his own personality or behavior. Being negligibly influenced by his girlfriend's feelings or opinions, his self-appraisal remains minimally affected, if affected at all, and continues to be more positive than is reflected by his actual behavior or the perceptions of his girlfriend.

Compensatory narcissism. Compensatory Narcissism consists of self-appraisal that is more positive than is reflected by measurable factors and/or the interpersonal perceptions of others (*distorted, inflated*), but is also fragile, or highly influenced by evaluative events (both

externally and internally generated) and/or the need to match external standards or expectations across time and situation (*unstable*). Included within this category are individuals who meet a clinical description of narcissism, which is characterized by an excessive self-admiration of one's own attributes, and includes features of grandiosity, arrogance, entitlement, and a lack of perceived need for personal change (Pincus, 2013; Stolorow, 1975; Wrzos, 1987). In its more extreme form, individuals may meet criteria for a diagnosis of narcissistic personality disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). As noted in DSM, this disorder involves a pattern that is inflexible and pervasive across a broad range of interpersonal and social situations, and is also marked by a lack of empathy for others. In contrast to Non-compensatory Narcissism, this type of self-appraisal is further delineated as being insecure in that it is highly influenced by evaluative events and the need to match external standards or expectations across time and situation. Therefore, the individual is in a psychological state of insecurity, attempting to make up for the lack of stability of his or her self-appraisal by erecting a false persona of excessive confidence as compensation. Theoretically and historically, narcissism has frequently been characterized by extreme emotional reactivity. For example, Kohut (1976) and Kernberg (1975) both spoke of narcissistic rage and a more general emotional lability characteristic of narcissism. More recent research has shown that high narcissism predicts aggression (Bushman & Baumeister, 1998). Even though measures of self-esteem have generally failed to predict objective behaviors when it comes to aggression, high scores on measures of narcissism have been empirically linked to aggressive retaliation (Baumesiter et al., 2003). According to DSM (2013), "Vulnerability in self-esteem makes individuals with narcissistic personality disorder very sensitive to 'injury' from criticism or defeat…[to which] they may react with disdain, rage,

or defiant counterattacks" (p. 671). The current researcher asserts that it is specifically Compensatory Narcissism (as compared to Non-compensatory Narcissism) that can be characterized by this propensity towards aggressive retaliation, due to the emotional instability and psychological insecurity underlying the compensating narcissists' self-appraisal.

For example, the same attorney described above who receives criticism from a judge, if instead placed within the Compensatory Narcissism category, would likely respond with rage, criticizing the judge and slamming the door as she storms out of the courtroom. Although her self-appraisal is more positive than is reflected by her actual courtroom performance or the perceptions of judges, it is insecure, fragile and highly influenced by the need to match external standards and expectations, resulting in her aggressive, emotionally explosive tantrum. As another example, the same man described above whose girlfriend informs him she is breaking up with him, if he were a Compensatory Narcissist, might frantically react with a sense of utter panic, feeling deeply wounded and devastated at the very thought that someone would reject him. Due to his self-appraisal being insecure and highly affected by evaluative events and external standards, he would be emotionally distraught and engage in frantic attempts to protect and preserve his distorted, inflated self-appraisal.

Pessimal self-esteem. Pessimal Self-Esteem consists of self-appraisal that is more negative than is reflected by measurable factors and/or the interpersonal perceptions of others (*distorted, negative*), and is also minimally influenced by evaluative events (both externally and internally generated) and/or by the need to match external standards across time and situation (*stable*). Pessimal Self-Esteem is the theoretical opposite of Optimal High Self-Esteem. An individual placed within this category appraises himself or herself in a manner that is inconsistent with measurable factors (e.g., academic success, occupational success) or the way he

or she is actually perceived by others. The individual's self-appraisal remains distorted and deflated regardless of evaluative events or external standards, resulting in an overall lack of hope.

For example, a professional athlete with Pessimal Self-Esteem may have an impressive athletic record, a significant fan base, and close friends and family members who are proud of him; however, he consistently maintains a negative self-appraisal regardless of his achievements or positive feedback from others.

