

Self-Esteem from a Clinical Perspective

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From a clinical perspective, self-esteem has the potential to shed light on both the etiology and the effective treatment of a number of clinical conditions. In this chapter, I highlight some of the established findings, as well as what I see as the important questions and conceptual issues. Unorthodox ideas concerning the pathways by which self-esteem could be associated with clinical conditions are raised, including reverse causation, self-esteem deficits as part of a clinical condition's prodrome (i.e., early subclinical symptomatology), and indirect causal pathways involving behavior and the environment. Different conceptualizations of the nature of vulnerable self-esteem are also highlighted.

Self-Esteem in Depression

Self-esteem has been most extensively investigated in depression, and this work can serve as a framework for anticipating issues that are likely to emerge as research develops on other clinical conditions. Given that feelings of worthlessness are part of the diagnostic criteria for depression (as well as a number of other clinical conditions), research designs need to guard against the possibility that self-esteem deficits are simply a symptom of the disorder itself, a prodrome to the disorder (i.e., an early symptom), or a scar of past episodes (Roberts & Gamble, 2001). Given that we cannot experimentally manipulate self-esteem (at least not in a meaningful manner in this clinical context), we need to be sensitive to the possibility that associations between self-esteem and depression result from third variables. Consequently, plausible common causes of self-esteem and depression, such as the personality dimension neuroticism (Schmitz, Kugler, & Rollnik, 2003), are sometimes used as covariates in data analyses (e.g., Roberts & Gotlib, 1997; Roberts, S. & Kendler, 1999).

A number of prospective studies have now demonstrated that individuals with temporally unstable or labile self-esteem are at risk for developing depressive symptoms

subsequent to stressful life events (e.g., Butler et al., 1994; Roberts & Monroe, 1992; Kernis et al., 1998). Individuals whose self-esteem is more unstable over time are prone to developing greater depressive symptoms following life stressors compared to those with more stable self-esteem. However, this effect seems to be largely limited to individuals who are initially low in depressive symptoms (Roberts & Gotlib, 1997; Roberts & Kassel, 1997; Roberts & Monroe, 1992; though also see Crocker, Karpinski, Quinn & Chase, 2003), and particularly among those who are initially low in symptoms but who have a past history of more serious depression (Roberts & Gotlib, 1997; Roberts & Kassel, 1997; see also Gable & Nezlek, 1998). These findings suggest that unstable self-esteem might be involved in the onset of depressive symptoms, but not the maintenance of already present depressive symptomatology. Interestingly, preliminary research suggests that the exact opposite phenomenon occurs in the maintenance of already existing depression. Specifically, clinically depressed individuals with greater perceived stability of their self-esteem at the start of treatment tend to have a poor treatment response, particularly when coupled with feelings of worthlessness (Roberts, Shapiro & Gamble, 1999). It may be that temporal variability in self-esteem contributes to the onset of depression, but once clinical depression sets in stability reflects an ingrained negative self-image that is resistant to change. Different processes may be involved in the onset versus maintenance of symptoms, and research samples that indiscriminately include all levels of symptomatology potentially yield misleading findings.

Although these findings appear both reliable and distinct from level of self-esteem (i.e., high vs. low SE), which does not consistently predict the development of depression (see Roberts & Monroe, 1999 for a review), the underlying mechanisms by which unstable self-esteem contributes to depression are not established. At least three as yet untested mechanisms appear

plausible. First, given their tenuous and unstable self-representations, it may be that individuals with unstable self-esteem have difficulty recruiting concrete mental representations of coping responses, leading to less effective problem solving. Consequently, stressors that would otherwise be brief and minor become prolonged and threatening. Second, individuals with unstable self-esteem may respond to threats with anger (Kernis, Grannemann, & Barclay, 1989) or excessive reassurance seeking from others, leading to interpersonal stressors that in turn amplify depression (Joiner & Metalsky, 2001). These first two models suggest that the effects unstable self-esteem on depression are indirect and are mediated by “stress generation” (Roberts & Ciesla, 2001). The final model suggests a more direct effect; there may be greater spreading activation of negative representations of self following stressors among those with unstable SE, which leads to pervasive negative thinking about the self, world and future (the so-called “negative cognitive triad”) and the development of depressive symptoms.

