The "Self-Esteem" Enigma: A Critical Analysis

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Despite popular beliefs that self-esteem plays a causal role in a wide range of both positive and negative social behaviors, research shows that it actually predicts very little beyond mood and some types of initiative. This is likely attributable to myriad conceptual and methodological problems that have plagued the literature. Consequently, this article utilizes specific critical thinking principles (metathoughts) to address five key questions: Why does there continue to be a lack of consensus in defining and understanding self-esteem? Given the heterogeneity of self-esteem, where do the distinctions lie? What are the most prominent problems with self-esteem research? Why does our obsession with self-esteem persist? What are the clinical implications for misunderstanding and misusing self-esteem? Metathoughts include: availability bias, confirmation bias, linguistic bias, naturalistic fallacy, nominal fallacy, emotional reasoning, correlation-causation conflation, reification error, assimilation bias, fundamental attribution error, belief perseverance, insight fallacy, and Barnum effect. Recommendations for improvement are discussed.

"Self-esteem"[1] is one of the oldest concepts in psychology, ranking among the top three covariates in personality and social psychology research (Rhodewalt & Tragakis, 2003). As of 2003, it was the subject of more than 18,000 published studies, and, by 2019 that number had increased to more than 25,000 publications (based on current database searches).

The term can be traced to 1890 and the work of William James (1983/1890; see Harter, 1999). Following James's early theoretical efforts, it was largely ignored for 75 years as a result of both academic and socioeconomic factors. A shift occurred in the 1960s, however, with the rise of wealth and consumerism. Along with these social and economic changes came the individual's ability to see himself or herself at the center of his or her own destiny (Seligman, Reivich, Jaycox, &

[1] For purposes of this article, self-esteem (without quotation marks) is used to refer to the concept, construct, or idea of self-esteem, while "self-esteem" (in quotation marks) is used to refer to the term itself, as used by a wide range of sources, from theorists, researchers, and clinicians, to the general population.

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Gillham, 2007). As humanistic psychology (see Maslow, 1970; Rogers, 1959) gained prominence, concepts such as self-determination, the power of free will, and human potential became major areas of interest; subsequently, self-esteem arose as an important and popular idea.

For over half a century, self-esteem has been viewed as the psychologist's "…Holy Grail: a psychological trait that would soothe most of individuals' and societies' woes" (Baumeister, 2005, p. 34). Not only did self-esteem grow to be one of the most prominent individual concerns in Western civilization, it became a household word and even a widespread societal concern. North American culture in particular came to embrace the idea that high self-esteem is not only desirable in and of itself, but it is also one of the central psychological sources from which all positive behaviors spring (Baumeister, Campbell, Kruger, & Vohs, 2003).

During the 1970s, when the "self-esteem movement" emerged as a powerful social force, many Americans came to believe that we suffer from an epidemic of low self-esteem (Baumeister, 2005). Proponents of the movement embraced a positive self-view as a panacea for an extraordinarily wide range of social problems, from academic, occupational, and interpersonal difficulties, to issues of public health, violence, and teenage pregnancy (Dawes, 1994; Mecca, Smelser, & Vasconcellos, 1989).

With this conviction as the driving force, in the 1980s, the California Task Force to Promote Self-Esteem and Personal and Social Responsibility was established (Dawes, 1994). The task force had high hopes of pioneering the quest to identify causes and cures of many social ills plaguing society, so much so that it compared its efforts to both unlocking the secrets of the atom in the 1940s and attempting to plumb the reaches and mysteries of outer space in the 1960s (Mecca et al., 1989). The results of its findings were published in Mecca's et al. (1989) book *The Social Importance of Self-Esteem*, in which one of its editors declared: "The causal link is clear: low self-esteem is the causally prior factor in individuals seeking out kinds of behavior that become social problems. Thus, to work on social problems, we have to work directly on that which deals with the self-esteem of the individuals involved.…We all know this to be true, and it is really not necessary to create a special California task force on the subject to convince us. The real problem we must address – and which the contributors to this volume address – is how we can determine that it is scientifically true" (p. 7).[2]

[2] This statement is remarkable for a number of reasons, not the least of which is that the editors claimed to know something to be true, but they had yet to determine that it is "scientifically true."

The editor and contributors were confronted with a profound problem, however, in that what they "knew to be true" turned out not to be scientifically true. Despite the lofty aspirations of that wide-ranging investigation, results failed to support virtually any of its assumptions and hypotheses, namely, that self-esteem plays a major causal role in determining nearly any significant social behaviors, let alone that government programs designed to enhance self-esteem would have beneficial social effects (Dawes, 1994; Mecca et al., 1989).

In 2003, Baumeister and colleagues published a comprehensive review of empirical research on the relationships between self-esteem and a multitude of variables of broad social relevance, including health, sexual behavior, financial status, grades, intelligence, job performance and satisfaction, and interpersonal relations. Their findings reached a similar conclusion, that self-esteem is not a major predictor of almost anything, with the notable exceptions of mood (happiness for high self-esteem and depression for low self-esteem) and some correlations with "enhanced initiative" (e.g., romantic intimacy).

Based on the results of these investigations, psychologists' faith in self-esteem has been deeply shaken. Not only has the research shown that self-esteem fails to accomplish what proponents of the movement hoped it would, but it has also been shown to be associated with a host of liabilities. For example, people who score high on measures of self-esteem tend to overestimate their intelligence, likeability, and attractiveness, making them less realistic about their strengths and weaknesses than people with lower scores (Taylor & Brown, 1988). Conversely, individuals with low self-esteem have been shown to make more balanced and unbiased assessments about the future (Ruehlman, West, & Pasahow, 1985; Taylor & Brown, 1988).

Even efforts to simply *pursue* self-esteem could, in some cases, backfire and contribute to some of the very problems it was thought to thwart (Baumeister et al., 2003; Blaine & Crocker, 1993; Crocker & Park, 2004; Kernis, 2003; Raskin, Novacek, & Hogan, 1991). Specifically, attempts to bolster self-esteem have been shown to interfere in several areas of functioning, such as learning and mastery (Covington, 1984; Deci & Ryan, 2000; Dweck, 1999). Moreover, when people seek to boost their self-esteem, interpersonal relationships can be hindered because they are focused on themselves at the expense of others' needs and feelings (Crocker & Park, 2004).

And what of the popular belief that we suffer from a low self-esteem "epidemic"? There are ample data on the American population showing that it is not, in fact, the case; if anything, we tend to *overvalue* ourselves (Taylor & Brown, 1988), with the average American perceiving himself

or herself as above average[3] (Baumeister, 2005). The fact that most individuals in the United States score toward the high end of self-esteem measures, therefore, casts serious doubts on the key assumption underlying the self-esteem movement, namely that there is a widespread deficit of self-esteem: How can American society be suffering from a widespread low self-esteem epidemic if the average American person regards himself or herself as above average?

These findings notwithstanding, the body of research and other works on self-esteem continue to grow. Even in the face of scant empirical evidence that self-esteem plays a direct causal role in most every social sphere, countless efforts to boost self-esteem are still being made by teachers, parents, and therapists alike (Baumeister et al., 2003). As a testament to the ubiquity of interest in self-esteem, a search conducted at the time of this writing in the WorldCat[4] bibliographic database yielded 6,317 books (both print and electronic) the titles of which include "self-esteem," and 18,473 books on the subject of self-esteem.

