A Therapist’s Guide to Children’s Self-Esteem

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The term self-esteem is frequently used by occupational therapists and other health care professionals who work with children. There are differing interpretations as to what this term actually means. In this article, we use Susan Harter’s model of self-esteem to define the nature of self-esteem and apply it to clinical practice. We outline the developmental characteristics important to consider when addressing the self-esteem of young children, such as the findings that young children’s self-esteem is often more related to their perceptions of parental acceptance than perceptions of competence and that children are generally unable to accurately verbalize their level of self-esteem until 8 years of age. Specific implications for occupational therapy evaluation include whether the use of self-report or observer-report measures is preferable and whether self-esteem or self-concept should be measured. We discuss when to address self-esteem and which dimensions of self-esteem should be treated. The dimensions of self-esteem that are identified as low during the evaluation and that the child perceives to be important are addressed. The reevaluation issue of what specifically should be measured after intervention is also discussed. For example, it is recommended that the reevaluation instrument be sensitive to the domains of self-concept targeted for intervention.

A s occupational therapists, which of us has not had “increase self-esteem” as a treatment goal at some time? Which of us has evaluated a child and found that he or she had low self-esteem or has feared that unless we could improve the child’s performance in certain skills, the child would end up with poor self-esteem? Certainly, the literature would suggest that most occupational therapy treatment programs with children are aimed directly at improving self-esteem (Mayberry, 1990) and that most occupational therapists believe it is part of their role to improve the self-esteem of the children with whom they work (Friedman, 1982; Lancaster & Mitchell, 1991; Magill & Hurlbut, 1986; Slominski, 1985). Yet, what exactly is self-esteem, and can it be changed?

The purpose of this article is to examine the issues involved in setting self-esteem goals with children and measuring self-esteem during evaluation, treatment, and reevaluation. First, the construct of self-esteem will be reviewed and differentiated from other related terms such as self-concept and self-efficacy. We use Harter’s (1983) model of self-esteem because it provides a developmental perspective of self-esteem and has been described as useful to occupational therapy practice (Mayberry, 1990). Finally, theoretical perspectives will be applied to the evaluation, treatment, and reevaluation stages of occupational therapy intervention, and specific implications for practice will be outlined.

The Construct of Self-Esteem

The term self-esteem is often confused or used interchangeably with other terms such as self-concept and self-efficacy (Mayberry, 1990). Yet, each of these terms refers to a unique and distinct construct. To clearly articulate treatment goals, select appropriate measurement tools, and communicate effectively with other team members, it is necessary to clearly define these constructs and distinguish between them. For example, an occupational therapist may describe a particular child’s self-esteem as being low whereas another therapist may argue that the child’s self-esteem is fine but he or she has poor self-concept in a specific area.

To promote meanings that can be shared with each other and other disciplines, the following definitions are suggested for occupational therapy use. These definitions are consistent with Harter’s model that is not only relevant to the goals and practice of occupational therapy but is also increasingly used in research on self-concept in children with disabilities (e.g., Appleton et al., 1994; King, Shultz, Steel, Gilpin, & Cathers, 1993).

Global self-esteem is the overall value that one places
on oneself as a person and the generalized feeling of worthiness one holds (Crocker & Major, 1989; Harter, 1989). The concept of self-esteem is qualified by the descriptor global to distinguish the term from the more specific dimensions of self-concept. However, the terms global self-esteem and self-esteem can be used interchangeably.

Self-concept is the description one attaches to oneself. It represents beliefs, ideas, and attitudes about the self and is based on the roles one plays and the attributes one possesses (Beane & Lipka, 1984). Rosenberg (1986) described self-concept as a body of knowledge that persons possess about themselves. Self-concept, therefore, refers to how one describes oneself, whereas self-esteem refers to an overall evaluation of oneself.

