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Review Article

Self-Esteem – A Psychiatric View

P. J. ROBSON

The literature relating to the acquisition, maintenance, and clinical significance of self-esteem reveals theoretical differences between earlier investigators. The nature of self-esteem remains controversial, and attention is drawn to some of the problems of construct validation and measurement. Despite the difficulties, self-esteem is a concept worthy of further pursuit. This will require a measuring instrument that captures the concept more effectively than those currently available.

Self-esteem is often discussed in a clinical context, both as an explanation for and consequence of psychological disorder, and clinicians may feel they have an intuitive understanding of the meaning and significance of the term. However, they might be surprised to discover that this hypothetical concept has attracted a number of discrepant definitions, each reflecting the theoretical stance of the writer. Should it be categorised as a need (Maslow, 1954), an attitude (Coopersmith, 1967), a consequence of competence (White, 1964), a necessary condition for achievement (Coopersmith, 1967), an index of mental health (Fitts, 1972), or a moderating variable (Ziller, 1973)? Is enhancement of self-esteem the main purpose of all human activity (Hayakawa, 1963), or is the whole idea of 'the self' as an objective entity an artefact (Lowe, 1961)?

Low self-esteem has been implicated as an aetiological or contributory factor in depression (Beck, 1967; Wilson & Krane, 1980; Ingham *et al*, 1986), anxiety (Rosenberg, 1962; Ingham *et al*, 1986), alcohol abuse (McCord & McCord, 1960) and drug abuse (Brehm & Back, 1968), adolescent interpersonal problems (Kahle *et al*, 1980), and child abuse (Shorkey, 1980). It has been said to play a part in determining motivation (Becker, 1971), conservatism (Boshier, 1969), prejudice (Bagley *et al*, 1979), authoritarianism (Bales, 1970), attraction (Abloff & Hewitt, 1985), and to be a predictor of various kinds of deviant behaviour (Kaplan, 1975).

Lack of a clear definition

As Wells & Marwell (1976) pointed out in their important monograph, three difficulties arise out of the ubiquity of the term. First, the reliance upon common-sense definitions gives the misleading impression that different writers are referring to the same thing when they discuss self-esteem. Secondly, the assumption that everyone has an intuitive understanding of its nature hides the fact that individual theorists hold different views as to what comprises a healthy component of personality: for example, high measures might be regarded as adaptive and desirable by one school, but rigid and defensive by another (Harder, 1984). Finally, because we all think we know about self-esteem, we tend to take its existence as a separate and independent entity for granted, when this is by no means established.

Even when central to a major theory, the concept is often defined rather imprecisely. For example Brown & Harris (1978) consider that vulnerability factors (e.g. early separation from parents) act through the common denominator of low self-esteem, yet this term was chosen at least in part because it was used spontaneously by subjects. The authors go on to say "there are several terms other than self-esteem that could be used almost interchangably – self-worth, mastery, and so on."

Cultural influences

There is a danger that self-esteem measures may come to reflect values deemed important by the culture (Feather, 1985), and these might differ considerably from the ideal for personal contentment. For example, 'masculine' traits such as competitiveness and independence are relevant to material success, but may be less conducive to inner satisfaction than 'feminine' traits such as gentleness, kindness, and concern for others. Many scales seem to represent the dominant masculine values of Western cultures and it has been shown that masculinity scores correlate highly with self-esteem scores in both sexes (Koffman & Lips, 1980). Males often score higher on self-esteem measures than females in normal populations (Feather, 1985), but high scores might simply represent conformity to the social group, and such individuals may also rate highly on submissiveness, rigidity, or insensitivity. Scales may fail to account for developmental, cultural, religious, and situational differences

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(Juhasz, 1985), as suggested by the fact that, in most studies, Blacks have higher self-esteem scores than Whites (Hoelter, 1983). Perhaps the steady increase of self-esteem in late adolescence (Demo & Savin-Williams, 1983) is related less to increasing self-acceptance than to progressive indoctrination into society's values.

The literature on self-esteem is extensive and although necessarily selective, this review covers a large range of studies. Critical evaluations of individual papers are avoided in favour of more general comments on methodology and interpretation. The development of the concept and the way different theorists characterise it, problems in measurement, how self-esteem is acquired and maintained, the effects of having high- or low self-esteem, and some proposals for the clear definition and application of the concept in clinical psychiatry are considered.