Another growing body of research suggests that self-esteem works together with negative attributional style in creating vulnerability to depressive symptomatology. According to the Hopelessness Theory of Depression (Abramson, Alloy & Metalsky, 1989), individuals with negative attributional styles (e.g., the tendency to attribute negative events to stable, general and internal causes) are prone to hopelessness when confronted with stressors, and hopelessness in turn leads to depression. Although a number of studies have shown that negative attributional style increases the impact of stress on the development of depressive symptoms, this effect appears to be stronger among those with low compared to high self-esteem (Abela & Payne, 2003; Metalsky, Joiner, Hardin, & Abramson, 1993; Robinson, Garber, & Hilsman, 1995; Southall & Roberts, 2002). Metalsky et al. (1993) assert that high self-esteem breaks the connection between negative attributional style, hopelessness and depression, but exactly how

this happens is left unexplained.

Regardless of level of SE, we would expect that negative attributional styles will impact one's outlook on the future when confronted with stressful life events – as a result of stability attributions, adversity would be expected to continue into the future, as a result of generality attributions, adversity would be expected to be pervasive across life domains, and as a result of internality attributions, adversity would be viewed as resulting from something internal to the person. Though the future would not look bright, those with higher self-esteem appear resistant to developing generalized hopelessness and depression. Why? Somehow high self-esteem buffers against the toxic effects of these attributions and allows these individuals to remain engaged and active in life. Perhaps a different form of hopelessness arises – hopelessness about the external situation but not about the value and worth of the self.

From the depression literature, several themes emerge. First, the effects of various facets of self-esteem play different roles in the onset versus maintenance of the condition. Second, self-esteem interacts with other risk factors, such as life stress and attributional style, in the prediction of depression. Third, more complex models of self-esteem that include facets beyond level contribute to our understanding. Finally, it should be noted that self-esteem may mediate the effects of adverse parenting and insecure attachment on the development of depressive symptoms emerging later in life (Gamble & Roberts, 2004; Garber, Robinson, & Valentiner, 1997; Roberts, Gotlib, & Kassel, 1996). Each of these issues is likely to be important in research exploring self-esteem in other mental disorders.

Self-Esteem in Other Clinical Conditions

From both diagnostic and theoretical standpoints, self-esteem plays a pivotal role in a number of clinical conditions beyond depression. For example, one of the cardinal symptoms of

eating disorders involves the overvaluing of body shape on self-esteem. This view suggests that individuals with self-esteem contingencies based on body shape will be at risk for eating disorders. Consistent with this perspective there is evidence that females who base their self-esteem on body shape are at risk for developing eating disorder symptoms (Crocker, 2002; Geller et al., 1998), as are females who base their self-esteem on intimate relationships (Geller, Zaitsoff, & Srikaneswaran, 2002). Furthermore, a series of studies has demonstrated that low self-esteem prospectively predicts symptoms of bulimia in interaction with perfectionism and the perception of being overweight. Specifically, perfectionistic women who perceive themselves as being overweight are at risk for developing symptoms of bulimia if they have low SE, but not if they have high self-esteem (Vohs et al., 2001; Vohs, Bardone, Joiner, & Abramson, 1999).

Although both clinical theory (e.g., Heimberg & Becker, 2002) and diagnostic criteria emphasize the importance of self-esteem issues in the social anxiety disorders (Social Phobia and Avoidant Personality Disorder), there is a paucity of empirical work examining the role of self-esteem in these conditions. Cross-sectional studies have demonstrated that social anxiety is correlated with low self-esteem on explicit measures of self-worth (Kocovski & Endler, 2000; de Jong, 2002), but not on implicit measures (de Jong, 2002). Likewise, according to both diagnostic criteria and clinical theory, several personality disorders including Narcissistic, Avoidant, Dependent and Borderline Personality Disorders are rooted in self-esteem deficits, but again there is little well designed empirical research. One exception is a recent study demonstrating that borderline features are associated with both lower levels of self-esteem and less stability of self-esteem from one day to the next (Tolpin, Gubnthert, Cohen, & O'Neill, 2004). Interestingly, two disorders raise issues concerning the global versus domain specific nature of self-esteem -- Body Dysmorphic Disorder and Gender Identity Disorder. The former

involves strong negative evaluation of a specific body part (e.g., one's nose), whereas the latter involves negative evaluation of one's assigned sex. To what extent is extreme dissatisfaction with a body part or negative evaluation of one's gender conceptually similar to the self-esteem construct?

Self-Esteem in Treatment

To what extent are improvements in self-esteem per se important in treatment? In other words, should interventions directly target self-esteem as an end in itself? Consistent with this idea, some clinicians have developed programs that are specifically designed to raise self-esteem (e.g., McKay & Fanning, 1992; Mruk, 1995; Newns, Bell, & Thomas, 2003). Likewise, cognitive therapists emphasize work on modifying beliefs about the self (e.g., Beck, 1995), including schema – deeply ingrained beliefs such as “I am fundamentally unlovable”, “I am unable to function on my own” and “I am morally bad” (Young, 1994). This work involves teaching clients to treat their thoughts (including their beliefs related to self-worth) as hypotheses rather than as hard truths. Clients would learn to examine the evidence for and against their negative beliefs, develop methods of testing these beliefs, and consider alternative beliefs that are more consistent with the facts. They would also learn to systematically monitor and challenge logical errors in their thinking – so-called “cognitive distortions” -- such as black and white thinking and overgeneralization.