Perceived self-efficacy concerns one’s estimation of how well one can execute the actions necessary to deal with life events and is said to vary depending on the activity in question (Bandura, 1982). Self-efficacy may be what some therapists actually attempt to address in their intervention efforts and perhaps should be the goal if therapists believe that it is the child’s perception of his or her skill level that will influence his or her motivation to participate in a given activity (Harter, 1990). For example, after receiving occupational therapy to improve printing skills, a child may perceive that he or she now possesses sufficient skills to keep up with classmates during printing activities. In this case, the child’s own perception may have more of an influence on his or her future printing performance than the therapist’s objective evaluation of printing skill level.

Harter’s Model of Self-Esteem Development

There are numerous models of self-esteem available (e.g., Cooley, 1902/1964; Coopersmith, 1981; Harter, 1983; James, 1890/1950; Mead, 1934). Mayberry (1990) has identified two types of self-esteem theories: (a) theories that view self-esteem primarily on the basis of the person’s perceived competencies (e.g., James, 1890/1950) and (b) theories that indicate that self-esteem is developed through perceived social parameters (e.g., Cooley, 1902/1964; Mead, 1934). Mayberry (1990) has indicated that occupational therapists must examine perceptions of both competence and social support to ensure an accurate assessment. Harter (1986) found that both perceived competency and social support were important predictors of global self-esteem in children.

Harter (1983) used a hierarchical structure to explain the development of self-esteem. According to Harter (1983), global self-esteem is composed of the four second-order dimensions (originally identified by Coopersmith, 1981): competence, power, moral worth (referred to as virtue by Coopersmith), and acceptance (referred to as significance by Coopersmith). Under each of the four second-order dimensions are the more specific domains that represent how the second-order dimensions are manifested. Although the model is hierarchical, Harter (1983) wrote that it is not sufficient to simply sum up the second-order dimensions and domains to arrive at an accurate estimate of global self-esteem. Self-esteem is more than the sum of its parts. In Harter’s (1983) model, self-concept refers to the second-order dimensions as measured, at least for children, by the domains of scholastic competence, athletic competence, physical appearance, behavioral conduct, and peer social acceptance. Figure 1 illustrates the second-order dimensions and domains that correspond to the subscales of Harter’s (1985) Self-Perception Profile for Children and gives specific examples of areas in each domain that are relevant to occupational therapists. All the domains listed in Figure 1 are appropriate for children between the ages of 8 and 12 years (Harter, 1983). Through her research, Harter has found that children at these ages are able to differentiate among the five domains. Younger children (aged 4 to 7 years) are only able to differentiate between the second-order dimensions of competence and acceptance (Harter, 1989).

Harter (1983) suggested that it is important to be aware of a number of aspects concerning the development and composition of self-esteem. First, it is likely that the dimensions of competence, power, moral worth, and acceptance are expressed differently at each developmental level. Second, she questioned whether certain dimensions may be more important than others at different developmental levels. For example, is a sense of competence more important to the school-age child than to the preschool-age child? A third consideration is the manner in which the four dimensions interact and influence each other during different developmental stages. A fourth point is whether this model is appropriate for children at all developmental stages. Do children in preoperational and concrete-operational stages actually base their overall self-evaluations on judgments of their skill or performance in the given domains? The implications of this model for occupational therapy evaluation, intervention, and reevaluation will be presented in the following sections.

Considerations for the Evaluation of Self-Esteem

Do Children With Special Needs Have Low Self-Esteem?

Children who have disabilities do not necessarily have low self-esteem and poor self-concept (King et al., 1993). Members of stigmatized groups (including persons with
disabilities) may, theoretically, develop coping mechanisms that enable them to protect their self-esteem (Appleton et al., 1994; Crocker & Major, 1989). Empirically, there is limited evidence that young children with disabilities have lower self-esteem or self-concept than their peers without disabilities. For example, one study found that young children (aged 4 to 8 years) with cerebral palsy maintained a positive self-esteem (as measured by the Coopersmith Behavior Rating Form) similar to that of their peers without disabilities until they entered early elementary school (Teplin, Howard, & O’Connor, 1981). After entering school, some of the children with cerebral palsy experienced a decline in self-esteem as they compared themselves with peers without disabilities.

