Self-esteem in a broad-spectrum approach for mental health promotion

Michal (Michelle) Mann, Clemens M. H. Hosman, Herman P. Schaalma, and Nanne K. de Vries

Abstract

Self-evaluation is crucial to mental and social well-being. It influences aspirations, personal goals and interaction with others. This paper stresses the importance of self-esteem as a protective factor and a non-specific risk factor in physical and mental health. Evidence is presented illustrating that self-esteem can lead to better health and social behavior, and that poor self-esteem is associated with a broad range of mental disorders and social problems, both internalizing problems (e.g. depression, suicidal tendencies, eating disorders and anxiety) and externalizing problems (e.g. violence and substance abuse). We discuss the dynamics of self-esteem in these relations. It is argued that an understanding of the development of self-esteem, its outcomes, and its active protection and promotion are critical to the improvement of both mental and physical health. The consequences for theory development, program development and health education research are addressed. Focusing on self-esteem is considered a core element of mental health promotion and a fruitful basis for a broad-spectrum approach.

Introduction

The most basic task for one’s mental, emotional and social health, which begins in infancy and continues until one dies, is the construction of his/her positive self-esteem. [(Macdonald, 1994), p. 19]

The beliefs and evaluations people hold about themselves determine who they are, what they can do and what they can become (Burns, 1982). These powerful, inner influences provide an internal guiding mechanism, steering and nurturing individuals through life, and governing their behavior. People’s concepts and feelings about themselves are generally labeled as their self-concept and self-esteem. These, together with their ability to deal with life’s challenges and to control what happens to them, are widely documented in literature (Seligman, 1975; Bandura, 1977; Bowlby, 1980; Rutter, 1992; Harter, 1999).

Self-concept is defined as the sum of an individual’s beliefs and knowledge about his/her personal attributes and qualities. It is classed as a cognitive schema that organizes abstract and concrete views about the self, and controls the processing of self-relevant information (Markus, 1977; Kihlstrom and Cantor, 1983). Other concepts, such as self-image and self-perception, are equivalents to self-concept. Self-esteem is the evaluative and affective dimension of the self-concept, and is considered as equivalent to self-regard, self-estimation and self-worth (Harter, 1999). It refers to a person’s global appraisal of his/her positive or negative value, based on the scores a person gives him/herself in different roles and domains of life (Rogers, 1981; Markus and Nurius, 1986). Positive
self-esteem is not only seen as a basic feature of mental health, but also as a protective factor that contributes to better health and positive social behavior through its role as a buffer against the impact of negative influences. It is seen to actively promote healthy functioning as reflected in life aspects such as achievements, success, satisfaction, and the ability to cope with diseases like cancer and heart disease. Conversely, an unstable self-concept and poor self-esteem can play a critical role in the development of an array of mental disorders and social problems, such as depression, anorexia nervosa, bulimia, anxiety, violence, substance abuse and high-risk behaviors. These conditions not only result in a high degree of personal suffering, but also impose a considerable burden on society. As will be shown, prospective studies have highlighted low self-esteem as a risk factor and positive self-esteem as a protective factor. To summarize, self-esteem is considered as an influential factor both in physical and mental health, and therefore should be an important focus in health promotion; in particular, mental health promotion.

Health promotion refers to the process of enabling people to increase control over and improve their own health (WHO, 1986). Subjective control as well as subjective health, each aspects of the self, are considered as significant elements of the health concept. Recognizing the existence of different views on the concept of mental health promotion, Sartorius (Sartorius, 1998), the former WHO Director of Mental Health, preferred to define it as a means by which individuals, groups or large populations can enhance their competence, self-esteem and sense of well-being. This view is supported by Tudor (Tudor, 1996) in his monograph on mental health promotion, where he presents self-concept and self-esteem as two of the core elements of mental health, and therefore as an important focus of mental health promotion.

This article aims to clarify how self-esteem is related to physical and mental health, both empirically and theoretically, and to offer arguments for enhancing self-esteem and self-concept as a major aspect of health promotion, mental health promotion and a ‘Broad-Spectrum Approach’ (BSA) in prevention.

The first section presents a review of the empirical evidence on the consequences of high and low self-esteem in the domains of mental health, health and social outcomes. The section also addresses the bi-directional nature of the relationship between self-esteem and mental health. The second section discusses the role of self-esteem in health promotion from a theoretical perspective. How are differentiations within the self-concept related to self-esteem and mental health? How does self-esteem relate to the currently prevailing theories in the field of health promotion and prevention? What are the mechanisms that link self-esteem to health and social outcomes? Several theories used in health promotion or prevention offer insight into such mechanisms. We discuss the role of positive self-esteem as a protective factor in the context of stressors, the developmental role of negative self-esteem in mental and social problems, and the role of self-esteem in models of health behavior. Finally, implications for designing a health-promotion strategy that could generate broad-spectrum outcomes through addressing common risk factors such as self-esteem are discussed. In this context, schools are considered an ideal setting for such broad-spectrum interventions. Some examples are offered of school programs that have successfully contributed to the enhancement of self-esteem, and the prevention of mental and social problems.