A second perspective suggests that improvements in self-esteem are primarily important as a means to other ends, for example, helping the client feel good enough and competent enough to try making a behavioral change. Within this perspective, self-esteem is relevant in terms of facilitating adaptive behavior. For example, the standard treatment for Specific Phobias involves exposure to the feared stimulus and the standard treatment for Obsessive-Compulsive Disorder

involves exposure to the feared stimulus (typically a frightening thought or image, or a “contaminated” object) with response prevention (i.e., preventing the ritualistic behavior that typically follows contact with the feared stimulus). Both cases are enormously challenging for the client, and consequently one of the most challenging tasks for the clinician is to help the client muster the psychological resources necessary to engage in treatment. Self-esteem would be a necessary ingredient for change, but would not be directly related to the actual mechanism of change – in this case habituation to feared stimuli.

A final perspective suggests that treatment should work toward decreasing self-focus and preoccupation with self-worth. In other words, the therapist should help the client decrease the struggle against negative self-evaluative thoughts. Paradoxically, the struggle for self-esteem itself may be problematic for many individuals (Crocker & Noah, 2003). Consistent with this possibility, low self-esteem among depressed patients who are highly self-focused and ruminative is predictive of poor response to behavioral treatment (Ciesla & Roberts, 2002). Given their elevated self-focus and rumination, these patients are likely to be highly preoccupied with their negative thoughts about themselves. Perhaps this idea is best exemplified among individuals with Narcissistic (Morf & Rhodewalt, 2001) and Borderline Personality Disorders. Such individuals find any feelings of inadequacy intolerable and wreak interpersonal havoc in their frantic efforts to avoid such feelings. In fact, recent developments in clinical practice emphasize the importance of acceptance in which the client learns to tolerate previously rejected aspects of themselves rather than struggling to change them (Hayes, Strosahl, & Wilson, 1999; Linehan, 1993; Segal, Williams, & Teasdale, 2002). This process may involve habituation to negative internal experience, including feelings of inadequacy and guilt, and learning to ease the struggle for positive self-worth.

If self-esteem becomes a focus in treatment, it is important that the clinician assess the nature and functional impact of the client's self-esteem issues. Rather than being a monolithic construct, self-esteem appears to have a multifaceted nature, and this perspective needs to be incorporated in clinical work. For example, Greenier, Kernis and Waschull (1995) raise the possibility that unstable self-esteem can arise from different causal pathways. Unstable self-esteem that results from high ego involvement in which they are continuously involved in self-evaluative processes would have different treatment implications than unstable self-esteem that results from impoverished self-concepts. One of the key aspects in case conceptualization involves a functional assessment of how self-esteem issues and related behaviors impact the client's life. For example, does the client verbalize negative self-statements? What situations do these behaviors tend to occur in? What are the consequences of this behavior? As an example, in some cases of depression feelings of worthlessness lead to social withdrawal, isolation and inactivity. The resulting loss of reinforcement and reward in turn directly contributes to depression (see Lewinsohn, Hoberman, & Hautzinger, 1985). In such cases, it may be more productive to concentrate efforts at improving social activity rather than directly trying to increase self-esteem.

Conclusions

Various facets of self-esteem appear to be associated with risk for depression, and perhaps other clinical disorders as well. Likewise they appear to be involved in the process of recovery. However, the causal pathways by which self-esteem is associated with clinical disorders and their treatment are unclear -- it may be that the causal effects of self-esteem are largely indirect and are mediated by behavior and the environment. Paradoxically, it may be that preoccupation with one's view of self is most problematic for some individuals as it interferes

with the pursuit of goals and engagement with life and the experience of reinforcement and reward from the environment. Greater attention to the mechanisms by which self-esteem is associated with mental disorders would be productive in both clinical practice and research. Such a functional analytic approach would examine the actual consequences of self-esteem deficits in the person's life, including interpersonal, behavioral, and environmental consequences, and how those consequences contribute to clinical conditions. Finally, given the close association between aspects of self-esteem and various mental disorders, it would be wise for social and personality researchers to consider the possibility that some of their findings are the result of elevated levels of clinical symptoms, such as depression, rather than self-esteem deficits per se.

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