Disorganized low self-esteem. Disorganized Low Self-Esteem consists of self-appraisal that is more negative than is reflected by measurable factors and/or the interpersonal perceptions of others (*distorted, negative*) and is also fragile, or highly influenced by evaluative events (both externally and internally generated) and/or the need to match external standards or expectations across time and situation (*unstable*). Therefore, individuals placed within this category may seek or crave opportunities to elevate their overall self-appraisal by matching various external standards or expectations of others; however, with a baseline self-appraisal that is generally distorted and deflated, the individual is likely to be untrusting and doubting of any evidence that might contradict his or her negative thoughts and feelings; thus, the individual's self-appraisal remains in a chaotic state and generally skewed in a negative direction.

For example, a man with Disorganized Low Self-Esteem may experience some success in his career and within his interpersonal relationships, but will still maintain self-appraisal that is skewed in a negative direction. Being highly influenced by the need to match external standards and expectations, he finds himself consistently trapped in a chaotic, unstable state, torn between seeking opportunities to refute his negative self-appraisal, but being wary of any evidence that contradicts how he feels about himself and what he believes about himself.

Recommendations for Researchers and Clinicians

Self-esteem has not proven to be the Holy Grail that psychologists and non-psychologists alike once believed it to be, nor has the research supported the notion that a low self-esteem epidemic is the cause of a wide range of social problems. However, as discussed previously, the term did not become one of the top covariates occurring in personality and social psychology research without reason. Regardless of the fact that the research has been plagued with confusion, discrepancies and disagreements, self-esteem—both the concept and the term itself— is far too embedded in the research literature and mass consciousness to discard altogether. Rather than abandoning or replacing it, the current researcher proposes a reconceptualization (as illustrated by the new model described above), one that incorporates a critical thinking perspective and acknowledges the heterogeneity of the construct. With these ideas in mind, and based upon the findings of the current investigation, the following are recommendations for future researchers and clinicians:

Reaching consensus on a definition. As discussed above, given the long history of the term, the research on self-esteem has given rise to a number of different definitions, based on different assumptions and theories, and yielding different findings. This lack of conceptual clarity is one of the primary reasons—if not the primary reason—for the rampant confusion surrounding the construct. Without a common language currency as a foundation, the research will continue to be inundated with conceptual and methodological problems. Just as agreed upon definitions enable physicists to communicate with one another and with the public about such basic concepts as heat, sound, or magnetism, psychologists also must strive for the same level of consensus with regard to self-esteem. With the plethora of definitions of self-esteem that exist currently, we are likely comparing apples to oranges when it comes to the various self-esteem

measures and research findings. A comprehensive definition and theoretical model have been proposed as part of the current study. Whether or not this particular version becomes widely adopted, it is imperative that we reach consensus about how we describe and define the term. Moreover, further research is indicated that specifically focuses on the generalizability of the definition and model across cultures. From a clinical perspective, reaching consensus on the specific nature of self-esteem will assist clinicians in diagnostic clarification, treatment planning and selecting interventions. Understanding the multidimensional nature of self-esteem and the full spectrum of ways that one's self-appraisal can manifest itself—as opposed to the oversimplified view of high versus low—will assist clinicians in becoming better diagnosticians and psychotherapists.

Developing a measure of self-esteem as a heterogeneous construct. Attempts to resolve the conflicting views of what exactly constitutes self-esteem have resulted in many researchers suggesting that self-esteem is a multifaceted construct. Further, the current research shows that what we have come to think of as self-esteem is a highly complex, dynamic concept that cannot be accurately summarized or confined to a simple definition that is unidimensional and fixed, focusing on just one aspect of human experience (e.g., feelings of worthiness). Therefore, an assessment measure of self-esteem that captures the heterogeneity of the term and accounts for multiple conceptual issues is greatly needed. Methodological and conceptual problems in the research have made valid, useful measurement of self-esteem especially difficult. As a remedy, the following are specific areas that should be addressed in developing an improved self-esteem measure:

- The new measure should possess psychometric properties that exceed those of the current measures. In particular, since self-esteem is a hypothetical construct, the measure must demonstrate evidence of construct validity (i.e., the scale actually measures what it purports to measure). This would best be achieved by applying the

mutitrait-multimethod matrix paradigm (described above), wherein convergence with similar constructs and divergence from dissimilar constructs is established.