How are we to reconcile this apparent disjuncture? How are we to account for the enigma of self-esteem? A useful starting point would be to recognize and analyze the numerous conceptual and methodological shortcomings extant in the literature (see, for example, Baumeister et al., 2003; Eromo & Levy, 2017). As such, it appears that the "widespread epidemic" from which we suffer is not one of low self-esteem per se, but rather of thinking critically about self-esteem. The purpose of this article, therefore, is to apply specific critical thinking principles to problematic areas in theory, research, and usage of "self-esteem."

Thinking Critically About "Self-esteem"

In his book, *Tools of Critical Thinking* (2010), Levy identifies and examines 30 principles of critical thinking (termed *metathoughts*), whose goal is to ameliorate deficits in this area by providing strategies for inquiry and problem solving. He notes that our judgment and decision making, although reasonably accurate much of the time, are frequently

[3] This perception is, of course, statistically impossible. Most people cannot be "above average" of anything. This type of self-favoring bias is akin to the research showing that 93% of the U.S. population consider themselves to be better than average drivers (Svenson, 1981), an example of what social psychologists have called the *above-average effect* or *illusory superiority* (Hoorens, 1995).

[4] WorldCat, published by the Online Computer Library Center, is the world's largest and most comprehensive catalog of library resources from around the globe, with more than 347 million bibliographic records that represent more than 2.3 billion items held by participating libraries (Online Computer Library Center, 2015).

clouded by a vast array of cognitive errors in the form of various biases and heuristics.[5] Further, there is widespread consensus that these errors reflect the workings of basically adaptive processes that are misapplied in specific circumstances (Gigerenzer, Todd, & ABC Research Group, 1999; Lilienfeld, Ammirati, & Landfield, 2009; Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2014; Shepperd & Koch, 2005; Tversky & Kahneman, 1974). Unfortunately, despite the considerable amount of psychological research that exists concerning the impact of these errors on human judgment, psychologists have made far more progress cataloguing them than they have in finding ways to correct or prevent them (Lilienfeld, et al., 2009). Even among scholars, the capacity to think critically is frequently and surprisingly non-generalizable across disciplines (see Feynman, 1985; Lykken, 1991).

Research studies on self-esteem have revealed numerous problems and contradictions leading to a plethora of unanswered questions. It is proposed here that identifying errors in critical thinking can provide a useful lens through which to examine such questions. With the goal of reducing these areas of confusion, Levy's metathoughts are applied to the following five questions:

1) Why does there continue to be a lack of consensus when it comes to defining and understanding self-esteem?
2) Given the heterogeneity of the construct "self-esteem," where do the distinctions lie?
3) What are some of the most prominent problems with the existing self-esteem research?
4) Despite the lack of evidence for its validity, why does our self-esteem obsession persist?
5) What are the clinical implications if we continue to misunderstand and misuse "self-esteem"?

1. Despite the fact that the construct has been in existence for nearly 130 years, why does there continue to be a lack of consensus when it comes to defining and understanding self-esteem?

[5] It should be noted that, although *biases* and *heuristics* are closely related terms that are often confused with one another, they are distinct and separate concepts. A bias is a "prejudicial inclination or predisposition that inhibits, deters, or prevents impartial judgment" (Levy, 2010, p. 264), such as cognitive biases and motivational biases (see also Fiske & Taylor, 1984, 2007). A heuristic is a "mental shortcut or rule-of-thumb strategy for problem solving that reduces complex information and time-consuming tasks to more simple, rapid, and efficient judgmental operations, particularly in reaching decisions under timed conditions of uncertainty" (Levy, 2010, p.270), such as the availability heuristic and representativeness heuristic (see also Fiske & Taylor, 1984, 2007).

What constitutes self-esteem is a fundamental question that has concerned personality and clinical psychologists for decades. Given the long history of the term "self-esteem," it is not surprising that numerous individuals have attempted to define it.[6]

But if self-esteem has been viewed as not only psychologists' Holy Grail, but also as a prominent concern of American educators, mental health professionals, and Westernized civilizations at large, why is it still so misunderstood? Why is there still a lack of consensus in the field about the very definition of self-esteem? Two potential problems are identified and examined here: *linguistic bias* and the *nominal fallacy/tautologous reasoning*.

Linguistic bias

Two of the most essential functions of language are description and evaluation. While we typically assume that descriptions are objective and evaluations are subjective, whenever we attempt to describe people (both others and ourselves), the words we use are almost invariably evaluative, in that they reflect our own personal values and preferences. As such, our use of any particular term serves not only to describe but also to *prescribe* what is desirable or undesirable to us. This confusion between objective description and subjective evaluation can be clearly illustrated by different connotative meanings of the term "self-esteem." For example, person A might perceive person C as having "high self-esteem" meaning that C is confident, self-assured, and assertive; however, person B – who possesses a different set of values or is from a different culture – might view that same person C as pushy, narcissistic, and overly ambitious. In like manner, person A might say that person D has "low self-esteem" because A perceives D to be self-doubting, insecure, and anxious; in contrast, person B might view D as deferential, humble, and respectful of authority. Thus, whether in the case of social scientists or the general population, the very use of the labels "self-esteem," "high

[6] For example, James (1890/1983) defined self-esteem as the ratio or relationship between one's achievements and one's aspirations. Rogers (1959) and Satir (1967) characterized self-esteem primarily in terms of self-worth. Maslow (1970) separated esteem needs into two levels: a lower form (needs for status, recognition, and fame) and a higher form (self-confidence, self-respect, and competence). Rosenberg (1965) viewed self-esteem as comprised of positive or negative attitudes towards the self that are a product of social interactions. Branden (1969) described self-esteem as a disposition to experience oneself as competent and as worthy of happiness. Eromo and Levy (2017) conceptualized self-esteem as multidimensional (viz., a function of its accuracy, directionality, and level of stability), and consisting of both emotional components (self-worth) and cognitive components (self-efficacy).

self-esteem" or "low self-esteem" can be largely contingent on one's own set of personal values and beliefs.

Nominal fallacy and tautologous reasoning

In a world where descriptive labels are a fundamental and indispensable part of science and everyday life, it is important not to conflate naming something with explaining it. This error in thinking, called the nominal fallacy (Pope & Vasquez, 2016), also typically involves circular or tautological reasoning. A tautology is a needless repetition of an idea or statement, using different words that essentially say the same thing twice (Tautology, 2018). For example, "People who like themselves have self-esteem; therefore, people who have self-esteem like themselves." When it comes to self-esteem and the field of psychology, examples of the nominal fallacy and tautological reasoning are commonplace in the conversations of clinicians, educators, and researchers alike. For instance:

"Why does that teenager think negatively about himself?"
"Because he has low self-esteem."
"How do you know he has low self-esteem?"
"Can't you see how negatively he thinks of himself?"

As another example:
"Why is that woman so happy with who she is?"
"Because she has high self-esteem."
"How do you know she has high self-esteem?"
"Well, just look at how happy she is with herself!"

These kinds of circular "explanations" are, of course, not explanations at all. To label someone as having "high self-esteem" or "low self-esteem" does not account for *why* they are happy or sad, *why* their interpersonal relationships are functional or dysfunctional, *why* they engage in healthy or unhealthy behaviors, or *why* they are successful or unsuccessful.