Development of the concept of self-esteem

Before William James (1890) addressed the nature of the self, this was considered to be the domain of the philosopher rather than the psychologist. James discriminated the self as known from the self as knower, and divided the former into three components: material (body/family/home); social ("a man has as many social selves as there are individuals who recognise him"); and spiritual (states of consciousness, psychic faculties, dispositions). The self concept was seen as being acquired through interaction with other people rather than being inborn, and it was recognised that the self as experienced may differ from the self as presented. James stressed the vital role of personal values in determining the affective response to self-evaluation, and argued that self-esteem is determined by the interaction between success and pretensions. Relevant to this idea is the notion of 'level of aspiration' (i.e. deciding how high to set one's goals), which was greatly elaborated by Lewin *et al*, (1944), who investigated empirically its major determinants including previous successes and failures, the values and aspirations of the family and social group, and certain characteristics of personality.

Cooley (1902) developed the idea of the 'looking-glass self', which stressed the importance of other people's reactions in shaping self-esteem. Similarly, Mead (1934) elaborated the notion that self-esteem derives largely from the reflected appraisals of others. McDougall (1928) called the units of character 'sentiments', defining sentiment as a "conative attitude towards some object induced by experience of that object". A sentiment (e.g. hatred) is enduring and must therefore be distinguished from an emotion (e.g. anger), which is a way of functioning. The most important and influential sentiment was thought to be that of self-regard. A person builds up a system of beliefs about himself rooted in the "conative dispositions" of self-assertion and submission. This system is continually activated by experience and extends to external expressions of self such as clothes, occupation, family, and social group. A judgement by others on any of these things reverberates within the self-regard system.

Many of Freud's followers have emphasised the importance of self-images (e.g. Mendelson, 1967). An example of a modern psychodynamic formulation is provided by Storr (1979). Infants become increasingly aware of their dependency and helplessness relative to adults, but if they are fortunate enough to have been born into a home in which they are cuddled, played with, and "irrationally adored", the resultant feeling of being significant and worthwhile will outweigh this helplessness. They will then gradually introject the parents as 'good objects', so that, eventually, repeated external affirmations of worth are no longer required, since a basic sense of self-approval has become a part of the personality. Bowlby (1973) too has drawn attention to the importance of a secure attachment to a principal figure in early childhood as a basis for incorporating self-reliance as an enduring personality trait.

Rosenberg (1965) conducted the first major empirical study on the subject. He explored the effect of various social factors, including social class, ethnic group, religion, order of birth, and parental concern, on self-esteem in a large number of adolescents. This study is also notable for having generated one of the most widely used measures of self-esteem.

Current views of self-esteem

Despite the colossal literature that has accumulated, a clear consensus as to the meaning of self-esteem is still lacking. Different researchers have related it to almost every variable at one time or another (Wylie, 1961). Some see self-esteem as stable and enduring, yet, at least in the short term, it has been shown to be susceptible to a number of experimental manipulations (Anderson & Williams, 1985; Jones *et al*, 1981), and age seems to account for some variance (Nehrke *et al*, 1980). Some workers (e.g. Rosenberg, 1965) propose a global concept (comprising self-evaluations of such items as adequacy, worth, goodness, health, appearance, skills, sexuality, social competence) while others prefer a "hierarchical multifaceted model" (Fleming & Courtney, 1964) made up of area-specific self-evaluation at

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home, within the peer group, or at school. Some believe that situational variance will always tend to interfere with measurement, as for example in assessment of social self-esteem (Lawson *et al*, 1979). Although classical behaviourists may reject the concept of self-esteem, it is interesting that there is a significant correlation between Eysenck's neuroticism trait and the "negative evaluation of self" factor from the Coopersmith self-esteem inventory (Bagley & Evan-Wong, 1975).

Problems of measurement

The difficulty in interpreting the various studies stems largely from the quality of the measuring instruments, because reliable and valid measurement of self-esteem presents formidable problems. Many instruments have been devised, but most are in some way unsatisfactory for the clinician, and only 29% of scales devised for social-science investigations are used more than once (Bonjean *et al*, 1967). As, on occasion, self-esteem scales have intercorrelated poorly, they may measure different constructs (Bridle, 1984), or different elements of the same construct (Lloyd *et al*, 1979). Some scales appear to incorporate connected but separate constructs, such as self-identity, contentment, or anxiety (Fleming & Courtney, 1984). There is overlap of items between some self-esteem and depression scales, and this may sometimes account for positive correlations between self-esteem and depression (MacLachlan, 1985).