In a matched control study of 79 subjects with spina bifida, Appleton and colleagues (1994) found no significant difference in self-esteem (as measured by the Self-Perception Profile for Learning Disabled Students) between young persons (aged 7 to 18 years) with spina bifida and their peers without spina bifida, although there were differences in some domains of self-concept. It is not clear why the investigators used a scale for children with learning disabilities when the children in the sample were not described as having a learning disability. This scale was also not appropriate for use with the older adolescents included in the sample because it was designed for children in grades 4 to 8.

Studies examining the self-esteem and self-concept of older children and adolescents with physical disabilities have not found these young persons to have lower levels of self-esteem than their peers without physical disabilities. For example, Ostring and Nieminen (1982) used Coopersmith’s Self-Esteem Inventory to compare the self-esteem of 30 children and young adolescents with cerebral palsy (aged 9 to 13 years) with that of a control group and found no significant differences between the groups. These investigators, however, did not use a matched control group, which may have affected the results. Magill and Huribut (1986) used the Tennessee Self-Concept Scale to compare the self-esteem of 22 adolescents (aged 13 to 18 years) with cerebral palsy with that of a control group. They found that the adolescents with cerebral palsy did not differ significantly in overall self-esteem from the control group. Steff, Shear, and Levinson (1989) used the Piers-Harris Children’s Self-Concept Scale to measure self-esteem in 36 young persons with rheumatic disease (aged 7 to 20 years) and found that their self-esteem was in the normal range when compared with the measure’s normative sample. Finally, King and colleagues (1993) examined the self-

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Figure 1. The second-order dimensions and domains that correspond to the subscales of Harter’s (1985) Self-Perception Profile for Children.
Self-esteem and self-concept (Gilberts, 1983; Harter, 1986, 1989, 1990) uncovered several important developmental themes related to self-esteem measurement in young children (i.e., aged 4 to 7 years). The first theme is that the content of items on measurement scales needs to be graded according to the developmental level of the child to ensure that his or her daily activities are represented. Hence, when choosing a measure, it is recommended that therapists look for an assessment that adequately taps children’s daily activities.

A second theme is that the items be described in a manner appropriate to the cognitive level of the young child. For example, pictorial items could be used to ensure that the behaviors presented to the child are concrete and observable (Harter, 1986, 1989; Harter & Pike, 1984).

The third theme is that children generally are not able to accurately verbalize their level of global self-esteem until the age of 8 years (Harter, 1989). Although young children are not yet able to express their global self-esteem, it is expressed through their behavior (Harter, 1990). Therefore, observer-report scales may be more helpful for younger children.

The fourth theme is that although young children are able to evaluate their competence and acceptance, they may have difficulty differentiating between the specific domains of scholastic and athletic competence (Harter, 1990). They are also likely to overestimate their competence because of (a) the age-appropriate tendency to confuse the desire to be competent with reality and (b) having received excessively positive feedback from significant others regarding their accomplishments. Hence, we as therapists can expect overestimation in children with cognitive skills younger than age 8 years.

Finally, Harter (1989) noted that young children’s global self-esteem, as rated by others (i.e., teachers, parents), is not expected to be related to their perceived competence level, whereas children’s perception of acceptance, particularly from parents, is expected to be related to global self-esteem. The dimension of competence only begins to play a critical role in global self-esteem during middle childhood (i.e., 8 years and older). Therefore, for the young child, it appears helpful for therapists to choose a measure that taps perceptions of acceptance (e.g., the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children [Harter & Pike, 1984]). For the school-aged child, it may be more effective for therapists to use measures that tap both acceptance and competence (e.g., the Self-Perception Profile for Children [Harter, 1985] or Marsh’s Self-Descriptive Questionnaire [Marsh, Barnes, Cairns, & Tidman, 1990]).
Is It Preferable to Use a Self-Report or Observer-Report Measure?

Certain authors have recommended that both self-report and observer-report be used to provide a comprehensive measure of a child's self-esteem (Coopersmith, 1981). However, reports from different respondents are often not highly correlated (Hughes, 1984; Marsh, 1985). High correlations between self-reports and observer-reports may be obtained only when the observer is very familiar with the person, observes a variety of behaviors, makes skillful observations, and uses the same frame of reference in formulating evaluations as the person being observed (Marsh & Parker, 1984). Difficulty in meeting all of these criteria also suggests that self-reports and observer-reports are not usually strongly correlated (Marsh & Parker, 1984).