Self-esteem and mental well-being

Empirical studies over the last 15 years indicate that self-esteem is an important psychological factor contributing to health and quality of life (Evans, 1997). Recently, several studies have shown that subjective well-being significantly correlates with high self-esteem, and that self-esteem shares significant variance in both mental well-being and happiness (Zimmerman, 2000). Self-esteem has been found to be the most dominant and powerful predictor of happiness (Furnham and Cheng, 2000). Indeed, while low self-esteem leads to maladjustment, positive self-esteem, internal standards and aspirations actively seem to contribute to ‘well-being’ (Garmezy, 1984; Glick and Zigler, 1992). According to Tudor (Tudor, 1996), self-concept,
identity and self-esteem are among the key elements of mental health.

Self-esteem, academic achievements and job satisfaction

The relationship between self-esteem and academic achievement is reported in a large number of studies (Marsh and Yeung, 1997; Filozof et al., 1998; Hay et al., 1998). In the critical childhood years, positive feelings of self-esteem have been shown to increase children’s confidence and success at school (Coopersmith, 1967), with positive self-esteem being a predicting factor for academic success, e.g. reading ability (Markus and Nurius, 1986). Results of a longitudinal study among elementary school children indicate that children with high self-esteem have higher cognitive aptitudes (Adams, 1996). Furthermore, research has revealed that core self-evaluations measured in childhood and in early adulthood are linked to job satisfaction in middle age (Judge et al., 2000).

Self-esteem and coping with stress in combination with coping with physical disease

The protective nature of self-esteem is particularly evident in studies examining stress and/or physical disease in which self-esteem is shown to safeguard the individual from fear and uncertainty. This is reflected in observations of chronically ill individuals. It has been found that a greater feeling of mastery, efficacy and high self-esteem, in combination with having a partner and many close relationships, all have direct protective effects on the development of depressive symptoms in the chronically ill (Penninx et al., 1998). Self-esteem has also been shown to enhance an individual’s ability to cope with disease and post-operative survival. Research on pre-transplant psychological variables and survival after bone marrow transplantation (Broers et al., 1998) indicates that high self-esteem prior to surgery is related to longer survival. Chang and Mackenzie (Chang and Mackenzie, 1998) found that the level of self-esteem was a consistent factor in the prediction of the functional outcome of a patient after a stroke.

To conclude, positive self-esteem is associated with mental well-being, adjustment, happiness, success and satisfaction. It is also associated with recovery after severe diseases.

Identity development and the sources of negative self-esteem

The evolving nature of self-esteem was conceptualized by Erikson (Erikson, 1968) in his theory on the stages of psychosocial development in children, adolescents and adults. According to Erikson, individuals are occupied with their self-esteem and self-concept as long as the process of crystallization of identity continues. If this process is not negotiated successfully, the individual remains confused, not knowing who (s)he really is. Identity problems, such as unclear identity, diffused identity and foreclosure (an identity status based on whether or not adolescents made firm commitments in life. Persons classified as ‘foreclosed’ have made future commitments without ever experiencing the ‘crises’ of deciding what really suits them best), together with low self-esteem, can be the cause and the core of many mental and social problems (Marcia et al., 1993).

The development of self-esteem during childhood and adolescence depends on a wide variety of intra-individual and social factors. Approval and support, especially from parents and peers, and self-perceived competence in domains of importance are the main determinants of self-esteem [for a review, see (Harter, 1999)]. Attachment and unconditional parental support are critical during the phases of self-development. This is a reciprocal process, as individuals with positive self-esteem can better internalize the positive view of significant others. For instance, in their prospective study among young adolescents, Garber and Flynn (Garber and Flynn, 2001) found that negative self-worth develops as an outcome of low maternal acceptance, a maternal history of depression and exposure to negative interpersonal contexts, such as negative parenting practices, early history of child maltreatment, negative feedback from significant
others on one’s competence, and family discord and disruption.

Other sources of negative self-esteem are discrepancies between competing aspects of the self, such as between the ideal and the real self, especially in domains of importance. The larger the discrepancy between the value a child assigns to a certain competence area and the perceived self-competence in that area, the lower the feeling of self-esteem (Harter, 1999). Furthermore, discrepancies can exist between the self as seen by oneself and the self as seen by significant others. As implied by Harter (Harter, 1999), this could refer to contrasts that might exist between self-perceived competencies and the lack of approval or support by parents or peers.