Very few instruments have been subjected to stringent testing of discriminant validity, despite acceptance of the desirability of multitrait–multimethod investigations (Campbell & Fiske, 1959). Even if such sophisticated analysis is undertaken, the fundamental problem of a circular relationship between validation of measures and definition of the concept remains: each requires the other (Wells & Marwell, 1976).

Other methodological artefacts that can cause response variance include: the ceiling effect in scoring (Bingham, 1983); response style variance (extreme/moderate, broad/focused); social differences lead-ing, for example, to semantic confusion; inconsistency or carelessness in younger subjects (O'Malley & Bachman, 1983); and social-desirability effects, which accounted for 22% of the variance in one study (Ryden, 1978), and include acquiescence, need for approval, and defensiveness. Normative data may be based on inadequate numbers or a limited sampling frame. Instructions for use of the questionnaire have a significant effect on item interpretation and may not be standardised between individuals or groups.

The majority of measures are based on verbal self-reports in which a stem statement relates to some form of scale, most frequently of the Likert type. The number of points on the scale represents a compromise between maximising reliability and remaining within the discriminatory range of the subject. Scales which require a judgement of whether each statement is 'Like me' or 'Unlike me' may be misleading, because a subject might disapprove a likeness that is ascribed a positive value by the researcher (Juhasz, 1985). Measures in which the 'real' self is contrasted with the 'ideal' self to obtain a real/ideal discrepancy score remain controversial, some workers arguing that inherent interpretative difficulties reduce reliability to an unacceptable degree (Hoge & McCarthy, 1983). Some studies demonstrate considerable racial differences (Hoelter, 1983), and these may be artefacts related to race-sensitive demographic variables such as parents' education, social discrimination, or number of siblings (Gray-Little & Appelbaum, 1979). Summation of response biases may impair the internal consistency of scales. For example, it seems that endorsement of negative items may be a better measure of vulnerability to depression than disagreement with positive items (Ingham *et al*, 1986). A similar finding was noted in assessing the effects on self-esteem of unemployment (Warr & Jackson, 1983). This may be because in responses to questions affirming a positive statement, two major response biases, social desirability and acquiescence, act synergistically, whereas for negative items they act in opposite directions. An alternative explanation is that positive and negative self-conceptions may 'uncouple' in certain adverse circumstances (Warr & Jackson, 1983).

Some investigators (Savin-Williams & Jaquish, 1981) feel that the self as experienced may differ significantly from the self as presented, as a result of lack of awareness, insight, or defences, emotional state, or the response biases outlined above. Consequently, a number of non-phenomenological or abstract measures have been devised ranging from structural efforts like the draw-a-person procedure (Machover, 1949), through to projective techniques such as thematic apperception (Mussen & Porter, 1959) or Rorschach interpretation (Spitzer, 1969). Potential advantages are that they are non-verbal, do not mould responses, avoid assumption of equivalent personal values, and are not culture-bound. After reviewing available measures, however, Wylie (1974) was forced to conclude that "both the conceptual and methodological problems of establishing construct validity of indices purported to reveal the unconscious self-concept have not been clearly recognised or coped with", and that none of the current instruments could be considered adequate.

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Given the inherent difficulties of defining and measuring self-esteem, it seems reasonable to suppose that failure to find positive associations is sometimes attributable to lack of instrument power (Richards, 1983), so that its role as an independent moderating variable or trait may have been underestimated. This lack of discrimination is underlined by the fact that on occasion, simple subjective self-ratings by patients have performed as well as complicated questionnaires (Van Tuinen & Ramanaiah, 1979). The interested reader is referred to the monograph of Wells & Marwell (1976) and to Wylie (1974, 1979) for a critical evaluation of research design and measurement techniques.

The acquisition of self-esteem

Coopersmith (1967) has identified what he believes to be clear antecedents of high self-esteem in childhood. These are: unconditional acceptance of children by their parents; clearly defined and enforced limits to behaviour; respect and latitude for individual action and interpretation within the defined limits; and high self-esteem in the parents. He argues that the major components of self-esteem are a sense of competence, significance, virtue, and power. There is some evidence that there may be sex differences in arriving at a self-view: boys may obtain a sense of worth from self-approval of an act or feeling, whereas girls tend to give more weight to approval by others (Rampel & Bingham, 1975).

