Ontario Centre of Excellence
for Child and Youth
Mental Health

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Evidence In-Sight request summary:

The relationship between self-esteem and mental health outcomes in children and youth

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This report summarizes a Level 1 Evidence In-Sight response. A Level 1 response involves a non-systematic search and summary of the research and grey literature. It is a snapshot and not an exhaustive search or systematic review. The findings are intended to inform the requesting organization, in a timely fashion, and do not imply an extensive knowledge of the current practices of the agency. This report does not include direct recommendations or endorsement of a particular practice or program.

This report was researched and written to address the question: What is the relationship between self-esteem and mental health?

Research is constantly evolving. As the literature changes, so does our idea of what is considered the "best available evidence". Research is a powerful starting point for organizational decision making, but it also has its limitations and should be interpreted carefully. Findings can be affected by methodological issues and efficacy studies might translate differently in each real-world setting. This reinforces the importance of incorporating evaluation into the implementation and delivery of evidence-informed practices and programs. This report contains the findings of a rapid scan of the research literature, but evidence-informed decision making should also draw upon agency expertise, program evaluation and client perspectives to ensure the best possible outcomes.

Thank you for contacting Evidence In-Sight for consultation on your question. Please do not hesitate to follow up or contact us at evidenceinsight@cheo.on.ca or by phone at 613-737-2297.

1. Overview of inquiry

This report was provided for a small community based agency that is evaluating an eight-week, gender-specific group program for children and youth ages 10-16. Participants in the groups come from a variety of backgrounds and present with a range of behaviours. Some have a history of aggression, have witnessed violence, have experienced bullying, and/or have problems communicating. The purpose of the groups is to decrease anger and bullying behaviours and to increase self-esteem. The program is delivered in nine different schools, is well-received by the schools and participants, and is in high demand.

To measure changes in self-esteem, participants complete the Rosenberg Self Esteem inventory pre- and post-completion of the program. Aggregate data indicate that the short-term goals of the program are being met and participants in the groups (male and female) make positive gains in their self-esteem. The agency would like to know that the program is making a long-term difference in the lives of the children who attend the group by ultimately improving mental health outcomes. While they can see that self-esteem increases in participants, the agency wants to know if the literature demonstrates a clear connection between improving self-esteem and mental health outcomes.

2. Summary of findings

- Prospective studies have demonstrated low self-esteem is a risk factor for developing mental health problems and positive self-esteem is a protective factor against developing mental health problems.
- Positive self-esteem is associated with mental well-being, happiness, adjustment, success, academic achievements, and satisfaction. Low self-esteem can contribute to negative outcomes such as depression, anxiety, eating disorders, poor social functioning, school drop-out, and high risk behaviour.
- Cognitive and psychoanalytic theories suggest that early life experiences create beliefs about the self (i.e., self-esteem) that serve as vulnerability factors that interact with subsequent negative life experiences to initiate and maintain depression.
- Whether low self-esteem leads to depression, or depression contributes to the development of low self-esteem, is a question of debate in the literature. Due to the nature of the data, conclusions cannot be made about causality. Studies that cite an association between self-esteem and psychopathology are correlational, and thus it is possible that there are other factors that explain this association.
- Improving self-esteem might reduce the risk of depression regardless of whether or not the individual is experiencing stressful life events.
- Given the relationship between self-esteem and depression, the inclusion of a validated, standardized measure such as the Children's Depression Inventory (CDI) would help measure the effectiveness programs already being delivered by the requesting agency.

3. Answer search strategy

- Databases searched: EBSCO Host (Medline, PsycINFO, CINAHL, Health Business Elite, Nursing & Allied Health Connection: Comprehensive, Psychology and Behavioral Sciences Collection, Biomedical Reference Collection, Comprehensive), Google Scholar, The Cochrane Library, and the Campbell Library
- Search terms used: self-esteem, mental health, psychopathology
- Expert contacted: Dr. Ian Manion, Ontario Centre of Excellence for Child and Youth Mental Health