Finally, negative and positive feelings of self-worth could be the result of a cognitive, inferential process, in which children observe and evaluate their own behaviors and competencies in specific domains (self-efficacy). The poorer they evaluate their competencies, especially in comparison to those of their peers or to the standards of significant others, the more negative their self-esteem. Such self-monitoring processes can be negatively or positively biased by a learned tendency to negative or positive thinking (Seligman et al., 1995).

### Outcomes of poor self-esteem

The outcomes of negative self-esteem can be manifold. Poor self-esteem can result in a cascade of diminishing self-appreciation, creating self-defeating attitudes, psychiatric vulnerability, social problems or risk behaviors. The empirical literature highlights the negative outcomes of low self-esteem. However, in several studies there is a lack of clarity regarding causal relations between self-esteem and problems or disorders (Flay and Ordway, 2001). This is an important observation, as there is reason to believe that self-esteem should be examined not only as a cause, but also as a consequence of problem behavior. For example, on the one hand, children could have a negative view about themselves and that might lead to depressive feelings. On the other hand, depression or lack of efficient functioning could lead to feeling bad, which might decrease self-esteem. Although the directionality can work both ways, this article concentrates on the evidence for self-esteem as a potential risk factor for mental and social outcomes. Three clusters of outcomes can be differentiated. The first are mental disorders with internalizing characteristics, such as depression, eating disorders and anxiety. The second are poor social outcomes with externalizing characteristics including aggressive behavior, violence and educational exclusion. The third is risky health behavior such as drug abuse and not using condoms.

### Self-esteem and internalizing mental disorders

Self-esteem plays a significant role in the development of a variety of mental disorders. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), negative or unstable self-perceptions are a key component in the diagnostic criteria of major depressive disorders, manic and hypomanic episodes, dysthymic disorders, dissociative disorders, anorexia nervosa, bulimia nervosa, and in personality disorders, such as borderline, narcissistic and avoidant behavior. Negative self-esteem is also found to be a risk factor, leading to maladjustment and even escapism. Lacking trust in themselves, individuals become unable to handle daily problems which, in turn, reduces the ability to achieve maximum potential. This could lead to an alarming deterioration in physical and mental well-being. A decline in mental health could result in internalizing problem behavior such as depression, anxiety and eating disorders. The outcomes of low self-esteem for these disorders are elaborated below.

### Depressed moods, depression and suicidal tendencies

The clinical literature suggests that low self-esteem is related to depressed moods (Patterson and Capaldi, 1992), depressive disorders (Rice et al., 1998; Dori and Overholser, 1999), hopelessness, suicidal tendencies and attempted suicide.
Correlational studies have consistently shown a significant negative relationship between self-esteem and depression (Beck et al., 1990; Patton, 1991). Campbell et al. (Campbell et al., 1991) found individual appraisal of events to be clearly related to their self-esteem. Low self-esteem subjects rated their daily events as less positive and negative life events as being more personally important than high self-esteem subjects. Individuals with high self-esteem made more stable and global internal attributions for positive events than for negative events, leading to the reinforcement of their positive self-image. Subjects low in self-esteem, however, were more likely to associate negative events to stable and global internal attributions, and positive events to external factors and luck (Campbell et al., 1991). There is a growing body of evidence that individuals with low self-esteem more often report a depressed state, and that there is a link between dimensions of attributional style, self-esteem and depression (Abramson et al., 1989; Hammen and Goodman-Brown, 1990).

Some indications of the causal role of self-esteem result from prospective studies. In longitudinal studies, low self-esteem during childhood (Reinherz et al., 1993), adolescence (Teri, 1982) and early adulthood (Wilhelm et al., 1999) was identified as a crucial predictor of depression later in life. Shin (Shin, 1993) found that when cumulative stress, social support and self-esteem were introduced subsequently in regression analysis, of the latter two, only self-esteem accounted for significant additional variance in depression. In addition, Brown et al. (Brown et al., 1990) showed that positive self-esteem, although closely associated with adequate social support, plays a role as a buffer factor. There appears to be a pathway from not living up to personal standards, to low self-esteem and to being depressed (Harter, 1986, 1990; Higgins, 1987, 1989; Baumeister, 1990). Alternatively, another study indicated that when examining the role of life events and difficulties, it was found that total level of stress interacted with low self-esteem in predicting depression, whereas self-esteem alone made no direct contribution (Miller et al., 1989). To conclude, results of cross-sectional and longitudinal studies have shown that low self-esteem is predictive of depression.

The potentially detrimental impact of low self-esteem in depressive disorders stresses the significance of Seligman’s recent work on ‘positive psychology’. His research indicates that teaching children to challenge their pessimistic thoughts whilst increasing positive subjective thinking (and bolstering self-esteem) can reduce the risk of pathologies such as depression (Seligman, 1995; Seligman et al., 1995; Seligman and Csikszentmihalyi, 2000).