2. Given the heterogeneity of the construct "self-esteem," where do the distinctions lie?

By and large, both theorists and researchers have concluded that self-esteem is heterogeneous in nature (e.g., Baumeister et al., 2003; Kernis & Waschull, 1995; Schneider & Turkat, 1975); however the specific distinctions between the various facts of self-esteem have been – and continue to be – widely debated. Generally speaking, "high self-esteem" is viewed as involving positive feelings of self-worth, self-liking, and acceptance; in contrast, "low self-esteem" is typically seen as reflecting negative feelings of self-worth, self-dislike, and lack of self-acceptance. Further, many theorists have invoked some differentiation between being

conceited, narcissistic, and defensive on one hand, versus being accepting of oneself with an accurate appreciation of one's strengths and worth on the other (see Eromo & Levy, 2017).

In this regard, a key issue in examining the heterogeneity of self-esteem is its relation to narcissism[7], or, in its extreme form, narcissistic personality disorder. Narcissism is associated with an extremely favorable, even grandiose sense of self-importance, arrogance, sense of entitlement, need for admiration, fantasies of personal brilliance or beauty, and lack of empathy (American Psychiatric Association, 2013). Research in this area has shown that although some people who score high on measures of self-esteem are narcissistic, others are not. However, the reverse is not true: narcissists rarely score low on measures of self-esteem (Baumeister et al., 2003). In other words, narcissism is a relatively reliable predictor of high self-esteem, but high self-esteem is not a reliable predictor of narcissism. Further, research has shown that the high self-esteem of narcissists tends to be both unstable (Rhodewalt, Madrian, & Cheney, 1998) and self-defensive (Paulhus, 1998). Taken together, these lines of research imply that the category of people with high self-esteem is a "mixed bag" of individuals whose self-concepts and feelings of self-worth differ in important ways (Baumeister et al., 2003).

Various other researchers (e.g., Crocker & Wolfe, 2001; Deci & Ryan, 1995; Kernis, 2003) have maintained that self-esteem falls along a continuum, from true or optimal to inauthentic or contingent. More recently, Eromo and Levy (2017) proposed a new model of self-esteem, which attempts to account for the construct's heterogeneous nature by incorporating three dimensions of self-appraisal: accurate versus distorted, inflated versus deflated, and stable versus unstable/fragile.

Below is a discussion of three critical thinking principles – *linguistic bias, conflating dichotomous variables with continuous variables*, and the *similarity-uniqueness paradox* – that should be considered in understanding the heterogeneous nature of the construct and determining wherein the distinctions lie.

Linguistic bias

As noted above, the words we use are almost always value laden, in that they reflect our own personal preferences. This concept should be considered not only in terms of defining "self-esteem," but also in

[7] Closely related to narcissism is the concept of *hubris*, which is also marked by over-confidence, pride, and arrogance; however, in contrast to narcissism, hubris does not necessarily involve a need for admiration or a lack of empathy for others.

examining the heterogeneity of the term. Where do the distinctions lie and to what degree are they in the eye of the perceiver? Regardless of the ostensibly "descriptive" words one chooses in regard to self-esteem – whether *authentic*, *true*, *optimal*, *arrogant*, *defensive*, *fragile*, *inauthentic*, or *narcissistic* – it is imperative that we realize how our own personal biases influence our language; we should, therefore, communicate our values as openly and clearly as possible, as opposed to presenting these subjective judgments as if they were objective reflections of truth.

When viewed through a broader sociocultural lens, many believe that concerns with self-esteem are largely idiosyncratic features of Western individualistic cultures (see Eromo & Levy, 2017). Therefore, according to this perspective, the quest for high self-esteem is not inherently a universal human motive, but differs based on largely sociocultural factors. For example, in collectivistic cultures (e.g., Japanese, South American, & some African cultures), the motivation to "have" high self-esteem is virtually nonexistent (Heine, Lehman, Markus, & Kitayama, 1999). Even within Western civilization, cultural differences exist based on a number of sociocultural factors (e.g., gender, ethnicity, socioeconomic status). Some historians have noted that the need for high self-esteem appears to be a relatively recent development in Western culture (Eromo & Levy, 2017). For example, the Judeo-Christian tradition, which has long reigned supreme in Western society, has historically considered excessive self-love to be suspect because it leads to attitudes of self-importance and arrogance, as opposed to modesty and humility – which are virtues believed to be conducive to spiritual growth (see Baumeister, 1987). These examples underscore the fact that, regardless of intent, the words we use – especially regarding people – are invariably value laden. Therefore, in attempting to reach consensus on where the distinctions lie within the heterogeneous category of self-esteem, the evaluative bias must be taken into account.

Conflating dichotomous variables with continuous variables

A *dichotomous variable* is comprised of two, mutually exclusive categories; in contrast, a *continuous variable* consists of a theoretically infinite number of points lying between two polar opposites. Most person-related phenomena, especially psychological constructs, are continuous variables, in that they are a matter of magnitude or degree, rather than of type. A common problem, however, is that of false dichotomization, wherein a continuous variable is erroneously treated as if it were a dichotomous variable.

Self-esteem is a prime example of a continuous variable that may be confused with a dichotomous variable. Within the general population,

throughout the popular media, and even sometimes in clinical settings, people are guilty of referring to individuals as either "having" or "not having" self-esteem. But, unlike say pregnancy, self-esteem is not equivalent to an on/off switch. (One can't be "just a little bit" pregnant.) It is more akin to a dimmer knob, which operates in terms of degree rather than discrete type. As such, self-esteem is both a heterogeneous construct and a continuous variable that is more appropriately represented as dimensional, rather than two opposite categories.

In this way, according to Eromo and Levy's (2017) multidimensional model, "optimal" self-esteem does not lie at either extreme (high vs. low); rather, it consists of self-appraisal assessed on three continua, characterized by (a) a high degree of accuracy (based on both objective outcomes of one's behavior and one's interpersonal interactions), (b) a self-evaluation that is by and large positive, and (c) a minimal influence of external events or standards across time and situation.

It also should be noted that the most widely used psychological assessments of self-esteem do, rightfully, represent self-esteem as a continuous variable. For example, Rosenberg's (1965) *Self-Esteem Scale* is a unidimensional measure of self-esteem, resulting in a range of 0-30, with higher scores representing higher self-esteem. The individual's score therefore lies somewhere on a continuum, rather than falling within one of two distinct categories.

However, regardless of the fact that such scales are typically used to measure self-esteem in formal research or clinical settings, it continues to be mistakenly regarded as a dichotomous variable across many other contexts. Thus, as we move towards more valid conceptualizations of self-esteem, it is important that we avoid the error of false dichotomization.

Similarity-uniqueness paradox

Identifying the similarities and differences between any set of events is a function of the perspectives from which one chooses to view them. In other words, all phenomena are both similar to and different from each other, depending on the variables or dimensions that have been selected to compare and contrast them. As an example, anxiety and depression are similar in that they both involve feelings of psychological distress and emotional dysphoria. With respect to their differences, however, anxiety is marked by fear, worry about the future, and physiological activation. In contrast, depression typically manifests by feelings of sadness, ruminations about the past, and physiological inhibition.