- Based on the proposed definition, the future measure should account for both the affective factors (feelings of self-worth) and the cognitive factors (self-efficacy) that comprise self-esteem.

- The future measure should yield scores for all eight types of self-esteem that have been identified in the proposed model. Ideally, each score should fall along a different dimensional scale, given that the sorting variables in the model are conceptualized as continuous, rather than categorical variables. The resulting graph of self-esteem scores might visually resemble the personality profiles found in the Minnesota Multiphasic Personality Inventory (MMPI-2; Hathaway & McKinley, 1989) or the Millon Clinical Multiaxial Inventory (MCMI-III; Millon, Davis, & Grossman, 2006).

- The social desirability of high self-esteem in North American culture generally leads subjects to respond to face-valid items accordingly, thereby inflating self-esteem scores on self-report measures. It is therefore recommended that future measures include a validity scale or internal check for social desirability bias. An empirically based correction scale (similar to the K scale in the MMPI-2) might be utilized to statistically deflate respondents' scores to more accurately reflect their true self-esteem, were they not responding in a socially desirable manner. The inclusion of peer or observer ratings is also recommended to counterbalance the effects of social desirability bias.

- Further research is needed to explore the possible cultural biases in self-esteem assessment. Even a measure that accounts for the heterogeneous nature of self-esteem is still subject to cultural bias, as all social labels and categorizations are inherently value laden.

Reducing the indiscriminate boosting of self-esteem. Some may argue that arbitrarily boosting self-esteem is harmless because it feels good, it could be linked to happiness, and it might even motivate people to accomplish things purely because they are striving for the recognition and acknowledgement associated with enhancing self-esteem. However, we must not ignore the ever-increasing amount of recent literature that has focused on the ensuing potential costs of having, or even pursuing, self-esteem. Some of these include: breeding narcissism, more biased perceptions of the future, increased tendency towards aggression, interference with learning and mastery, and detrimental interpersonal effects (e.g., people focusing on themselves

at the expense of others' needs and feelings). With these potential *costs* in mind, the current researcher urges future clinicians and researchers to devote greater attention to the second component of the proposed definition (i.e., self-efficacy) as well as to measurable behavioral outcomes. As discussed above, self-efficacy refers to people's cognitive beliefs regarding their capability to accomplish a certain level of performance (see Bandura, 2001) and has been shown to be a useful and attainable clinical goal (Riggio, 2012). Focusing on one's self-efficacy, along with his or her actual behavior, might promote a more realistic sense of competence that is less susceptible to the costs associated with arbitrarily attempting to make people simply feel good about themselves.

Disentangling the links among self-esteem, happiness, and depression. Based upon the current literature review, the research on self-esteem, happiness, and depression emerged as yielding the only real consistent findings by far. Thus, this area warrants further study. However, it is important for future researchers to remember the scientific tenet that the correlation between two variables is just that—a correlation, not necessarily causation. Although the link between high self-esteem and happiness, and low self-esteem and depression, appear strong, future research should address the methodological shortcomings of the work that has been done thus far to determine the exact nature of the relationships between these variables, including pathways and direction of causation. We must also remember that, although much of the existing research makes claims of meaningful relationships between these variables, statistically significant relationships are not necessarily meaningful.

Future studies should attempt to identify (and possibly rule) out potential third variable causes. For example, research might be indicated to determine to what degree the specific items on certain commonly used self-report measures (e.g., The Rosenberg Self-Esteem Scale, The

Oxford Happiness Inventory) could be measuring the same construct. For instance, determining

to what degree low self-esteem is just one of the various symptoms of depression could account

for the overlap between items on self-report measures of both constructs (e.g., The Rosenberg

Self-Esteem Scale and the Beck Depression Inventory).

Avoiding common errors in thinking when conceptualizing self-esteem. In Chapter 3,

the current researcher addressed the question of why self-esteem is still widely misunderstood

when it is such a prominent concern of so many people, from mental health professionals to

Westernized civilizations at large. The following are specific guidelines for researchers,

clinicians, and many others in avoiding the same common errors in thinking that have

propagated and sustained this confusion for decades:

- Remember that self-esteem is not a thing that someone actually has. Instead, it is a human-made construct that should be evaluated in terms of its usefulness, rather than its veracity. Understanding self-esteem in this manner will help to guard against people being stuck in a relentless and ultimately elusive pursuit of something that does not objectively exist in the world.