However, there is some evidence that self-reports and teacher-reports of the self-esteem of children can demonstrate substantial agreement (Marsh & Parker, 1984). A preliminary study of differences between self-report and teacher-report of self-esteem in young children has indicated that the two types of reports may evaluate different characteristics of self-esteem (Harter, 1989). The results of Harter's study suggest that during early childhood, high self-esteem, as defined by teachers, is not demonstrated through the display of skills but rather through the child's attitude of confidence, whereas young children are able to make judgments about their competence and the acceptance they receive from others but are not yet able to conceptualize or articulate their global self-esteem.

Hence, use of observer-report or self-report measures alone appears insufficient when trying to gain insight into how the child feels about himself or herself. Use of both types of measures with young children is particularly useful as observer-reports enable access to information that the young child may not yet be able to verbalize (Harter, 1989, 1990), and self-report measures provide insight into the child's perceptions of his or her competence.

Does One Measure Self-Esteem or Self-Concept?

Another issue, which has been extensively debated in the self-esteem literature, is whether global self-esteem or aspects of self-concept (e.g., social acceptance) should be measured (Harter, 1982, 1983, 1986; Marsh, 1986; Mayberry, 1990; Rosenberg, 1979, 1986). It is recommended that practicing occupational therapists measure what we are interested in improving and evaluating. Sometimes it might be self-esteem; sometimes it might be self-concept. For example, if the therapist is interested in examining the child's evaluation of his or her overall self-worth, it will be important to use a measure that evaluates global self-esteem, such as the Piers-Harris Children's Self-Concept Scale (Piers, 1984). Although as previously discussed, one could argue that this measure simply sums up evaluations of the self-concept and is not a very accurate measure of global self-esteem (Harter, 1983). The global self-worth score of Harter's (1985) Self-Perception Profile for Children could be used as an alternative measure. If the therapist is interested in more specific evaluations of the self-concept, such as the child's evaluation of his or her social acceptance, then a measure that includes these specific domains should be selected. The Self-Perception Profile for Children could also be used for this purpose.

In summary, there are many factors to consider when evaluating self-esteem and self-concept in children. When selecting a self-esteem measure for a child, it is helpful to consider the child's cognitive developmental level as well as chronological age (Harter, 1982, 1983). Self-report measures provide important information on children's perceptions of their own competence (Harter, 1989). However, the child's cognitive level appears particularly important for self-report measures of self-esteem where the child must understand the wording and concepts contained in the scale (Gilberts, 1983; Harter, 1982, 1983; Rosenberg, 1986). It is also important that we recognize that children with a cognitive age of less than 8 years are not usually able to evaluate their global self-esteem (Harter, 1983). Specific subscale scores on self-report measures are more useful with this age group (Harter, 1990). Mixed findings are reported regarding the amount of agreement between self-report and observer-report methods of rating self-esteem (Harter, 1986, 1989; Marsh & Parker, 1984). Both types of measures are recommended to obtain information that will be useful in providing a full understanding of children's self-esteem.

Considerations for Intervention

As discussed above, it is useful to consider the dimensions of self-esteem that the child perceives as important (Harter, 1986; King et al., 1993; Mayberry, 1990). Simply addressing the domains of self-concept identified as low at assessment may not be sufficient. If children or adolescents do not consider particular skill areas to be important, their negative perceptions of their skill in those areas will not cause them any distress (Harter, 1986). Harter (1986) recommended addressing the domains of self-concept that are low and important to the child or adolescent. This thinking is consistent with the recommendation in the Occupational Therapy Guidelines for Client-Centred Mental Health Practice (Canadian Association of Occupational Therapists [CAOT], 1993) that the client...
participate in therapeutic goal setting.