Keeping these principles in mind, how do we differentiate between self-appraisal, self-esteem, self-efficacy, and narcissism? How are they similar? How are they different? First, they all are a part of one's self-

concept. Second, self-esteem, self-efficacy, and narcissism may be seen as different forms or subsets of the broader term, self-appraisal. Further, the appraisal is in a positive direction and they all lie on a continuum rather than in dichotomous categories. With respect to their distinctions, self-esteem and self-efficacy are typically judged positively in Western society and are seen as aspirational goals; in contrast, narcissism is generally eschewed and, from a clinical standpoint, is deemed to be pathological. In terms of delineating self-esteem versus self-efficacy, the former is typically defined with an emphasis on affect (i.e., how one feels about himself or herself), whereas the latter is usually defined with a focus on thoughts and cognition (i.e., one's beliefs about his or her ability to complete tasks or reach goals; see Bandura, 1986, 2001).

Thus, as we attempt to delineate where the distinctions lie within the heterogeneous concept of self-esteem, it is important to keep in mind that the variables selected for the purposes of evaluation will determine just how similar or unique the various types or categories of self-esteem turn out to be.

3. What are some of the most prominent problems with the existing self-esteem research?

The research literature on self-esteem is plagued with a variety of conceptual and methodological problems. Some of these include: imprecise definitions and operationalizations, dependence on unreliable and poorly validated self-report measures, lack of external validity, haphazard instrumentation variance, failure to rule out the influence of third variables, and claiming "significant" findings on the basis of relationships that are not necessarily meaningful, substantive, or useful (see Eromo & Levy, 2017, for discussion). Below is a brief examination of four potential sources of error: *reactivity*, *correlation-causation conflation*, *bidirectional causation*, and *multiple causation*.

Reactivity

Given the ultimately subjective nature of self-esteem, the vast majority of research on self-esteem relies solely on self-report measures (Blascovich & Tomaka, 1991). While self-report instruments are a relatively efficient method of measuring self-esteem, such measures are associated with a host of potential biasing factors. One of those biasing factors is reactivity, a phenomenon in which the conduct of research or measurement, in itself, affects the very entity that is being studied. In other words, reactivity refers to the extent to which measuring something causes it to change (Heppner, Wampold, & Kivlighan, 2008; Kazdin, 1979).

Almost without exception, the moment subjects become aware that they are being observed, they develop expectations and hypotheses about the purpose of the study and how they may be expected to behave. Based on this awareness, they may be motivated to behave in ways that they believe to be socially desirable. For example, in an individualistic, Western culture where it is considered desirable to present oneself as possessing high rather than low self-esteem, one might be likely to respond – even unintentionally – to face-valid items accordingly, thereby artificially inflating self-esteem scores. Alternatively, under other circumstances, sociocultural factors (e.g., valuing humility over self-importance) or variables such as the research subject's level of cooperativeness, passivity, or modesty, might affect responding to test items in a manner that deflates his or her self-esteem score. Moreover, simply asking subjects to think about self-esteem (e.g., by administering the Rosenberg [1965] *Self-Esteem Scale*) may stimulate them to consider the topic in a new way, or even prompt them to formulate an opinion when they previously had none. Therefore, due to the effects of reactivity, researchers using self-report measures of self-esteem are hindered in assessing naturalistic, authentic attitudes or feelings, which would invariably compromise the validity of their observations.

Correlation-causation conflation

While the statistical links between high self-esteem and happiness, and low self-esteem and depression, appear to be strong, the methodological limitations of the research that has been conducted thus far must be addressed prior to determining the exact nature of these relationships (Eromo & Levy, 2017). In particular, given the fact that virtually all of the published self-esteem research consists of correlational designs, it is essential to bear in mind that a correlation between variables demonstrates only the direction and strength of a relationship, but not causality. In other words, cause and effect is not implied, should not be inferred – and in fact, cannot be proven – simply by virtue of a correlation (Bleske-Rechek, Morrison, & Heidtke, 2015; Hatfield, Faunce, & Job, 2006).

Nevertheless, several studies in the literature (e.g., Cheng & Furnham, 2003; Michalak, Teismann, Heidenreich, Ströhle, & Vocks, 2011; Sowislo and Orth, 2013) inappropriately imply a causal relationship between low self-esteem and depression, and between high self-esteem and happiness, simply by virtue of statistical correlations. Such presumptive inferences are reflected in unsubstantiated conclusions and wording choices such as: "…the detrimental effects of low self-esteem on depression" (Michalak, et al., 2011, p. 751) and "…the effect

of self-esteem on depression was significantly stronger than the effect of depression on self-esteem" (Sowislo & Orth, 2013, p. 213).

To take another example, low self-esteem is considered to be an associated feature of eating disorders (e.g., anorexia, bulimia nervosa), along with a negative or distorted body image. Further, evaluation of body appearance has been shown to be significantly correlated with global self-esteem among both clinical populations (O'Brien & Epstein, 1988) and normal populations (Harter, 1999). However, such relationships do not prove a causal link between these variables. It certainly is plausible that a negative evaluation of body appearance causes low self-esteem. Conversely, it is also possible that low self-esteem might cause a negative evaluation of body appearance. Further, low self-esteem and negative body evaluations may be a cause and effect of each other (see discussion below of bidirectional causation). Moreover, some other "third-factor" variables – such as family upbringing, environmental influences, or emotional dynamics (e.g., anxiety, depression) – might cause both low self-esteem and negative body evaluations. In sum, caution must be exercised when attempting to determine causal relationships based solely on correlational relationships.

Bidirectional causation

Causal relationships frequently are thought of as being unidirectional (wherein variable A causes variable B); however, often times the causal relationship between two variables is bidirectional (A causes B and B causes A). Consider, for example, beliefs about the relationship between self-esteem and popularity (see Chambliss, Muller, Hulnick, & Wood, 1978; Lorr & Wunderlich, 1986), namely that people with high-esteem are more popular than people with low-esteem. It is reasonable to suppose that high self-esteem might improve interpersonal relationships or popularity (A causes B). Under this assumption, high self-esteem causes a person to be more likeable or attractive in that others might prefer to be around confident, outgoing individuals, while avoiding interacting with individuals who are more insecure.

At the same time, the reverse causal relationship (B causes A) could also be true. This is illustrated by Leary's (2005) *sociometer theory* of self-esteem, which maintains that self-esteem evolved in order to monitor social acceptance and avoid social rejection. In other words, self-esteem is an internal measure of one's interpersonal appeal and success, and virtually all influences on self-esteem involve factors that have real, potential, or imagined implications for the individual's acceptability to other people (Leary & Baumeister, 2000; Leary & Downs, 1995; Leary, Tambor, Terdal, & Downs, 1995). Therefore, popularity, according to this model, would cause self-esteem to rise, while social rejection would

cause it to diminish. As such, it is not a question of whether popularity causes self-esteem or self-esteem causes popularity – because both directions of causality are, to some degree, likely to be valid.

The same principle would hold true for any number of other relationships involving self-esteem: high self-esteem and happiness and social initiative, low self-esteem and depression and eating disorders, and so on. Owing to the principle of bidirectional causation, "cause" and "effect" are relative terms, with cause in one instance becoming effect in another. Therefore, from this perspective, attempting to understand which phenomenon came first, in many instances, may be both unanswerable and moot.