- Avoid the tendency to dichotomize self-esteem, which is a continuous, not categorical, variable. By learning to view self-esteem in more relative (and therefore more realistic) terms, an individual can gain a greater sense of acceptance, flexibility, and control over his or her life.

- Do not confuse a name or a label with an explanation. To label individuals as having high self-esteem or low self-esteem does not explain their emotions, behaviors, thoughts, or life situations.

- Work towards increasing awareness of your own and other people's personal values and biases because they inherently influence the language we use (e.g., high self-esteem vs. narcissism, low self-esteem vs. humility). Try to communicate these values as openly and fairly as possible, as opposed to presenting them as if they were objective reflections of truth.

- Learn to differentiate between Barnum statements (e.g., My client has self-esteem issues) versus specific interpretations that are based on a particular individual or group. Statements about self-esteem issues are often so generic that they can be true of practically all human beings. To reduce the Barnum Effect, use applicable

specifiers (e.g., stable, fragile, inflated, compensatory) or descriptive words to denote degree (e.g., mild, moderate, severe).

• As we attempt to identify where the distinctions lie within the heterogeneous concept of self-esteem, remember that the dimensions or variables selected for the purposes of evaluation (e.g., cognitive vs. affective focus) will determine just how similar or unique the various types or categories of self-appraisal (e.g., self-efficacy vs. self-esteem) turn out to be.

• Do not confuse subjective prescriptions with objective descriptions. In particular, remember that the quest to obtain high self-esteem is not universal. By conflating what is common-uncommon with what is good-bad, clinicians and educators are not only failing to uphold a commitment to cultural awareness and sensitivity, but could also be contributing to the clinical problems they are seeking to alleviate.

Avoiding common misattributions when attempting to understand and change self-esteem. In attempting to understand any phenomena, we typically seek explanations that are simple and easy to understand, which frequently results in making hasty and flawed attributions. Keeping in mind some of the most common misattributions, the following are guidelines in order to avoid settling for simple and uncomplicated explanations regarding self-esteem at the cost of ensuring that they are also comprehensive and accurate:

• Remember that how people behave depends on both internal and external determinants, and we should never underestimate the power of external determinants. We have a tendency to weigh internal causes (e.g., self-esteem) too heavily, and external causes (e.g., one's social environment) too lightly, which can be especially problematic when it leads us to minimize or even ignore important sociocultural factors that shape behavior.

• Do not assume that a favorable response to an intervention proves the cause of the problem. For example, if a therapist/researcher implements an intervention designed to boost self-esteem for people in emotional distress, and a client-subject subsequently exhibits a positive response on a mood scale, it does not necessarily mean that the original cause of the individual's distress was due to low self-esteem. This common misattribution can lead to overlooking other causal factors as play.

• Remember that what feels good is neither necessarily good nor necessarily true. Research has linked high self-esteem to happiness, which naturally suggests that it feels good. However, this link alone does not justify that we should indiscriminately boost self-esteem amongst the populations we serve and ignore the potential

associated costs (such as fueling narcissism). Put simply, we should not rely on our emotions as the sole gauge for distinguishing between truth and falsehood.

Circumventing common pitfalls in future efforts to investigate self-esteem. While the majority of the current investigation has been devoted to highlighting the problems and discrepancies plaguing the existing research, the current researcher acknowledges both the difficulty and the importance of understanding the complexities of our self-related thoughts, feelings and behaviors. Thus, as stated above, despite the fact that the associated body of work as been wrought with confusion, rather than abandoning or replacing self-esteem, the current researcher urges a reconceptualization of the term. As future researchers and clinicians continue to investigate the subject, the following are suggestions for avoiding some of obstacles and pitfalls that have characterized efforts of the past:

- Do not underestimate the extent to which our prior beliefs and expectations shape our current perceptions. Our inclination to make data fit into our schemas (*assimilation*) versus modifying our schemas to fit new data (*accommodation*) could account for our propensity to distort or overlook the evidence that contradicts our common assumptions about self-esteem (such as its lack of explanatory or predictive power).