**Other internalizing disorders**

Although low self-esteem is most frequently associated with depression, a relationship has also been found with other internalizing disorders, such as anxiety and eating disorders. Research results indicate that self-esteem is inversely correlated with anxiety and other signs of psychological and physical distress (Beck et al., 2001). For example, Ginsburg et al. (Ginsburg et al., 1998) observed a low level of self-esteem in highly socially anxious children. Self-esteem was shown to serve the fundamental psychological function of buffering anxiety, with the pursuit of self-esteem as a defensive avoidance tool against basic human fears. This mechanism of defense has become evident in research with primary (Ginsburg et al., 1998) and secondary school children (Fickova, 1999). In addition, empirical studies have shown that bolstering self-esteem in adults reduces anxiety (Solomon et al., 2000).

The critical role of self-esteem during school years is clearly reflected in studies on eating disorders. At this stage in life, weight, body shape and dieting behavior become intertwined with identity. Researchers have reported low self-esteem as a risk factor in the development of eating disorders in female school children and adolescents (Fisher et al., 1994; Smolak et al., 1996; Shisslak et al., 1998), as did prospective studies (Vohs et al., 2001). Low self-esteem also seems predictive of the poor outcome of treatment in such disorders, as has been found in a recent 4-year prospective follow-up...
study among adolescent in-patients with bulimic characteristics (van der Ham et al., 1998). The significant influence of self-esteem on body image has led to programs in which the promotion of self-esteem is used as a main preventive tool in eating disorders (St Jeor, 1993; Vickers, 1993; Scarano et al., 1994).

To sum up, there is a systematic relation between self-esteem and internalizing problem behavior. Moreover, there is enough prospective evidence to suggest that poor self-esteem might contribute to deterioration of internalizing problem behavior while improvement of self-esteem could prevent such deterioration.

Self-esteem, externalizing problems and other poor social outcomes

For more than two decades, scientists have studied the relationship between self-esteem and externalizing problem behaviors, such as aggression, violence, youth delinquency and dropping out of school. The outcomes of self-esteem for these disorders are described below.

Violence and aggressive behavior

While the causes of such behaviors are multiple and complex, many researchers have identified self-esteem as a critical factor in crime prevention, rehabilitation and behavioral change (Kressly, 1994; Gilbert, 1995). In a recent longitudinal questionnaire study among high-school adolescents, low self-esteem was one of the key risk factors for problem behavior (Jessor et al., 1998).

Recent studies confirm that high self-esteem is significantly associated with less violence (Fleming et al., 1999; Horowitz, 1999), while a lack of self-esteem significantly increases the risk of violence and gang membership (Schoen, 1999). Results of a nationwide study of bullying behavior in Ireland show that children who were involved in bullying as either bullies, victims or both had significantly lower self-esteem than other children (Schoen, 1999). Adolescents with low self-esteem were found to be more vulnerable to delinquent behavior. Interestingly, delinquency was positively associated with inflated self-esteem among these adolescents after performing delinquent behavior (Schoen, 1999). According to Kaplan’s self-derogation theory of delinquency (Kaplan, 1975), involvement in delinquent behavior with delinquent peers can increase children’s self-esteem and sense of belonging. It was also found that individuals with extremely high levels of self-esteem and narcissism show high tendencies to express anger and aggression (Baumeister et al., 2000). To conclude, positive self-esteem is associated with less aggressive behavior. Although most studies in the field of aggressive behavior, violence and delinquency are correlational, there is some prospective evidence that low self-esteem is a risk factor in the development of problem behavior. Interestingly, low self-esteem as well as high and inflated self-esteem are both associated with the development of aggressive symptoms.

School dropout

Dropping out from the educational system could also reflect rebellion or antisocial behavior resulting from identity diffusion (an identity status based on whether or not adolescents made firm commitments in life. Adolescents classified as ‘diffuse’ have not yet thought about identity issues or, having thought about them, have failed to make any firm future oriented commitments). For instance, Muha (Muha, 1991) has shown that while self-image and self-esteem contribute to competent functioning in childhood and adolescence, low self-esteem can lead to problems in social functioning and school dropout. The social consequences of such problem behaviors may be considerable for both the individual and the wider community. Several prevention programs have reduced the dropout rate of students at risk (Alice, 1993; Andrews, 1999). All these programs emphasize self-esteem as a crucial element in dropout prevention.

Self-esteem and risk behavior

The impact of self-esteem is also evident in risk behavior and physical health. In a longitudinal study, Rouse (Rouse, 1998) observed that resilient adolescents had higher self-esteem than their
non-resilient peers and that they were less likely to initiate a variety of risk behaviors. Positive self-esteem is considered as a protective factor against substance abuse. Adolescents with more positive self-concepts are less likely to use alcohol or drugs (Carvajal et al., 1998), while those suffering with low self-esteem are at a higher risk for drug and alcohol abuse, and tobacco use (Crump et al., 1997; Jones and Heaven, 1998). Carvajal et al. (Carvajal et al., 1998) showed that optimism, hope and positive self-esteem are determinants of avoiding substance abuse by adolescents, mediated by attitudes, perceived norms and perceived behavioral control. Although many studies support the finding that improving self-esteem is an important component of substance abuse prevention (Devlin, 1995; Rodney et al., 1996), some studies found no support for the association between self-esteem and heavy alcohol use (Poikolainen et al., 2001).