According to Beck (1967), a person acquires his self-concept from personal experiences, from the judgements made of him by others, and from identification with family and friends. Once a concept begins to emerge, events are interpreted in such a way as to consolidate the concept, eventually giving rise to a permanent cognitive structure. Investigation from a rational–emotive perspective has associated the development of low self-esteem with certain specific irrationalities such as excessive need for approval, perfectionism, problem avoidance, and anxious overconcern (Daly & Burton, 1983).

A more spiritual view is that self-esteem relates to the satisfaction of needs related to having, relating, and being (Campbell, 1981). The latter involves a feeling of having control over the direction of one's life and a sense of contentment and fulfilment. A further need might be for some form of transcendence, i.e. commitment to purposes that involve ultimate meaning for life (Ellison, 1983).

Brown & Harris' (1978) hypothesis that certain "vulnerability factors" lower self-esteem in certain women is supported by results from an important community survey (Ingham *et al*, 1986). This confirmed that early separation from parents and lack of a personal confidante were associated with low self-esteem in both normal women and those with psychiatric disorder. In the latter group, those with three young children at home or an unemployed spouse had lower self-esteem than women without these factors. In this same group, working-class women had lower self-esteem than middle-class women. A major conclusion was that the level of self-esteem could not simply be explained as a consequence of mood change or depressive illness. In a subsequent prospective study (Ingham *et al*, pers. comm.) the vulnerability factors most closely associated with low self-esteem were not those that best predicted future onsets of depression. In considering the finding that low self-esteem may pre-date the onset of clinical depression, the possibility that it is simply an early manifestation of the clinical disorder was considered. It was concluded that those vulnerable to depressive illness are distinguished by chronic self-disparagement not explainable by changes in mood. Brown *et al* (1986) have shown, in a prospective community study, that the level of social support correlated quite highly with measures of self-esteem in a large group of working-class women. Negative evaluation of self and a lack of social support were associated with a much higher risk of depression in the face of a subsequent stressor.

Maintenance of self-esteem

As with other psychological sets, self-esteem is associated with self-fulfilling types of behaviour (Coopersmith, 1967). For example, a child that evolves a low opinion of his abilities may adopt a demeanour and style signalling pessimism and apathy, which may be construed by teachers and peers as evidence of poor ability and treated accordingly. The child's expectations are confirmed, his self-defeating behaviour reinforced, and a vicious circle completed.

Children with different levels of self-esteem have been shown to attribute different causes to their successes and failures (Fielstein *et al*, 1985). Those with high scores are more likely to attribute success to ability (stable, internal attribution) and failure to lack of effort or bad luck (unstable or external attributions), whereas children with low scores make external, unstable attributions to success, and stable, internal attributions to failure. These attributions may be the major determinants of the affective response to success and failure (McFarland & Ross, 1982). Children with low self-esteem put less effort into their endeavours (Sigall & Gould, 1977) because they have lower expectations of success (Coopersmith, 1967). There is evidence that self-esteem stabilises

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as a person progresses into adolescence and the positive correlation with achievement increases in this period (Rubin, 1978). This stability is independent of the level of self-esteem (Padin *et al*, 1981). In order to defend their self-esteem, individuals evaluate the results of their efforts in such a way as to maintain consistency between objective evidence and protective explanations of outcome (Pyszczynski *et al*, 1985), e.g. by using self-handicapping strategies ("I failed the exam because I was drunk the night before") or control of post-outcome interpretation (as in Aesop's fable of the sour grapes).

It seems that to maintain a positive self-image, it is necessary to seek out and accept positive information about oneself while avoiding or rejecting negative information. As an example of this process, there is evidence that normal subjects remember pleasant self-descriptive phrases better than unpleasant ones (Bower & Gilligan, 1979). As indicated above, it is also helpful to attribute positive outcomes internally, stably, and globally, and negative consequences externally, unstably, and specifically. Internal attributions to negative consequences may be adaptive if they are at the same time unstable and specific (e.g. lack of effort).

In the elderly, the preservation of self-determination in institutional settings and work-roles is important (Brisset, 1972), and loss of self-esteem caused by retirement from competitive activities, and awareness of society's largely unsympathetic attitude to old people, may predispose them to the depression that commonly occurs at this time in life (Butler & Lewis, 1973).