Another issue in occupational therapy intervention is whether to address self-esteem when it is above average at initial assessment. The reader of this article might assume that a therapist would not select self-esteem as a therapeutic goal if it is not a problem area when initially assessed. A review of the occupational therapy literature reveals that this assumption is not necessarily true. For example, Bolding and Llorens (1991) examined the effects of a habilitative hospital admission on children with above-average global self-esteem during initial assessment. When the client's self-esteem is above average at pretest, gains in self-esteem due to intervention are unlikely because there is little room for improvement (Harter, 1990). Additionally, addressing a client's self-esteem when it is high is generally not a good use of therapy time and resources, especially in these times of economic constraint.

There may be occasions when we decide to address self-esteem when it is above average at pretest, for example, when the therapeutic goal is to help the client establish a more realistic evaluation of his or her self-worth (Harter, 1990). Although therapists are more likely to enhance self-esteem (Friedman, 1982; Lancaster & Mitchell, 1991; Magill & Hurlbut, 1986; Slominski, 1985), it may appear more therapeutic in some cases to address inflated self-esteem, or an inaccurate self-concept, to help develop a more realistic self-evaluation. For example, if a client has above-average perceptions of social acceptance yet regularly experiences problems relating to peers at school, role-playing techniques may be useful in helping the client gain insight into social expectation and social skills. But it is important to realize that, although as therapists we may want to help our client develop a more realistic self-concept, this treatment goal is inconsistent with the philosophy of client-centered (or, more recently, client-driven) practice, which recommends that the client's perceptions of his or her strengths and problems supersede the therapist's (CAOT, 1993; Gage, 1994).

Although occupational therapists frequently profess that they have the ability to enhance self-esteem (Friedman, 1982; Magill & Hurlbut, 1986; Slominski, 1985), this claim is usually not substantiated because (a) self-esteem is a relatively stable construct, and (b) studies provide very little evidence that intervention leads to changes in self-esteem (Bolding & Llorens, 1991; Polatajko, Law, Miller, Schaffer, & Macnab, 1991; Wilson, Kaplan, Fellowes, Gruchy, & Faris, 1992). Examination of the stability of self-esteem and self-concept suggests that they are relatively stable constructs when the child's environmental demands, performance expectations, and social comparison group remain relatively consistent (Harter, 1983). The self-concept appears to become less stable during the transition from kindergarten to first grade and from grade school to junior high school when environmental demands and expectations change (Harter, 1983; Rosenberg, 1979, 1986).

The following studies provide little empirical evidence that occupational therapy intervention influences a change in self-esteem or self-concept. Bolding and Llorens (1991) used the Piers-Harris Children's Self-Concept Scale to measure the self-esteem of four young persons (aged 9 to 14 years) before and after participation in a habilitative hospital program. The time spent in the hospital ranged from 8 days to 2 months. Results indicated that one adolescent's self-esteem score remained the same, one's increased, and one's decreased. (Follow-up data were not available for one preadolescent.) Polatajko and colleagues (1991) used the Behavioral Academic Self-Esteem Scale to compare the effects of sensory integration treatment and perceptual-motor treatment on the self-esteem of 67 learning disabled children aged 5 to 9 years. Results indicated that only the group's academic self-concept improved significantly at 6 months posttest. Wilson and colleagues (1992) examined the self-concept of 29 children (aged 5 to 9 years) before and after participation in either sensory integration therapy or a tutoring program. The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter & Pike, 1983) was used. Results indicated that there were no major differences in perceived competence or acceptance for either treatment group at 6 or 12 months posttest. Other authors have reviewed the role of occupational therapy in changing children's self-esteem but have not tested it empirically (Lancaster & Mitchell, 1991; Slominski, 1985).

Hence, we need to be cautious when making the claim that occupational therapy can enhance self-esteem until there have been more examinations of whether interventions can improve a child's feelings of self-worth. It is more likely that our intervention lies in addressing specific domains of the self-concept and feelings of self-efficacy. More research on perceptions of self-efficacy both before and after occupational therapy intervention would also be helpful in clarifying this theory.