Empirical evidence suggests that positive self-esteem can also lead to behavior which is protective against contracting AIDS, while low self-esteem contributes to vulnerability to HIV/AIDS (Rolf and Johnson, 1992; Somali et al., 2001). The risk level increases in cases where subjects have low self-esteem and where their behavior reflects efforts to be accepted by others or to gain attention, either positively or negatively (Reston, 1991). Lower self-esteem was also related to sexual risk-taking and needle sharing among homeless ethnic-minority women recovering from drug addiction (Nyamathi, 1991). Abel (Abel, 1998) observed that single females whose partners did not use condoms had lower self-esteem than single females whose partners did use condoms. In a study of gay and/or bisexual men, low self-esteem proved to be one of the factors that made it difficult to reduce sexual risk behavior (Paul et al., 1993).

To summarize, the literature reveals a number of studies showing beneficial outcomes of positive self-esteem, and conversely, negative outcomes of poor self-esteem, especially in adolescents. Prospective studies and intervention studies have shown that self-esteem can be a causal factor in depression, anxiety, eating disorders, delinquency, school dropout, risk behavior, social functioning, academic success and satisfaction. However, the cross-sectional character of many other studies does not exclude that low self-esteem can also be considered as an important consequence of such disorders and behavioral problems.

To assess the implications of these findings for mental health promotion and preventive interventions, more insight is needed into the antecedents of poor self-esteem, and the mechanisms that link self-esteem to mental, physical and social outcomes.

**Mechanisms linking self-esteem and health behavior**

What are the mechanisms that link self-esteem to health and social outcomes? Several theories used in health promotion or prevention offer insight into such mechanisms. In this section we discuss the role of positive self-esteem as a protective factor in the context of stressors, the developmental role of negative self-esteem in mental and social problems, and the role of self-esteem in models of health behavior.

**Positive thinking about oneself as a protective factor in the context of stressors**

People have a need to think positively about themselves, to defend and to improve their positive self-esteem, and even to overestimate themselves. Self-esteem represents a motivational force that influences perceptions and coping behavior. In the context of negative messages and stressors, positive self-esteem can have various protective functions.

Research on optimism confirms that a somewhat exaggerated sense of self-worth facilitates mastery, leading to better mental health (Seligman, 1995). Evidence suggests that positive self-evaluations, exaggerated perception of control or mastery and unrealistic optimism are all characteristic of normal human thought, and that certain delusions may contribute to mental health and well-being (Taylor and Brown, 1988). The mentally healthy person appears to have the capacity to distort reality in
a direction that protects and enhances self-esteem. Conversely, individuals who are moderately depressed or low in self-esteem consistently display an absence of such enhancing delusions. Self-esteem could thus be said to serve as a defense mechanism that promotes well-being by protecting internal balance. Jahoda (Jahoda, 1958) also included the ‘adequate perception of reality’ as a basic element of mental health. The degree of such a defense, however, has its limitations. The beneficial effect witnessed in reasonably well-balanced individuals becomes invalid in cases of extreme self-esteem and significant distortions of the self-concept. Seligman (Seligman, 1995) claimed that optimism should not be based on unrealistic or heavily biased perceptions.

The protective role of self-worth is also present in stress theories, in which positive thinking about oneself is considered to buffer the impact of stressors. The transactional model of stress and coping, as developed by Lazarus and Folkman (Lazarus and Folkman, 1984), is frequently used as a theoretical basis of preventive interventions in mental health. The model emphasizes cognitive appraisals, which center on the evaluation of harm, threats and challenges, as well as on the options to cope with such threats. The transactional character refers to the cognitive process in which particular environmental conditions are appraised by a particular person with certain psychological characteristics. Self-esteem is considered as one of the factors that influence both the perception of threats and the evaluation of possible coping reactions. Positive self-esteem and self-confidence can buffer stress by mitigating the perceived threat and by enhancing the selection and implementation of efficacious coping strategies. As Lazarus and Folkman state:

> Viewing yourself positively can also be regarded as a very important psychological resource for coping. We include in this category those general and specific beliefs that serve as a basis for hope and that sustain coping efforts in the face of the most adverse condition... Hope can exist only when such beliefs make a positive outcome seem possible, if not probable. [(Lazarus and Folkman, 1984), p. 159]  