Significance of self-esteem

Before considering the role self-esteem might play, we must reconsider the problem of interpreting scores. One might reasonably suppose that people who think well of themselves are more likely to be happy and well adjusted, but the assumption that this is a simple linear relationship may be wrong. The majority of writers seem to assume without discussion that high self-esteem scores equate with optimal personal functioning, but this ignores the possibility of defensively high self-evaluation (Harder, 1984). Subjects whose true self-view is one of rejection or loathing sometimes score very highly on self-esteem questionnaires. Such people may appear self-confident, ambitious, arrogant, aggressive, and present an image of 'haughty superiority' (Reich, 1933). Low scores are generally held to be undesirable, although they may be associated with more flexibility, less authoritarianism, and a greater ability to admit weaknesses. A third proposition is that an intermediate position is best for mental health, and that self-esteem and adjustment have a curvilinear relationship (Block & Thomas, 1955). In considering correlational relationships it is essential to bear in mind that statistical associations may relate to either cause or effect, or be merely fortuitous.

Consequences of low self-esteem

Bearing in mind the above qualifications, these have been said to include: dependency, the need for approval, helplessness, and masked hostility (Storr, 1979); depression, anxiety, and submissiveness (Luck & Heiss, 1972); poor general health (Goldberg & Fitzpatrick, 1980); apathy, feelings of powerlessness, isolation, unloveability, withdrawal, passivity, and compliance (Coopersmith, 1967); the tendency to downgrade or denigrate others (Adler, 1926; Keller & Bishop, 1985) or project one's own failings onto others (Bramel, 1963); reduced ability to choose jobs well suited to needs and abilities (Korman, 1966) and a lessened association between task performance and satisfaction (Korman, 1968); a tendency to accept unfavourable assessments as accurate (Swanson & Weary, 1982); less likelihood of scholastic success (Brookover *et al*, 1964); and vulnerability to multiple interpersonal problems in adolescence (Kahle *et al*, 1980). In the elderly, low self-esteem has been associated with poorer health, more daily pain, greater disability, increased somatisation, anxiety, and depression (Hunter *et al*, 1981). It was not related to age, education, income, or living arrangements in this group.

Consequences of high self-esteem

In the face of such disadvantages, one would expect the benefits to be extensive, and this is indeed the case.

It has long been posited that perception of others is coloured by the self-concept. Adler believed that a sense of inferiority led to an intense struggle for self-assertion that might incorporate deprecation of others, while Fromm contended that self-love and love of others were closely related (Brown, 1961). Rogers (1951) argued that those who approve of themselves are more objective in recognising positive and negative characteristics of others, because they have less need to distort perception as a means of self-defence. When psychotherapy is successful, and negative self-attitudes decrease, he reported an associated improvement in acceptance of others (Rogers, 1967). A lack of self-esteem inhibits what Sullivan (1953) referred to as "conjunctive motivations", i.e. impulses directed towards satisfying

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needs and enhancing security, for example falling in love. High self-esteem lessens the tendency to social isolation, exploitative attitudes or hostile dependency. According to Coopersmith (1967), people with this attribute are more accepting and are more likely to be leading active lives with a sense of being self-determining; are better able to tolerate internal or external distress without isolating themselves from inner experiences; are less anxious (unless there is a discrepancy between self-evaluation and public regard (Lundgren, 1978)); are less sensitive to criticism; are more willing to express a controversial opinion, paying greater attention to personal values than group mores. They tend to have better physical health, enjoy better relationships, value independence, welcome competition, and anticipate more success (Rosenberg, 1965). There is a positive association between self-esteem and assertiveness (Lefevre & West, 1981).

Self-esteem and affective disorder

The link between low self-esteem and depression is well documented and widely accepted, but controversy persists as to whether changes occur independently of changes in mood. A behavioural view of depression would be that low self-esteem is a consequence of depressive behaviour (Lewinsohn, 1974), while others see it as one component of a depression-prone personality (Altman & Wittenborn, 1980). Beck (1967) argues that negative attitudes towards the self are not merely symptomatic of the depressive syndrome, but are, in association with negative value judgements, central to its pathogenesis. They may increase vulnerability to depression by existing in a latent state ready to be activated by relatively minor experiences of deprivation or rejection. He points out that depression-prone people often relate their worth to external factors beyond their control, for example, the approval of others (Beck *et al*, 1979). Other workers conclude that low self-esteem arises as a consequence of depression, and neither precedes nor follows it (Lewinsohn *et al*, 1981). Low self-esteem and anxiety are also highly correlated, and the arguments about direction of causality and overlap between the two concepts are reviewed by Bagley *et al* (1979).