Multiple causation

Practically every behavior has multiple determinants; any single explanation is almost invariably an oversimplification. For example, what is the cause of overeating? Is it feelings of stress and tension? Or early childhood trauma? Or maladaptive learning patterns? Or some biochemical malfunction? Or feelings of emptiness or loneliness? Or low self-esteem?

The reality is that any given effect may be – and typically is – the result of not just one single cause, but numerous causes that are interacting together. The question "what is the cause of?" any particular phenomenon can be linguistically misleading in that it suggests there is a single cause of that event – when, in fact, there are likely to be multiple causes. In this way, the question of "what is the cause of…" should be replaced with "what are the causes of…" In other words, rather than assuming *either/or*, the question of causation is usually a matter of *both/and*.

Viewed through this lens, what, then, are the potential causes of low self-esteem? An unhappy or even traumatic childhood? Repeated failure experiences? A weak sense of self-efficacy? Poor academic performance? Chronic social problems? Genetic vulnerability? Conversely, what might be the causes of high self-esteem? A loving and supportive upbringing? Repeated success experiences? A strong sense of self-efficacy? Academic achievement? Fulfilling interpersonal relationships? Genetic resiliency? The existing research findings that have sought to answer these questions are hazy at best, likely because no single cause alone produces the effects in question. Instead, they are a result of multiple factors interacting with one another, a principle that some researchers of self-esteem have failed to explicitly address.

As discussed above, not only has research (Baumeister et al., 2003) shown that self-esteem does not have a direct causal effect on most phenomena but the lack of conceptual clarity and consensus in the field

on a definition of self-esteem also suggest that the findings on what causes self-esteem are about as unclear as what self-esteem causes. Overlooking the principle of multiple causation might help to explain, at least in part, why the California Task Force to Promote Self-Esteem and Personal and Social Responsibility failed to confirm their hypothesis that low self-esteem is "*the* [emphasis added] causally prior factor in individuals seeking out kinds of behavior that become social problems" (Mecca, et al., 1989, p. 8).

4. In light of the lack of empirical evidence for self-esteem as psychology's "Holy Grail," why does our obsession with self-esteem persist?

Despite the striking dearth of empirical support that self-esteem plays a direct causal role in most objective outcomes, and regardless of the weaknesses of even the correlational data, countless efforts to boost self-esteem continue to be made by teachers, parents, and therapists alike. Our culture still seems to be characterized by this self-esteem obsession, as the quest to raise self-esteem continues to be both an individual fixation and a national preoccupation, as evidenced by the multitude of self-help books, popular psychology articles, talk shows, and advertisements that center around boosting self-esteem. The following section applies seven metathoughts to help explain why the self-esteem obsession persists: *availability bias*, *assimilation bias*, the *Barnum effect*, the *fundamental attribution error*, *emotional reasoning*, *confirmation bias*, and the *belief perseverance effect*.

Availability bias

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

If examples are readily available in our memories, we tend to overestimate the frequency of those phenomena. Conversely, if we are unable to quickly recall examples of a particular phenomenon, we are quick to assume that it is uncommon. However, there are numerous biasing factors (e.g., life experience, cultural background, level of

education) that affect the availability of particular events in our memories. When our use of the availability heuristic to make judgments results in systematic errors, this is referred to as the availability bias.

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

Assimilation bias

Human beings have an innate predisposition to classify, group, or otherwise structure the world around us into categories, which we conceptualize as mental representations or *schemas*. While this propensity does have helpful attributes in terms of organizing information and processing data, it can also become problematic in that it leads us to overlook, misconstrue, or even reject valid information when it is not consistent with our existing schemas (Fiske & Taylor, 1984, 2007).

With the self-esteem movement having found its way into mainstream psychotherapeutic, educational, and occupational practices, we may have become so accustomed to viewing behavior through a prism of self-esteem that we simply do not even question whether or not it is valid. Your co-worker abuses drugs? Hmm, sounds like a self-esteem problem. Your child is acting out in school? Must be due to damaged self-esteem. Your friend has an eating disorder? Clearly self-esteem issues. You continue to select the wrong partners to date? Yep, gotta be low self-esteem all right.

To the extent that we are inclined to make the data fit into our schemas (a process which Piaget, 1954, 1970 termed *assimilation*) versus modifying our schemas in order to fit new data (*accommodation*), this common cognitive bias could lead us to overlook the overwhelming amount of evidence that contradicts our common assumptions about self-esteem. Moreover, because of the remarkable pervasiveness of the term in our culture, we may have become accustomed to viewing the world through "self-esteem colored glasses," making it easier to view every problem – irrespective of its nature or cause – as a self-esteem issue, rather than modifying our existing schemas to account for disconfirming data.

Barnum effect

The famous circus master P.T. Barnum was reputed to have asserted, "A good circus should have a little something for everybody." This axiom led to coining the term *Barnum statement*, which involves a personality description or interpretation about a particular person that is true of practically all human beings (Vohs, 2016). In other words, the statement is general and vague enough to apply to a vast range of people, and consequently, has "a little something for everybody." The Barnum effect refers to one's tendency to accept the validity of such generic interpretations (see Meehl, 1956, 1973). This error in critical thinking can be seen as an explanation for the pervasive acceptance of such practices such as astrological horoscopes, fortune telling, numerology, aura readings, and certain types of popular personality questionnaires.

Unfortunately, in the context of clinical psychology, Barnum statements can also parade in the guise of psychological evaluations or assessments. For instance, a therapist may confidently conclude, "My client's problem is that he has ambivalent feelings toward his parents." (*Who doesn't?*) Or, "My client doesn't want to be rejected." (*Who does?*) Or, "My client is her own worst enemy." (*Who isn't?*) The same holds true for declaring that one's client has "control issues," "trust issues," or "self-esteem issues." To some degree, *everybody* has these issues – it's just a matter of specific form and magnitude.

As such, at least part of the reason for the persistent focus on "self-esteem issues" is that so many people are easily subsumed under that category. Put another way, when the psychological net is cast wide enough, virtually everybody can become ensnared in its web. Thus, the ostensible ubiquity of "self-esteem issues" (whether too high, too low, or some combination thereof) leads us to overuse the term, without regard to specific meaning. Although Barnum statements might – and by their very nature usually do – have prima facie validity, they are practically useless in describing anything distinctive about a particular individual.

Yet, because of their semantic elasticity, people continue uncritically to use and accept them.

Fundamental attribution error

Nearly all significant behaviors can be attributed to multiple determinants (see discussion of multiple causation above) that vary in the degree to which they are responsible for causing a person's actions. However, in arriving at causal attributions, we have a tendency to weigh internal determinants (i.e., personality traits, characteristics, attitudes) too heavily, and external determinants (i.e., one's circumstances, surroundings, environment) too lightly. This attributional bias, termed the fundamental attribution error (FAE), leads us to minimize or ignore the importance of the particular situations in which people find themselves, and therefore to explain the behavior of others as resulting predominately from their personalities (see Heider, 1958; Ross, 1977).