4. Findings

Self-esteem and mental health

Self-esteem can serve as both a protective factor and as a risk factor in the development of mental health problems. Positive self-esteem can be a protective factor that contributes to positive social behaviour and act as a buffer against the impact of negative influences (Mann et al., 2004). It is associated with mental well-being, adjustment, happiness, productivity, coping, success, and satisfaction (Baumeister, Campbell, & Krueger, 2003). By example, high self-esteem may protect against depressive symptoms by decreasing the impact of negative thoughts (Orth, Robins, & Meier, 2009). Alternatively, negative self-esteem can play a critical role in the development of a number of mental disorders and social problems, including depression, anxiety, anorexia nervosa, bulimia, violence, substance abuse, high-risk behaviours, and borderline personality disorder, in addition to feelings of hopelessness, suicidal tendencies, and attempted suicide (DeHart, Pelham, & Tennen, 2006; Mann et al., 2004).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) lists negative or unstable self-perceptions as a key component in the diagnostic criteria of major depressive disorder, manic or hypomanic episodes, dysthymic disorders, dissociative disorders, anorexia nervosa, bulimia nervosa, and in personality disorders such as borderline, narcissistic and avoidant behaviour. Theories of depression suggest that low self-esteem is a defining feature of the disorder, but the temporal nature of this relationship remains unclear. Whether low self-esteem leads to depression or depression contributes to the development of low self-esteem is a question of debate in the literature (Orth, Robins, & Roberts, 2008).

Self-esteem has been researched most extensively in relation to depression. Feelings of worthlessness are included in the diagnostic criterion for depression, and low self-esteem may be an early symptom of depression (Roberts & Gamble, 2001). Individuals who are at risk of developing depression sometimes acquire negative cognitive styles that include low self-esteem and irrational beliefs as a result of negative experiences (Beck et al., 1979). Negative cognitive styles may express themselves during adolescence at the experience of a negative life event (Hammen, 1992). It is possible that self-esteem interacts with other risk factors, such as negative life events, in the prediction of depression (Roberts, 2006).

On the other hand, it has also been found that stressful life events contribute to depression regardless of whether an individual has high or low self-esteem (Orth et al., 2009). Three longitudinal studies were conducted to elucidate the relationship between self-esteem, negative life events, and depression. An adolescent and young-adult population was assessed at multiple time-points. It was found that low self-esteem was a risk factor for depression, regardless of negative life events, and stressful events are a risk factor for depression, regardless of their level of self-esteem. The authors concluded that low self-esteem and stressful events are independent risk factors for depression. They suggest that improving self-esteem reduces the risk of depression regardless of whether the individual is experiencing stressful life events. Ultimately, prevention of stressful life events and increasing one’s coping resources will reduce the risk of depression amongst those with low and high self-esteem.

A longitudinal study found that low self-esteem measured at age 15 was significantly associated with higher rates of depression, anxiety, conduct/anti-social personality disorder, and suicidal ideation at ages 18, 21, and 25 (Boden, Fergusson, Horwood, 2008). This relationship weakened to non-significance after adjusting for confounding factors, such as age of the mother, childhood sexual and physical abuse, gender, family changes, and other factors. The only

exception was with suicidal ideation. These results suggest that with the exception of suicidal ideation, associations between self-esteem at age 15 and mental health problems are non-causal and reflect the influence of other factors associated with self-esteem. The authors of this study conclude that the effects of self-esteem on mental health can be attributed to the "psychosocial context within which self-esteem develops". Self-esteem may be more of a "risk marker" than the cause of psychopathology. This idea is supported by one study found that individuals who scored high in negative evaluation of the self experienced later onset of depression, after the occurrence of a provoking event (Brown, Bifulco, Harris, & Bridge, 1986).

The vulnerability and scar models

Two models have been proposed that examine the relationship between self-esteem and mental health. The vulnerability model theorizes that low self-esteem increases the probability of psychopathology, while the scar model theorizes that low self-esteem is a consequence of psychopathology rather than the cause (Ziegler-Hill, 2011; Orth et al., 2008).