- Keep an open mind to points of view that challenge our existing beliefs. In our Western, individualistic society, beliefs about the importance of high self-esteem are not only widely accepted, but as research has shown, high self-esteem feels good. Therefore, our emotional investment in these beliefs about self-esteem likely contributes significantly to our tendency to discount, deny or simply ignore any information that runs counter to them.

- Make it a point to actively seek out evidence that could disconfirm our expectations. As researchers and clinicians, we may be unknowingly gathering data and eliciting information that affirms our common misconceptions about self-esteem, causing us to cling to the same conclusions that have been refuted by the evidence time and again.

- Remember that measuring something changes it. Due to the effects of reactivity, researchers using self-report measures of self-esteem are never really ever able to measure natural, authentic cognitions, feelings or behavior, which invariably compromises the validity of their observations. Even if reactivity cannot be eliminated completely, we can reduce its impact by choosing minimally reactive measures or, at least, acknowledging its potential effects when conveying findings.

- Initiate safeguards to reduce the impact of self-fulfilling expectancy effects. With or without our intent, the assumptions, attitudes, and beliefs we hold towards others (e.g., assuming they are suffering from low self-esteem) could actually be contributing to people inadvertently adopting these expected traits. As such, continuing to believe that there is a widespread epidemic of low self-esteem might be detrimental, given the growing amount of research on the potential costs of indiscriminately boosting self-esteem.

- Keep in mind that understanding a problem will not necessarily solve it. As we continue our quest to both understand and improve self-esteem, we must remember that insight alone into our thoughts and feelings about ourselves will not necessarily change them.

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APPENDIX A

Biasing Factors Associated With Self-Report Measures: Glossary of Terms

APPENDIX A

Biasing Factors Associated With Self-Report Measures: Glossary of Terms

bias of acquiescence The tendency for survey respondents to agree with statements regardless of their content (Lavrakas, 2008).

bias of extreme responding The tendency for survey respondents to answer categorical rating scales in the extreme, end-most intervals, across a wide range of item content (Lavrakas, 2008).

bias to the middle The tendency for respondents to avoid extremes and choose middle responses as a way to provide *safe* answers (Williams, 2014).

demand characteristics Cues provided to research participants (e.g., by the experimenter, by the research context, etc.), often unintentionally and inadvertently, regarding the appropriate or desirable behavior. Demand characteristics might bias the outcome of an investigation, which seriously undermines internal and external validity (Lewis-Beck, Bryman, & Liao, 2004).

faking bad/malingering Feigning impairment for secondary gain (Woo & Keatinge, 2008).

faking good Attempting to intentionally manipulate psychological test results in a nonpathological direction (Bruns & Disorbio, 2014).

random responding The tendency of a respondent to answer questions without applying much thought or effort. The respondent is essentially providing random answers, which are not an accurate prediction of their opinions, attitudes, or behaviors (Williams, 2014).

reactivity A phenomenon wherein the conduct of research, in itself, affects the very entity that is being studied; the extent to which measuring something causes it to change (Levy, 2010).

response set The tendency of an assessed individual to respond in a particular way to a variety of instruments, such as when a respondent repeatedly answers as he or she believes the researcher desires even when such answers do not reflect the respondent's true feelings (Gay, Mills, & Airasian, 2009).

social desirability The tendency of some respondents to report an answer in a way they deem to be more socially acceptable than would be their *true* answer (Lavrakas, 2008).

APPENDIX B

Complete List of Measures Cited by the Studies Reviewed

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Complete List of Measures Cited by the Studies Reviewed

Measures of Self-Esteem:

- Rosenberg Self-Esteem Scale (Rosenberg, 1965)
- The Global Self-Worth Scale from Harter's (1982) Perceived Competence Scale for Children (PCSC)
- The Harter (1985) Self-Perception Profile for Children (SPPC)
- Implicit Measures of Self-Esteem
     o Implicit Association Test (IAT; Greenwald & Farnham, 2000)
     o Initial-preference task (IPT; Nuttin, 1985)
- Weinberger Adjustment Inventory (Weinberger & Schwartz, 1990)