For instance, we may attribute people's behavior to their level of self-esteem while overlooking any number of situational factors that also could account for their behavior. Consider, as an example, a person at a job interview who comes across as timid, insecure, and lacking in confidence. The interviewer, due to the FAE, might therefore explain the interviewee's behavior in terms of "low self-esteem." But, in fact, the circumstance itself may be highly intimidating or even hostile, which could be the primary (but of course not only) cause of the observed behavior. To take another example, a person who generally struggles with feelings of low self-worth might be perceived by others as confident and outgoing – but only while under the influence of alcohol at a lively party. In this instance, observers might be inclined to make a dispositional attribution ("high self-esteem"), essentially disregarding situational factors (i.e., alcohol and social setting) that could be chiefly responsible for producing these observed behaviors. In this way, the FAE can lead to over-attributions to "self-esteem," thereby perpetuating the self-esteem obsession.

Emotional reasoning

We can be prone to rely erroneously on our subjective experiences of emotional comfort or discomfort as a gauge for differentiating what is true from what is false. In other words, we have a tendency to use our feelings – both good and bad – as a basis on which we formulate appraisals of events around us. This process of assuming that what we feel must be true has been termed emotional reasoning (Beck, 1976). But emotions are not intrinsically a valid barometer of veracity: what feels good is not necessarily correct, and what feels bad is not necessarily incorrect. Put another way, feelings aren't facts.

As previously discussed, we know from the research literature (e.g., Baumeister et al., 2003) that "having self-esteem" does not necessarily inherently make people perform better in school or at work, nor end problems associated with violence and aggression, nor ensure that people engage in healthier lifestyle behaviors, and so on. At the same time, the research also demonstrates that high self-esteem is directly linked to happiness. Clearly, then, having self-esteem feels good – even if the evidence shows that it doesn't actually predict very much. How do we reconcile this disjunction between feelings and facts? We might mistakenly believe that because self-esteem feels good then it somehow must produce all kinds of other positive outcomes. Perhaps high self-esteem is such a "feel-good" phenomenon that we are willing to overlook the overwhelming lack of support for its validity.

Even the belief in the very *idea* of "self-esteem" can produce good feelings – which, in turn, might lead us to cling to false assumptions as valid and true. As a construct, in and of itself, "self-esteem" is simple, easy for nearly everyone to understand, and internally based (see fundamental attribution error, above). Thus, it is something that seems manageable and controllable, which holds out the hope (even if false) that we can actually do something constructive with it. These points might shed further light as to why the pervasive quest to boost self-esteem persists in our society.

Confirmation bias

As discussed previously, when attempting to explain phenomena, we are faced with a multitude of obstacles that can impair our ability to reach trustworthy and valid conclusions. One such obstacle involves the biased manner in which we gather information forming the basis of our decisions. Specifically, we tend to selectively seek out information or evidence that is consistent with our prior expectations, thereby confirming our own beliefs; conversely, we are much less likely to seek evidence that will refute them. Our propensity to search for information in this way is called confirmation bias (see Higgins & Bargh, 1987; Jonas, Traut-Mattausch, Frey, & Greenberg, 2008). Confirmation bias can lead us to draw distorted conclusions regarding evidence that runs counter to our views by guiding us to seek out evidence in a self-fulfilling manner (Lilienfeld, et al., 2009).

For instance, in an article on why ineffective psychotherapies appear to work, Lilienfeld et al. (2014) assert that confirmation bias can predispose clinicians to attend to "hits" and forget the "misses," thereby overestimating the extent to which their interventions are associated with ensuing improvement. In this way, confirmation bias can foster a propensity toward *illusory correlation*, which is defined as the perception

of a statistical association in its absence (Chapman & Chapman, 1967). With regard to the persistence of our popular assumptions about self-esteem, part of the reason for our continual disregard of contradictory evidence may be a result of this common cognitive bias. As researchers and clinicians, we may be unknowingly gathering data and thereby eliciting information that affirms our common misconceptions about self-esteem (for many of the reasons described in this section), causing us to cling to the same conclusions that have been refuted by the evidence time and again.

To take a clinical example, suppose a therapist assumes that all of the problems of his or her prospective clients stem primarily from low self-esteem. On this basis, in the course of gathering information in the intake interview, the therapist poses the following questions: "Are you prone to judge yourself too harshly? Is your self-worth what it should be? Would you be better off if you had more self-confidence? Do you ever doubt your value? Do you have any issues around self-esteem?" In addition to their Barnum-like quality (see above), such leading questions are virtually certain to yield a diagnostic impression of "low self-esteem."

Belief perseverance effect

Over the course of a lifetime, we develop a wide range of different beliefs, the content of which ranges from the ordinary to the profound. One of the most significant characteristics of our beliefs is the degree to which we become emotionally attached in them. The more personally invested we are in our beliefs, the more likely we are to cling to them, even in the face of contrary evidence, a bias in thinking that is referred to as the belief perseverance effect (Anderson, 1983; Lord, Ross, & Lepper, 1979).

But what happens when our beliefs are questioned, particularly those beliefs that we have come to hold dear or accept as truths? The more emotionally attached we are to our beliefs, the more we are prone to feel personally criticized – perhaps even threatened – when our beliefs are challenged. As discussed above, in Western, individualistic society, beliefs about the importance of high self-esteem are not only widely accepted, but as research has shown, high self-esteem also feels good. Therefore, it is highly likely that our emotional investment in these beliefs about self-esteem contributes significantly to our tendency to discount, deny, or simply ignore any information that runs counter to them.

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

Despite the striking lack of empirical support that self-esteem plays a significantly direct role in nearly every outcome, the pursuit of self-esteem continues to be a central preoccupation of North American culture. Thousands of books offer strategies to boost self-esteem, childrearing manuals coach parents on how to raise children high in self-esteem, and schools across the United States continue to implement programs aimed at cultivating self-esteem, all in hopes of reducing an array of problematic feelings and behaviors.

One might be inclined to ask, *why not* try to raise self-esteem? If self-esteem essentially involves feeling good about oneself, what's the harm in that? However, we should not assume *a priori* that having self-esteem – or even pursuing self-esteem – is without costs; in fact, as discussed above, it has been shown to be associated with an array of potential negative consequences. To take one example, contrary to the popular belief that people benefit from positive self-statements (such as the self-affirmations found in self-help books), when those with low self-esteem repeat highly positive self-statements, their moods, their feelings, and their self-related thoughts actually can become *worse*, not better (Wood, Anthony, & Foddis, 2006).

While additional research is needed to explore further such liabilities, we have adequate evidence to warrant some serious concerns when it comes to indiscriminately boosting self-esteem. This section utilizes six metathoughts relevant to the clinical application of self-esteem: *reification error*, *naturalistic fallacy*, *conflating dichotomous variables with continuous variables*, *intervention-causation fallacy*, *self-fulfilling prophecy*, and the *insight fallacy*.

Reification error

The reification error involves mistakenly treating an abstract concept as if it were a tangible object. The litany of psychological constructs that are routinely reified is virtually limitless: the mind, the unconscious, personality traits, intelligence, motivation, the self, and so on. In this context, it's easy to forget that self-esteem is not some objective *thing* that an individual actually "has" (although it can be tempting to regard it as such); rather, it is a hypothetical concept that we have created to help us organize and make sense out of people's behavior. Unfortunately, however, many clinicians are prone to reify this construct, for instance, by advising their clients, "Your self-esteem is too low, so you need to get more of it" (as if self-esteem were some kind of commodity that can be purchased at your local automotive supply store).