A high level of self-esteem together with strong social support makes individuals less vulnerable to stressors (Brown et al., 1990; Rutter, 1992). Self-esteem can be seen as an internal moderator of stressors and social support as an external moderator (Caplan, 1974; Hobfoll and Waalkens, 1984). On a far more general level, this is reflected in Albee’s (Albee, 1985) formula for the incidence of emotional illness in society, used as a theoretical fundament for primary prevention:

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\text{Incidence} = \frac{\text{organic causes and stressors/competence, coping skills, self-esteem and social support}}{\text{actions that increase the size of the numerator will increase the incidence of dysfunctional behavior in society and activities that reduce, modify or eliminate these factors will diminish the incidence of dysfunction. Efforts that reduce the size of the denominator will correspondingly increase the incidence, whereas actions that increase the size of the denominator, such as self-esteem, will reduce incidence.}}
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Identity, self-esteem, and the development of externalizing and internalizing problems

Erikson’s (Erikson, 1965, 1968) theory on the stages of psychosocial development in children, adolescents, and adults and Herbert’s flow chart (Herbert, 1987) focus on the vicissitudes of identity and the development of unhealthy mental and social problems. According to these theories, when a person is enduringly confused about his/her own identity, he/she may possess an inherent lack of self-reassurance which results in either a low level of self-esteem or in unstable self-esteem and feelings of insecurity. However, low self-esteem—likewise inflated self-esteem—can also lead to identity problems. Under circumstances of insecurity and low self-esteem, the individual evolves in one of two ways: he/she takes the active escape route or the passive avoidance route (Herbert, 1987). The escape route is associated with externalizing behaviors: aggressive behavior, violence and school dropout, the seeking of reassurance in others through high-risk behavior, premature
relationships, cults or gangs. Reassurance and security may also be sought through drugs, alcohol or food. The passive avoidance route is associated with internalizing factors: feelings of despair and depression. Extreme avoidance may even result in suicidal behavior.

Whether identity and self-esteem problems express themselves following the externalizing active escape route or the internalizing passive avoidance route is dependent on personality characteristics and circumstances, life events and social antecedents (e.g. gender and parental support) (Hebert, 1987). Recent studies consistently show gender differences regarding externalizing and internalizing behaviors among others in a context of low self-esteem (Block and Gjerde, 1986; Rolf et al., 1990; Harter, 1999; Benjet and Hernandez-Guzman, 2001). Girls are more likely to have internalizing symptoms than boys; boys are more likely to have externalizing symptoms. Moreover, according to Harter (Harter, 1999), in recent studies girls appear to be better than boys in positive self-evaluation in the domain of behavioral conduct. Self-perceived behavioral conduct is assessed as the individual view on how well behaved he/she is and how he/she views his/her behavior in accordance with social expectations (Harter, 1999). Negative self-perceived behavioral conduct is also found to be an important factor in mediating externalizing problems (Reda-Norton, 1995; Hoffman, 1999).

The internalization of parental approval or disapproval is critical during childhood and adolescence. Studies have identified parents’ and peers’ supportive reactions (e.g. involvement, positive reinforcement, and acceptance) as crucial determinants of children’s self-esteem and adjustment (Shadmon, 1998). In contrast to secure, harmonious parent–child relationships, poor family relationships are associated with internalizing problems and depression (Kashubeck and Christensen, 1993; Oliver and Paull, 1995).

Self-esteem in health behavior models
Self-esteem also plays a role in current cognitive models of health behavior. Health education research based on the Theory of Planned Behavior (Ajzen, 1991) has confirmed the role of self-efficacy as a behavioral determinant (Godin and Kok, 1996). Self-efficacy refers to the subjective evaluation of control over a specific behavior. While self-concepts and their evaluations could be related to specific behavioral domains, self-esteem is usually defined as a more generic attitude towards the self. One can have high self-efficacy for a specific task or behavior, while one has a negative evaluation of self-worth and vice versa. Nevertheless, both concepts are frequently intertwined since people often try to develop self-efficacy in activities that give them self-worth (Strecher et al., 1986).

Self-efficacy and self-esteem are therefore not identical, but nevertheless related. The development of self-efficacy in behavioral domains of importance can contribute to positive self-esteem. On the other hand, the levels of self-esteem and self-confidence can influence self-efficacy, as is assumed in stress and coping theories.

The Attitude–Social influence–self-Efficacy (ASE) model (De Vries and Mudde, 1998; De Vries et al., 1988a) and the Theory of Triadic Influence (TTI) (Flay and Petraitis, 1994) are recent theories that provide a broad perspective on health behavior. These theories include distal factors that influence proximal behavioral determinants (De Vries et al., 1998b) and specify more distal streams of influence for each of the three core determinants in the Planned Behavior Model (Azjen, 1991) (attitudes, self-efficacy and social normative beliefs). Each of these behavioral determinants is assumed to be moderated by several distal factors, including self-esteem and mental disorders.