**Self-Esteem and Self-Concept Considerations at Reevaluation**

When addressing self-esteem or self-concept as a therapeutic goal, it is important for reevaluation to follow the intervention. An instrument that is sensitive to the domains of self-concept addressed in therapy will be most effective (Harter, 1990). For example, if the client is
interested in enhancing his or her feelings of scholastic competency, the measure selected should include this domain. It is also helpful to document the domains of self-concept that are not expected to change due to intervention (Harter, 1990). This prediction would help enhance the credibility of the intervention's effectiveness.

Harter (1990) has also recommended including measures of the component or underlying processes believed to be related to the change in self-concept. For example, if the therapist believes that enhancing motor skill performance will be related to an increase in perceived athletic competence, it will be important to measure both the child's perceptions of perceived athletic competence and changes in motor skill performance both before and after intervention. Only then can a change in this domain be attributed to changes in motor performance. We cannot infer that the hypothesis was supported without measuring both constructs at pre- and posttest (Harter, 1990).

Summary of Implications for Occupational Therapists

On the basis of a review of the current self-esteem literature, the points discussed in the following sections might be considered when addressing self-esteem and self-concept with pediatric clients.

At Evaluation

- It is suggested that we not assume that the client has low self-esteem or low self-concept simply because he or she has a disability. Previous research has indicated that many children and adolescents with disabilities do not have low self-esteem or self-concept.
- It is most effective to evaluate self-esteem and self-concept formally with instruments that are psychometrically sound and sensitive to the domains of self-concept of interest to the client and the therapist. It is suggested that we not report conclusively that the client has low levels of self-esteem and self-concept on the basis of subjective opinions alone. The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter & Pike, 1983) for children ages 4 to 7 years, the Self-Perception Profile for Children (Harter, 1985) for young persons ages 8 to 15 years, and the Self-Perception Profile for Adolescents (Harter, 1988) for adolescents in grades 9 to 12 are recommended for assessing self-esteem and self-concept of young clients. However, the validity of these measures (and many others in the literature) has not been clearly established for children with special needs.
- It is recommended that we keep in mind that most children under 8 years of age cannot verbalize global self-esteem. Therefore, use of both self-report and observer-report measures may be required for young children. It is important to consider the child's cognitive developmental level in addition to chronological age when selecting self-esteem and self-concept measures.

During Treatment

- It is most effective to address dimensions of self-concept that are of concern to the child or adolescent. These dimensions may be in the areas of competence, power, moral worth, or acceptance.
- If the child's self-esteem is above average during the initial evaluation, it will be difficult to detect improvements in self-esteem at reevaluation. It also may be questionable to set "self-esteem improvement" as a therapeutic goal when there is evidence that the client has satisfactory self-esteem.
- Although occasionally it may appear to be most therapeutic to help the child or adolescent with inflated self-esteem or self-concept develop a more reality-based evaluation or view of him or herself, this treatment goal would be inconsistent with a client-centered philosophy.

At Reevaluation

- If one of the therapeutic goals of occupational therapy intervention is to enhance self-esteem or self-concept, it is important to objectively reevaluate these constructs to determine whether the intervention has been effective.
- It is recommended that the reevaluation measure be sensitive to the domains of self-concept targeted for intervention.
- If underlying processes are believed to be involved in enhancing self-concept, it is recommended that these processes be reassessed and compared with corresponding changes in self-concept.

Conclusion

The constructs of self-esteem and self-concept appear to be very important to pediatric occupational therapists because many of us believe that it is part of our role to enhance these constructs in our clients. This examination of current issues relating to self-esteem is intended to help enhance our understanding of the construct and
facilitate more consistency in our use of the terms self-esteem and self-concept. It is also recommended that we objectively listen to our young clients when they tell us what they do and do not like about themselves and believe their reports. This self-report information may be just as important as the information obtained from sound psychometric assessment instruments when both sources are used together. By acknowledging that clients’ perceptions are as valuable as our own, we are facilitating clients’ participation in the therapeutic process. This acknowledgment itself may enhance the clients’ feelings of self-efficacy, even if it does not enhance their self-esteem. ▲

References