If people view self-esteem as though it is a thing that objectively exists in the world, they are likely to pursue its literal attainment. But there is no "there" there. Being stuck in a relentless quest of something

that does not tangibly exist can be experienced as failure, which paradoxically could lead to even lower levels of self-esteem. On the other hand, accepting self-esteem for just what it is – a human-made, imperfect construct – is more conducive to an appropriate, manageable understanding of one's self-directed appraisals and feelings. In the final analysis, the construct of self-esteem should be evaluated more in terms of it clinical utility, rather than its actual attainment.

Naturalistic fallacy

As described above, our perceptions and consequent descriptions of the world are inescapably affected by our personal beliefs. Further, we tend to equate our descriptions of what *is* with our prescriptions of what *ought to be*. Specifically, we typically consider what is typical to be normal and therefore good, while what is atypical to be abnormal and therefore bad. In other words, if most people do something, we may be inclined to think that it's acceptable, and if most people don't, we may think it's unacceptable. The converse can also be true, such as idealizing someone simply for being different from the crowd or condemning someone solely for doing as most others do. This error in thinking is called the naturalistic fallacy (see Hume, 1978). As responsible clinicians, educators, and researchers, it is important to be aware of this bias and to avoid presenting our value judgments as objective reflections of truth.

Examining self-esteem through a cross-cultural lens highlights the importance of acknowledging the bidirectional nature of our perceptions and our personal beliefs and biases (see Shiraev & Levy, 2017). As applied here, just because the quest for high self-esteem is common in North American society, it does not inherently make it good or right. From the perspective of European-American culture, the self is defined primarily in terms of its internal attributes, such as personality traits, competence, and abilities. Thus, in this cultural context, self-enhancing perceptions are encouraged, reinforced, and subsequently internalized as an automatic response tendency. Individuals within this type of culture would therefore be highly motivated to confirm the positivity of their internal attributes of the self (Paulhus & Levitt, 1987).

On the other hand, many Asian cultures adhere to a very different model of the self as *interdependent*, in which the self is defined primarily in terms of its relationship to others. Within this collectivistic cultural context, self-esteem as a positive appraisal of the self is often antithetical to the objective of interdependence. Therefore, in Asian interdependent cultures, an expression of the Westernized concept of "high self-esteem" is prone to be perceived as a sign of insecurity, incompetence (Yoshida, Kojo, & Kaku, 1982), and psychological vulnerability (Miller, Wang,

Sandel, & Cho, 2002). Further, self-critical or self-effacing self-perceptions – the very attributes that Western cultures might view as "low self-esteem" – are frequently encouraged, reinforced and eventually internalized as a habitual response tendency (Kitayama, 2006).

As these examples illustrate, the quest to obtain high self-esteem is not intrinsically a universal human motive. Nonetheless, in the United States and other Westernized societies, countless mental health providers, educators, and parents behave as if it is. From a clinical perspective, what might be the consequences of a therapist consistently encouraging a client to strive for higher self-esteem if, in fact, that client does not share the therapist's Westernized belief system? Similarly, how might a therapy intern be affected by a clinical supervisor who regularly instructs him or her to work toward increasing a client's self-esteem (or even his or her own self-esteem), if the intern does not adhere to the same cultural values? In other words, as clinicians, how often are we confusing what *is* with what *should* be? By confusing what is with what should be, clinicians and educators are not only failing to uphold a commitment to cultural awareness and sensitivity, but could also be contributing to or even creating the clinical problems they are seeking to alleviate.

Conflating dichotomous variables with continuous variables

As discussed above, "self-esteem" is a prime example of a continuous variable that is often erroneously viewed as if it were a dichotomous variable. One significant problem with this particular error is that it can lead to psychological distress across a range of clinical presentations.

The dynamic of false dichotomization has been addressed by several theoretical orientations in the field of clinical psychology. Psychoanalytic theory, for example, identifies the ego defense mechanism of *splitting* (i.e., falsely categorizing the world into good versus bad components and treating them in an all-or-none fashion), which can contribute to unstable relationships and intense emotional experiences (Fairbairn, 1952; Klein, 1937). From this perspective, the therapeutic objective would be one of integrating or synthesizing these disparate psychological elements. Alternatively, from a cognitive therapy orientation, a common goal is to help clients modify their dichotomous "black-or-white" thinking into seeing more middle ground or "shades of grey" (see Beck, 1976; Ellis, 1984). By learning to see their situations in less absolute terms, clients can gain a greater sense of flexibility, acceptance, and realistic control over their lives.

Just as there are potential negative effects of binary thinking for an individual with an eating disorder ("fat or "thin"), depression ("success or failure"), or paranoia ("safe or unsafe"), so too can viewing self-esteem through an all-or-none prism have equally undesirable

consequences. For example, if we regard self-esteem as something that one either "has" or "does not have," what might be the effects on a person who is constantly seeking the "attainment" of high self-esteem, but to no avail? That individual is much more likely to perceive himself or herself as ineffective, inadequate, and unsuccessful. In contrast, by learning to view self-esteem in less rigid or absolute ways, the individual is likely to experience a more positive self-appraisal and a decrease in emotional distress.

Intervention-causation fallacy

The intervention-causation fallacy (sometimes termed the *treatment-etiology fallacy*) refers to a common misattribution wherein the cause of an event is erroneously determined simply on the basis of its response to an intervention. In point of fact, however, the resolution of a problem does not necessarily prove its cause.

For example, suppose a psychotherapist implements a treatment intervention designed to boost self-esteem. Let's assume further that the strategy yields favorable outcomes. Can we conclude therefore that low self-esteem must have been the cause of the client's original distress? Not necessarily. There are other plausible explanations for the beneficial results in this scenario. For instance, the intervention may have inadvertently ameliorated other separate but related symptoms, such as dysphoric mood, passivity, apathy, or social isolation. In addition, the results could have been due, at least in part, to the placebo effect.

As such, a positive response to an intervention aimed at boosting self-esteem does not inherently prove the etiology of the individual's problems as being due to low self-esteem. Further, incorrectly concluding that the primary cause must be low self-esteem could potentially undermine the efforts of clinicians to accurately understand and treat an individual's specific needs. As discussed above, having (or even pursuing) high self-esteem is not without risks. Therefore, to draw this fallacious conclusion could lead not only to continuing the relentless – and potentially detrimental – pursuit of self-esteem, but also to the clinician overlooking the real causal factors at play.

Self-fulfilling prophecy

The self-fulfilling prophecy is a phenomenon whereby a perceiver's assumptions about another person lead that person actually to adopt those attributes. In perhaps the most famous study of the self-fulfilling prophecy, the researchers (Rosenthal & Jacobson, 1968) found that by simply informing elementary school teachers that some of their pupils would show dramatic improvement in academic performance during the upcoming school year, the children who had been identified as

"intellectual bloomers" (students who were really chosen at random) did in fact show an improvement in their schoolwork and even their IQ scores. Thus, their teachers had unwittingly helped to create the very behaviors they expected.

While the expectations of the teachers in this study were socially desirable, the self-fulfilling prophecy has been demonstrated with a wide range of both positive and negative perceiver expectancies, including hostility (Snyder & Swann, 1978), extraversion (see Snyder, 1984), gender and racial stereotypes (Ferguson, 2003; Skrypnek & Snyder, 1982; Word, Zanna, & Cooper, 1974), and even stereotypes concerning physical attractiveness (Snyder, Tanke, & Berscheid, 1977).