The TTI regards self-esteem in the same sense as the ASE, as a distal factor. According to this theory, self-efficacy is influenced by personality characteristics, especially the ‘sense of self’, which includes self-integration, self-image and self-esteem (Flay and Petraitis, 1994).

The Precede–Proceed model of Green and Kreuter (Green and Kreuter, 1991) for the planning of health education and health promotion also recognizes the role of self-esteem. The model directs health educators to specify characteristics.
of health problems, and to take multiple determinants of health and health-related behavior into account. It integrates an epidemiological, behavioral and environmental approach. The staged Precede–Proceed framework supports health educators in identifying and influencing the multiple factors that shape health status, and evaluating the changes produced by interventions. Self-esteem plays a role in the first and fourth phase of the Precede–Proceed model, as an outcome variable and as a determinant. The initial phase of social diagnosis, analyses the quality of life of the target population. Green and Kreuter [(Green and Kreuter, 1991), p. 27] present self-esteem as one of the outcomes of health behavior and health status, and as a quality of life indicator. The fourth phase of the model, which concerns the educational and organizational diagnosis, describes three clusters of behavioral determinants: predisposing, enabling and reinforcing factors. Predisposing factors provide the rationale or motivation for behavior, such as knowledge, attitudes, beliefs, values, and perceived needs and abilities [(Green and Kreuter, 1991), p. 154]. Self-knowledge, general self-appraisal and self-efficacy are considered as predisposing factors.

To summarize, self-esteem can function both as a determinant and as an outcome of healthy behavior within health behavior models. Poor self-esteem can trigger poor coping behavior or risk behavior that subsequently increases the likelihood of certain diseases among which are mental disorders. On the other hand, the presence of poor coping behavior and ill-health can generate or reinforce a negative self-image.

Self-esteem in a BSA to mental health promotion and prevention in schools

Given the evidence supporting the role of self-esteem as a core element in physical and mental health, it is recommended that its potential in future health promotion and prevention programs be reconsidered.

The design of future policies for mental health promotion and the prevention of mental disorders is currently an area of active debate (Hosman, 2000). A key question in the discussion is which is more effective: a preventive approach focusing on specific disorders or a more generic preventive approach?

Based on the evidence supporting the role of self-esteem as a non-specific risk factor and protective factor in the development of mental disorders and social problems, we advocate a generic preventive approach built around the ‘self’. In general, changing common risk and protective factors (e.g. self-esteem, coping skills, social support) and adopting a generic preventive approach can reduce the risk of the development of a range of mental disorders and promote individual well-being even before the onset of a specific problem has presented itself. Given its multi-outcome perspective, we have termed this strategy the ‘BSA’ in prevention and promotion.

Self-esteem is considered one of the important elements of the BSA. By fostering self-esteem, and hence treating a common risk factor, it is possible to contribute to the prevention of an array of physical diseases, mental disorders and social problems challenging society today. This may also, at a later date, imply the prevention of a shift to other problem behaviors or symptoms which might occur when only problem-specific risk factors are addressed. For example, an eating disorder could be replaced by another type of symptom, such as alcohol abuse, smoking, social anxiety or depression, when only the eating behavior itself is addressed and not more basic causes, such as poor self-esteem, high stress levels and lack of social support. Although there is, as yet, no published research on such a shift phenomenon, the high level of co-morbidity between such problems might reflect the likelihood of its existence. Numerous studies support the idea of co-morbidity and showed that many mental disorders have overlapping associated risk factors such as self-esteem. There is a significant degree of co-morbidity between and within internalizing and externalizing problem behaviors such as depression, anxiety, substance disorders and delinquency (Harrington et al., 1996; Angold et al., 1999; Swendsen and Merikangas, 2000). By considering the individual
as a whole, within the BSA, the risk of such an eventuality could be reduced.

The BSA could have practical implications. Schools are an ideal setting for implementing BSA programs, thereby aiming at preventing an array of problems, since they cover the entire population. They have the means and responsibility for the promotion of healthy behavior for such a common risk and protective factor, since school children are in their formative stage. A mental health promotion curriculum oriented towards emotional and social learning could include a focus on enhancing self-esteem. Weare (Weare, 2000) stressed that schools need to aim at helping children develop a healthy sense of self-esteem as part of the development of their ‘intra-personal intelligence’. According to Gardner (Gardner, 1993) ‘intra-personal intelligence’ is the ability to form an accurate model of oneself and the ability to use it to operate effectively in life. Self-esteem, then, is an important component of this ability. Serious thought should be given to the practical implementation of these ideas.

It is important to clearly define the nature of a BSA program designed to foster self-esteem within the school setting. In our opinion, such a program should include important determinants of self-esteem, i.e. competence and social support.