Measures of Happiness and Depression:

Happiness:
- Bradburn Affect Balance Scale (Bradburn & Caplovitz, 1965)
- Gurin Scale (Gurin, Veroff, & Feld, 1960)
- Oxford Happiness Inventory (OHI; Argyle, Martin, & Crossland, 1989)
- Subjective Happiness Scale (SHS; Lyubomirsky & Lepper, 1999)

Depression:
- Beck Depression Inventory (BDI; Beck, Ward, Mendelson, & Erbaugh, 1961)
- Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer, & Brown, 1996)
- Hamilton Rating Scale of Depression (HRSD; Hamilton, 1960)
- Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974)

Measures of *Initiative*:

Aggression:
- 12-item delinquent behaviors scale adapted by Elliot, Huizinga, and Ageton (1985)
- Buss-Perry Aggression Questionnaire (AQ; Buss & Perry, 1992)

Bullying and Victimization:
- Peer Relations Questionnaire (Rigby & Slee, 1995)

Externalizing Problems:
- Rutter Child Scale (RCS; Rutter, Tizard, & Whitmore, 1970)
- Revised Behavior Problem Checklist (RBPC; Quay & Peterson, 1987)

Gender Role Tendencies:
- Bem Gender Roles Inventory (Bem, 1974)

Initiating Romantic Intimacy:

- Markers of Starting Romantic Intimacy Scale (Eryilmaz & Atak, 2009)

Interpersonal Dependency:
- Interpersonal Dependency Scale (IDI; Hirschfeld, 1976)

Narcissism:
- Narcissistic Personality Inventory (Raskin & Terry, 1988)

Non-Judgmental Accepting Stance:
- Kentucky Inventory of Mindfulness Skills—accept without judgment subscale (KIMS-A; Baer, Smith, & Allen, 2004)

Parental Rearing Styles:
- Parental Bonding Instrument (Parker, Tupling, & Brown, 1979)

Prosocial Behavior:
- Ratings of Children's Social Behavior Scale (CSBS; Crick, 1996)

APPENDIX C

Rosenberg Self-Esteem Scale

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Rosenberg Self-Esteem Scale

Directions: The next questions ask about your current feelings about yourself. For each of the following, please circle the number that corresponds with the answer that best describes how strongly you agree or disagree with the statement about yourself now.

For the items marked with an (R), reverse the scoring (0=3, 1=2, 2=1, 3=0). For those items without an (R) next to them, simply add the score. Add the scores. Typical scores on the Rosenberg scale are around 22, with most people scoring between 15-25. Scores below 15 suggest low self-esteem.

		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1.	I feel that I am a person of worth, or at least on an equal plane with others.	3	2	1	0
2.	I feel that I have a number of good qualities.	3	2	1	0
3.	All in all, I'm inclined to feel that I am a failure. (R)	0	1	2	3
4.	I am able to do things as well as most other people.	3	2	1	0
5.	I feel I do not have much to be proud of. (R)	0	1	2	3
6.	I take a positive attitude toward myself.	3	2	1	0
7.	On the whole, I am satisfied with myself.	3	2	1	0
8.	I certainly feel useless at times. (R)	0	1	2	3
9.	I wish I could have more respect for myself. (R)	0	1	2	3
10.	At times, I think I am no good at all. (R)	0	1	2	3

Note. From Rosenberg (1965).

APPENDIX D

Harter's Self-Perception Profile for Children

APPENDIX D

Harter's Self-Perception Profile for Children

Instructions to the Child: We have some sentences here and, as you can see from the top of your sheet where it says, "What I am like," we are interested in what each of you is like, what kind of person you are like. Thus is a survey, *not* a test. There are no right or wrong answers. Since kids are very different from one another, each of you will be putting down something different.