The vulnerability model theorizes that low self-esteem contributes to both the development and maintenance of depression (Orth et al., 2008). One of the core tenets of this model is that low self-esteem increases the probability of poor adjustment in the wake of stressful or negative experiences (Ziegler-Hill, 2011). This is said to occur because those with low self-esteem have fewer coping resources than those with high self-esteem. Also, those with low self-esteem are more likely to ruminate, and rumination is a key feature of depression. Individuals with low self-esteem seek reassurance of personal worth externally (i.e., friends and partners) and this increases their risk of rejection and depression (Joiner, 2000). The vulnerability model suggests that low self-esteem and stress interact to produce psychopathology, and while high self-esteem buffers against the effects of stress, low self-esteem increases one's vulnerability to the effects of stress (Orth, Robins, & Meier, 2009). The results of studies testing the vulnerability hypothesis are inconsistent, but the majority of studies have found that individuals with low self-esteem reported higher levels of psychopathology and distress than those with high self-esteem (Ziegler-Hill, 2011).

According to the scar model, psychological disorders lead to a deficit in mental resources and leave "scars" that impact how people feel about themselves. Psychopathology may impact self-esteem in that a depressive episode may wound important relationships or social support networks (Orth et al., 2008). The scar model theorizes that self-esteem is permanently changed by the experience of depression, particularly in the wake of a major depressive episode. Compared to the vulnerability model, the scar model has received less attention in the literature.

The vulnerability and scar models might operate together. For example, low self-esteem may contribute to psychopathology at the same time that psychopathology erodes self-esteem (Harter, 1999). Another theory is that self-esteem and depression are one construct that operate along a continuum (Watson, Suls, & Haig, 2002). Proponents of this theory argue that low self-esteem and depression derive from negative emotionality, and therefore the question of the temporal nature of this relationship is not relevant (Orth et al., 2008).

Two large (n = 2,403) longitudinal studies were conducted to test the vulnerability and the scar models (Orth et al., 2008). The mean ages of the groups was 15.5 years and had even gender representation. Four repeated assessments were conducted between the ages of 15 and 21. In support of the vulnerability model, both studies found that low self-

esteem predicted subsequent levels of depression, even when controlling for prior levels of depression. Depression did not predict subsequent levels of self-esteem while controlling for prior levels of depression. It should be noted that this study did not control for the effects of a potential third variable (such as the involvement in a supportive relationship), and therefore causal conclusions cannot be drawn.

Based on the literature, self-esteem appears to be linked with psychopathology. High self-esteem is likely a protective factor or a buffer against the effects of negative experiences, while those with low self-esteem likely experience a range of forms of psychopathology due to a lack of coping resources. One consideration is that low self-esteem could result from psychopathology, or both self-esteem and psychopathology might result from a third factor such as a difficult childhood experience (Ziegler-Hill, 2011). Due to the nature of the data, conclusions cannot be made about causality. Studies that cite an association between self-esteem and psychopathology are correlational, and thus it is possible that there are other factors that explain this association (Ziegler-Hill, 2011). Additionally, studies examining the relationship of self-esteem and mental health typically rely on self-report measures in a non-clinical population and may not be reflective of a clinical population. Due to inconsistent results across studies and the limitations described, the theoretical controversy of the nature of the relationship between self-esteem and psychopathology has not yet been resolved (Baumeister et al., 2003).

5. Next steps and other resources

Given the relationship between self-esteem and depression, the inclusion of a validated, standardized measure such as the Children's Depression Inventory (CDI) would help measure the effectiveness of the program. The CDI is a 27-item self-report scale suitable for youth aged 7 to 17. The scale is sensitive to changes in depression over time, and gives an index of the severity of depression. The scale produces a total score, in addition to the following subscales: Negative Mood, Interpersonal Problems, Ineffectiveness, Anhedonia, and Negative Self-Esteem (Kovacs, 1985). Measures can be accessed at http://www.excellenceforchildandyouth.ca/resource-hub/measures-database.

Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive "drivers" related to staff competency, organizational leadership, and organizational capacity. Choosing a practice is an initial step toward implementation, but the implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful, and that clinical staff members are successful in their work.

For assistance in planning, doing and using program evaluation to strengthen services, the Centre of Excellence has free consultation services. Contact the **evaluation support service**:
http://www.excellenceforchildandyouth.ca/support-tools/evaluation

For assistance in planning to implement a community assessment, contact our **implementation support** team:
http://www.excellenceforchildandyouth.ca/support-tools/implementation

For information on **youth and family engagement** (evidence-informed practices that should be integrated into all services), including training opportunities:
http://www.excellenceforchildandyouth.ca/training/youth-engagement

For general mental health information, including links to resources for families:
http://www.ementalhealth.ca

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