Harter (Harter, 1999) stated that competence and social support, together provide a powerful explanation of the level of self-esteem. According to Harter’s research on self-perceived competence, every child experiences some discrepancy between what he/she would like to be, the ‘ideal self’, and his/her actual perception of him/herself, ‘the real self’. When this discrepancy is large and it deals with a personally relevant domain, this will result in lower self-esteem. Moreover, the overall sense of support of significant others (especially parents, peers and teachers) is also influential for the development of self-esteem. Children who feel that others accept them, and are unconditionally loved and respected, will report a higher sense of self-esteem (Bee, 2000). Thus, children with a high discrepancy and a low sense of social support reported the lowest sense of self-esteem. These results suggest that efforts to improve self-esteem in children require both supportive social surroundings and the formation and acceptance of realistic personal goals in the personally relevant domains (Harter, 1999).

In addition to determinants such as competence and social support, we need to translate the theoretical knowledge on coping with inner self-processes (e.g. inconsistencies between the real and ideal self) into practice, in order to perform a systematic intervention regarding the self. Harter’s work offers an important foundation for this. Based on her own and others’ research on the development of the self, she suggests the following principles to prevent the development of negative self-esteem and to enhance self-worth (Harter, 1999):

(1) Reduction of the discrepancy between the real self and the ideal self.
(2) Encouragement of relatively realistic self-perceptions.
(3) Encouraging the belief that positive self-evaluations can be achieved.
(4) Appreciation for the individual’s views about their self-esteem and individual perceptions on causes and consequences of self-worth.
(5) Increasing awareness of the origins of negative self-perceptions.
(6) Providing a more integrated personal construct while improving understanding of self-contradictions.
(7) Encouraging the individual and his/her significant others to promote the social support they give and receive.
(8) Fostering internalization of positive opinions of others.

Examples of school health promotion programs that foster self-esteem

Haney and Durlak (Haney and Durlak, 1998) wrote a meta-analytical review of 116 intervention studies for children and adolescents. Most studies indicated significant improvement in children’s and adolescents’ self-esteem and self-concept, and as a result of this change, significant changes in behavioral, personality, and academic functioning. Haney and
Durlak reported on the possible impact improved self-esteem had on the onset of social problems. However, their study did not offer an insight into the potential effect of enhanced self-esteem on mental disorders.

Several mental health-promoting school programs that have addressed self-esteem and the determinants of self-esteem in practice, were effective in the prevention of eating disorders (O’Dea and Abraham, 2000), problem behavior (Flay and Ordway, 2001), and the reduction of substance abuse, antisocial behavior and anxiety (Short, 1998). We shall focus on the first two programs because these are universal programs, which focused on ‘mainstream’ school children. The prevention of eating disorders program ‘Everybody’s Different’ (O’Dea and Abraham, 2000) is aimed at female adolescents aged 11–14 years old. It was developed in response to the poor efficacy of conventional body-image education in improving body image and eating behavior. ‘Everybody’s Different’ has adopted an alternative methodology built on an interactive, school-based, self-esteem approach and is designed to prevent the development of eating disorders by improving self-esteem.

The program has significantly changed aspects of self-esteem, body satisfaction, social acceptance and physical appearance. Female students targeted by the intervention rated their physical appearance, as perceived by others, significantly higher than control-group students, and allowed their body weight to increase appropriately by refraining from weight-loss behavior seen in the control group. These findings were still evident after 12 months. This is one of the first controlled educational interventions that had successfully improved body image and produced long-term changes in the attitudes and self-image of young adolescents.

The ‘Positive Action Program’ (Flay and Ordway, 2001) serves as a unique example of some BSA principles in practice. The program addresses the challenge of increasing self-esteem, reducing problem behavior and improving school performance. The types of problem behavior in question were delinquent behavior, ‘misdemeanors’ and objection to school rules (Flay and Ordway, 2001). This program concentrates on self-concept and self-esteem, but also includes other risk and protective factors, such as positive actions, self-control, social skills and social support that could be considered as determinants of self-esteem. Other important determinants of self-esteem, such as coping with internal self-processes, are not addressed. At present, the literature does not provide many examples of BSA studies that produce general preventive effects among adolescents who do not (yet) display behavioral problems (Greenberg et al., 2000).

**Conclusion**

To conclude, research results show beneficial outcomes of positive self-esteem, which is seen to be associated with mental well-being, happiness, adjustment, success, academic achievements and satisfaction. It is also associated with better recovery after severe diseases. However, the evolving nature of self-esteem could also result in negative outcomes. For example, low self-esteem can be a causal factor in depression, anxiety, eating disorders, poor social functioning, school dropout and risk behavior. Interestingly, the cross-sectional characteristic of many studies does not exclude the possibility that low self-esteem can also be considered as an important consequence of such disorders and behavioral problems.

Self-esteem is an important risk and protective factor linked to a diversity of health and social outcomes. Therefore, self-esteem enhancement can serve as a key component in a BSA approach in prevention and health promotion. The design and implementation of mental health programs with self-esteem as one of the core variables is an important and promising development in health promotion.

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