Applying this principle in a clinical setting, suppose that a therapist expects his or her new client to be fragile, resistant, or manipulative, or to have low self-esteem? In these cases, and countless more, the therapist's prior beliefs may unknowingly produce the very behaviors they expect to find – both for better and for worse. Regardless of our intent, assuming *a priori* that clients suffer from a core problem of low self-esteem can be more pernicious than we might think.

Insight fallacy

One of our most widespread and enduring societal myths, especially in the field of clinical psychology, is that insight alone produces meaningful change. And nowhere is the insight fallacy more apparent than in beliefs about the conduct of psychotherapy. Therapists and clients alike cling to the alluring conviction that understanding a psychological difficulty will somehow inevitably cause the problem to resolve itself. Understanding the "roots" of a problem, however, is not necessarily the key to solving the problem.

This is not to suggest that insight is without value. There are numerous potential benefits to insight in psychotherapy, such as providing a sense of relief or comfort by helping the client to grasp an unexplained phenomenon, serving as a critical initial step toward the client adopting specific problem-solving strategies, and providing clients with the ability to generalize their therapeutic gains to other situations and challenges. These advantages notwithstanding, the problem lies in failing to recognize that insight alone has significant limitations.

As discussed above, low self-esteem is regularly identified as the root cause of a vast array of negative psychological conditions, including narcissism, depression, addictions, eating disorders, abuse (both as perpetrator and victim), dysmorphia, and relationship problems, to list but a few. But what exactly do clinicians actually accomplish by diagnosing low self-esteem as a (or even *the*) root cause of people's problems?

One potential benefit of guiding clients to gain insight about their feelings of low self-worth is helping to pave a pathway toward improved psychological health, based on the correlation between high self-esteem and enhanced mood or happiness. That notwithstanding, however, it is essential to remember that insight alone into one's feelings or perceptions about himself or herself will not necessarily change those feelings or perceptions.

In fact, some critics have argued that emphasizing insight can be detrimental to the therapeutic process in that focusing primarily on cognitive understanding allows both clients and therapists to avoid unpleasant emotions (see A. Freud, 1936; Holland, 2003). In sum, insight might be useful in some ways, but clinicians should recognize its limitations and therefore seek to explore alternative avenues of change, such as emotion-focused therapy (Greenberg, 2016), cognitive behavior therapy (Beck, 2011), or solution-focused therapy (de Shazer & Dolan, 2012).

Summary of Applications and Recommendations

Self-esteem, viewed for decades as psychology's "Holy Grail," has proved to be an elusive and surprisingly porous vessel, rife with a plethora of conceptual and methodological fissures. This section summarizes the application of specific metathoughts to address areas of concern. Researchers, clinicians, educators, and others should be mindful of these errors in critical thinking regarding self-esteem as they attempt to surmount these cognitive errors and improve the quality and effectiveness of their professional work.

Understanding Self-Esteem

Part of the reason for the continued lack of consensus in defining and understanding self-esteem is a deficit in critical thinking. More specifically, we sometimes fail to realize and accept that: (a) the terms "self-esteem," "high self-esteem," and "low self-esteem" are value laden and highly contingent on one's own personal set of attitudes and beliefs (*linguistic bias*); and (b) to simply label someone as having high or low self-esteem does not actually explain his or her behavior (*nominal fallacy and tautologous reasoning*).

The Heterogeneity of Self-Esteem

Research supports the heterogeneity of self-esteem, but insufficient success has been achieved at determining where the distinctions lie. In attempting to delineate these differences, it is important to remember that: (a) various facets of self-esteem should be viewed through multiple sociocultural lenses (*linguistic bias*); (b) self-esteem is often erroneously

regarded as if it fits into dichotomous categories, when it rightfully belongs on a continuum (*conflating dichotomous variables with continuous variables*); and (c) self-esteem, self-concept, self-appraisal, self-efficacy, and narcissism are all both similar to and different from each other, depending on the variables or dimensions that are selected as the basis of comparison (*similarity-uniqueness paradox*).

Problems with the Research on Self-Esteem

Self-esteem research has been hindered by insufficient attention to the following factors: (a) while self-report measures are an efficient and the most commonly used method of measuring self-esteem, they are associated with a host of biasing factors which can compromise the validity of researchers' observations (*reactivity*); (b) cause and effect cannot be proven simply on the basis of a statistically significant correlation (e.g., self-esteem and mood) (*correlation-causation conflation);* (c) "cause" and "effect" are relative terms, with cause in one instance becoming effect in another (e.g., self-esteem and popularity) (*bidirectional causation*); (d) most effects (such as low self-esteem) are likely the result of not just one cause but numerous causes that are interacting together (*multiple causation*).

The Obsession with Self-Esteem

Why does our obsession with self-esteem persist? The answers to this question can be summarized by the following errors in critical thinking: (a) we tend to draw conclusions based on information that is readily available in our memories, thereby erroneously assuming a causal connection between self-esteem and other variables simply by virtue of their mental salience (*availability bias*); (b) we are inclined to force data to fit into our existing schemas about self-esteem, rather than modifying our schemas to account for data about self-esteem (*assimilation bias*); (c) statements about individuals' self-esteem are often so generic and overly inclusive that they are true of practically all human beings, resulting in people continuing to accept them uncritically (*Barnum effect*); (d) we have a tendency to weigh internal determinants (e.g., self-esteem) more heavily than external determinants (e.g., environmental or sociocultural factors) (*the fundamental attribution error*); (e) the fact that self-esteem feels good might lead us to overlook the lack of empirical evidence for its value in shaping behavior and psychological well-being (*emotional reasoning);* (f) we have a propensity to selectively gather information that is consistent with our popular beliefs about self-esteem, while ignoring evidence that refutes them (*confirmation bias*); (g) we tend to be personally invested in our beliefs about self-esteem, which makes us more likely to cling to them (*belief perseverance effect*).

Clinical Implications of Misusing "Self-Esteem"

We should not assume *a priori* that having self-esteem – or even pursuing self-esteem – is without costs. There is adequate evidence that indiscriminately boosting self-esteem is associated with an array of potential negative outcomes. While further research is needed to explore further such liabilities, the following are some of the more important clinical implications: (a) if we continue to treat "self-esteem" as though it were an objective thing rather than a subjective construct, people risk feeling failure when they can't "attain" it (*reification error*); (b) by confusing what is with what should be, clinicians are not only failing to uphold a commitment to cultural awareness and sensitivity, but could also be contributing to the clinical problems they are seeking to alleviate (*naturalistic fallacy*); (c) by learning to view self-esteem in less absolute terms, clients can gain a greater sense of flexibility, acceptance, and realistic control over their lives (*conflating dichotomous variables with continuous variables)*; (d) incorrectly concluding that a positive response to self-esteem boosting interventions proves that the client initially suffered from low self-esteem could lead to overlooking true etiology (*intervention-causation fallacy*); (e) clinicians' assumptions that their clients must be suffering from low self-esteem might inadvertently contribute to the lowering of self-esteem (*the self-fulfilling prophecy*); (f) insight alone into one's feelings about himself or herself will not necessarily change those feelings (*insight fallacy*).

In conclusion, it is hoped that this paper will serve as a starting point for a critical examination of numerous other widely used but problematic terms and concepts in the field, such as mental illness, personality disorders, addiction, transference/countertransference, and mental health.

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