It seems that low self-esteem may be a feature in both phases of bipolar affective disorder, although in the manic phase it may not be directly expressed. Manic patients score similarly to normal people on self-esteem scales, but they have much higher social desirability and self-deception ratings. More importantly, when asked to explain the causes of positive and negative events, they much more closely resemble depressed patients than normal people, and could therefore be said to present an example of defensively high self-esteem (Winters & Neale, 1985).

Self-esteem and unemployment

This relationship is topical but complicated. There are many confounding variables, such as age, previous occupational status, and degree of social support, but generally a significant correlation has been found between low self-esteem and unemployment (Feather, 1982). In a study of young people, there was some evidence that in boys it might predispose to unemployment, whereas in girls the reverse was true (Tiggeman & Winefield, 1984). Differences in self-esteem between employed and unemployed young people were due to a larger increase in those obtaining jobs rather than a reduction in those who did not. Interestingly, unemployment seems to give rise to an increase in negative self-appraisal rather than a decrease in positive self-appraisal (Warr & Jackson, 1983), a point that should be borne in mind when selecting an instrument of measurement.

Manipulation of self-esteem in treatment

The central effect of many forms of psychotherapy is assumed to be an improvement in self-esteem, although usually this is not specifically targeted or monitored and, despite the work of such therapists as Frank (1974) and Rogers & Dymond (1954), remains largely unsubstantiated.

Self-esteem can be manipulated experimentally, and lowering it has been shown to produce depression, anxiety, hostility, and withdrawal (Wilson & Krane, 1980). From this, one might expect that increasing self-esteem might counteract these maladaptive mood states and types of behaviour and there is some support for this in the work of Fennell & Zimmer (1987), who demonstrated short-term improvement in depressed mood in severely depressed in-patients who spent 30 min focusing on positive aspects of the self concept. Whether such changes in self-esteem or mood are lasting is unknown. It is difficult to alter general attributional style (Sober-Ain & Kidd, 1984), but task performance of subjects with low self-esteem may be improved if attributions for previous failures can be made external (Brockner & Guare, 1983).

A negative attitude towards the self is central to the cognitive model of depression, and improvements in self-esteem, at least in the short term, have been reported in response to various cognitive–behavioural interventions. These include cognitive restructuring and rehearsal (Gauthier *et al*, 1983), activity

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scheduling, and rational emotive therapy (Gardner & Oei, 1981), although both these studies require cautious interpretation. Irrational beliefs that could be specifically targeted include excessive need for approval, unduly high self-expectations, anxious overconcern, and tendency to avoid problems (Daly & Burton, 1983; Lefevre & West, 1981).

Beck (1967) has noted that depressed patients characteristically view themselves as wanting in the very attributes they value most. Shortcomings are magnified and strengths ignored. The distorted self-view is maintained by specific faults in interpretation, including overgeneralising from a single event, ignoring positive information, and drawing conclusions that are unsupported by the evidence as a whole. The patient also indulges in frequent moralistic value-judgements about himself (e.g. being worthless, lazy, incompetent).

In treatment, cognitive therapists regard negative self-evaluations as "hypotheses that require empirical testing" (Beck *et al*, 1979). The patient is first made aware of his pervasive self-criticisms and then taught to assess objectively the evidence for and against them. He learns the connection between thought and mood, and is helped to interpret experiences more realistically.

Discussion

Quite clearly, self-esteem is an idea rather than an entity, and signifies different things to different people. The interpretation of self-esteem scores is complicated by poorly conceptualised scales and artefacts resulting from study design or the interpolation of personal and cultural factors. Are the needs of clinical psychiatrists and experimental psychologists in applying the concept different? There is much to be learnt from the experimental literature, but to improve clinical usefulness the idea has to be developed along different lines. To the clinical or experimental psychologist, self-esteem does not seem to have been a particularly useful construct, being too broad and vague a term, without a satisfactory empirical base. The tendency has been to reduce and refine it to more specific and tightly defined concepts, which might have greater analytical or predictive usefulness, or to abandon it in favour of different phenomena such as self-efficacy (Bandura, 1977).