First, let me explain how these questions work. There is a sample question at the top marked (a). I'll read it out loud and you follow along with me. (*Examiner reads the sample question*). This question talks about kinds of kids, and we want to know which kids are most like *you.*

(1) So, what I want you to decide first is whether *you* are more like the kids on the left side who would rather play outdoors, or whether you are more like the kids on the right side who would rather watch T.V. Don't mark anything yet, but first decide which kinds of kids are *most like you,* and go to that side of the sentence.
(2) Now the *second* thing I want you to think about, now that you have decided which kinds of kids are most like you, is to decide whether that is only *sort of true for you,* or *really true for you.* If it's only sort of true, then put an X in the <u>box</u> under "Sort of True for me;" if it's really true for you, then put an X in that box, under "Really True for me."
(3) For each sentence, you only check **one** box. Sometimes it will be on one side of the page, another time it will be on the other side of the page, but you can only check *one box* for each sentence. **YOU DON'T CHECK BOTH SIDES, JUST THE ONE SIDE MOST LIKE YOU.**
(4) OK, that one was just for practice. Now we have some more sentences that I will read out loud. For each one, just check one box- the one that goes with what is true for you, what you are most like.

What I Am Like

	Really True for me	Sort of True for me			Sort of True for me	Really True for me
a.			*Sample: Some kids would rather play outdoors in their spare time*	*Sample: Other kids would rather watch T.V.*		
1.			Some kids feel that they are very good at their school work	Other kids worry about whether they can do the school work assigned to them		
2.			Some kids find it hard to make friends	Other kids find it pretty east to make friends		

3.			Some kids do very well at all kinds of sports	Other kids don't feel that they are very good when it comes to sports		
4.			Some kids are happy with the way they look	Other kids are *not* happy with the way they look		
5.			Some kids often do not like the way they behave	Other kids usually like the way they behave		
6.			Some kids are unhappy with themselves	Other kids are pretty pleased with themselves		
7.			Some kids feel like they are just as smart as other kids their age	Other kids aren't so sure and wonder if they are as smart		
8.			Some kids know how to make classmates like them	Other kids don't know how to make classmates like them		
9.			Some kids wish they could be a lot better at sports	Other kids feel they are good enough at sports		
10.			Some kids are happy with their height and weight	Other kids wish their height or weight were different		
11.			Some kids usually do the right thing	Other kids often don't do the right thing		
12.			Some kids don't like the way they are leading their life	Other kids *do* like the way they are leading their life		
13.			Some kids are pretty slow in finishing their school work	Other kids can do their school work quickly		
14.			Some kids don't have the social skills to make friends	Other kids do have the social skills to make friends		
15.			Some kids think they could do well at just about any new sports activity they haven't trued before	Other kids are afraid they might not do well at sports they haven't ever tried		
16.			Some kids wish their body was different	Other kids like their body the way it is		
17.			Some kids usually act the way they know they are supposed to	Other kids often don't act the way they are supposed to		
18.			Some kids are happy with themselves as a person	Other kids are often not happy with themselves		
19.			Some kids often forget	Other kids can remember		

			what they learn	things easily		
20.			Some kids understand how to get peers to accept them	Other kids don't understand how to get peers to accept them		
21.			Some kids feel that they are better than others their age at sports	Other kids don't feel they can play as well		
22.			Some kids wish their physical appearance (how they look) was different	Other kids like their physical appearance the way it is		
23.			Some kids usually get in trouble because of things they do	Other kids usually do things that get them in trouble		
24.			Some kids like the kind of person they are	Other kids often wish they were someone else		
25.			Some kids do very well at their classwork	Other kids don't do very well at their classwork		
26.			Some kids wish they knew how to make more friends	Other kids know how to make as many friends as they want		
27.			In game and sports some kids usually watch instead of play	Other kids usually play rather than watch		
28.			Some kids wish something about their face or hair looked different	Other kids like their face and hair the way they are		
29.			Some kids do things they know they shouldn't do	Other kids hardly ever do things they know they shouldn't do		
30.			Some kids are very happy being the way they are	Other kids wish they were different		
31.			Some kids have trouble figuring out the answers in school	Other kids almost always figure out the answers		
32.			Some kids know how to become popular	Other kids do not know how to become popular		
33.			Some kids don't do well at outdoor games	Other kids are good at new games right away		
34.			Some kids think they are good looking	Other kids think that they are not very good looking		
35.			Some kids behave themselves very well	Other kids often find it hard to behave themselves		

36.			Some kids are not very happy with the way they do a lot of things	Other kids think they way they do things is fine		

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