We have seen that low self-esteem has been associated in the literature with a large number of undesirable or maladaptive traits, symptoms, or behaviour. Unfortunately, measurement scales inevitably reflect the differing theoretical stances of their inventors, and it is therefore difficult to relate the results of one study to another with confidence. Wylie (1961, 1974, 1979) drew attention to the widespread use of unvalidated instruments and flawed research designs. She suggested that investigators should use only instruments with acceptable levels of validity and reliability, give more attention to validating the construct, and qualify their conclusions according to the limitations of the instruments chosen. All too often this advice is ignored.

The research points convincingly to an association between self-esteem and clinical disorder, but cross-sectional correlations cannot demonstrate the evolution of these associations. The relative deficiency of prospective investigations is unfortunate, as it seems unlikely that the true essence of the concept can be grasped from glimpses through the windows provided by an array of isolated, one-dimensional vignettes. A causal link between self-esteem and clinical disorder has yet to be clearly established, and questions as to the stability of self-esteem or induced changes remain largely unanswered. Notwithstanding the above difficulties, the cumulative weight of the evidence indicates that high self-esteem is associated with adaptive functioning and, unsurprisingly, greater personal contentment. Low self-esteem frequently accompanies psychological disorders such as anxiety and depression, and may be a causative or maintaining factor. It could play a part in undermining a positive response to adverse social circumstances, such as unemployment.

For the practising psychiatrist, the broader concept of self-esteem finds frequent usage in everyday clinical discussions, presumably because it has been felt to contribute to an understanding of the individual patient. Reducing the concept to a more basic level to simplify its measurement risks lessening its clinical meaning, so an attempt should be made to capture more precisely this broader, clinically applicable, notion. Some prominent workers, notably Rosenberg, have from the start had a 'global' view of self-esteem, but the scales devised seem to target a truncated concept, which does not capture the richer, intuitive, clinical idea. In the words of Ingham *et al* (1986) ". . . the available instruments are at best conceptually primitive (though psychometrically sophisticated)". It is the content of the scale which is of primary importance to the clinician, and it is in this context that existing scales are unsatisfactory. Despite the scientific soundness of a reductionist approach, psychiatrists are unlikely to moderate their perception of self-esteem because of the imprecision of the term. It would be more constructive to retain this wider concept, but focus more attention on defining precisely the elements that converge to make up this whole. Items derived from these clearly specified elements could then form the basis for a

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new measuring instrument that would provide a rapid and systematic means of recording and monitoring self-esteem. In this way, the intuitive clinical meaning will be preserved within a scale that incorporates the psychometric properties necessary for rigorous scientific enquiry. Examination of component change is important because global alterations of self-esteem may mask subtler shifts in the subordinate elements. Anxiety and depression cause similar global changes, but the balance of components giving rise to this change may be quite different. It may be that these individual components, once clearly identified, will be useful targets for manipulation in treatment.

Because it is an abstract concept, any definition of self-esteem that is more than an exercise in semantics must incorporate hypotheses based on the theoretical viewpoint of the writer, and must remain provisional pending the empirical investigation. The definition can then be modified and refined in the light of observation and experiment.

In discussing abstract ideas, some assumptions are required that are initially untestable, and one of these is that self-esteem is a composite rather than a single entity. Pursuing this assumption, what are the components that make up this global entity? From Rosenberg's work (1965), we note the contribution of the sense of personal worth, appearance, and social competence. Coopersmith (1967) has drawn attention to the need for a feeling of competence and power, while Abramson *et al* (1978), in their reformulation of the learned helplessness hypothesis, have pointed out how attributional style may effect self-esteem. Beck (1967, 1979) has demonstrated the importance of interpretation of events in arriving at a self-view. On the basis of this work, self-esteem can be defined as:

> "The sense of contentment and self-acceptance that stems from a person's appraisal of his own worth, significance, attractiveness, competence, and ability to satisfy his aspirations."

The next step is to define the components within this definition as items of the new measuring scale proposed above, which could take the form of a self-report questionnaire. This formulation of self-esteem can then be tested by prospective investigation.

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P. J. Robson, MB, BS, MRCP(UK), MRCPsych, *Clinical Lecturer in Psychiatry, Oxford University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX*

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