Self-Esteem in Children: Considerations for Measurement and Intervention

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A differentiated model of self-esteem, based on William James’s (1890), C. H. Cooley’s (1902/1968), and G. H. Mead’s (1925/1968) works and developed by Dr. Susan Harter (1983), is presented as a valuable tool for the occupational therapist to use in evaluation and intervention. Competence and social support are considered important components, and discounting is presented as a mechanism for the maintenance or improvement of self-esteem. Social comparison, social desirability, and defensiveness are discussed as important considerations, particularly regarding children with disabilities.

Self-Esteem and Self-Concept

To understand self-esteem, one must also examine a related construct, self-concept. For many, self-esteem and self-concept are synonymous. Self-concept for these people, among them Combs (1981), involves not only the thoughts that people have about themselves but the affect (i.e., values) that accompany those thoughts. Such reasoning often leads to the view that self-esteem is simply a total of all the parts of the self-concept, with all the parts being equally weighted. This is the measurement approach that has been used by Coopersmith (1967) and by Piers and Harris (1969).

Such a unitary approach has been used in most of the self-esteem studies reported in the literature involving children with disabilities. Most of these studies have been directed toward the discovery of differences between groups (e.g., disabled versus nondisabled) or the determination as to whether a particular manipulation affects self-esteem (Barrett, 1986; Battle & Blowers, 1982; Bohmstedt & Felson, 1983; Harvey...
& Greenway, 1982; VanPutte, 1979). Although the resulting information may be valuable in the demonstration that there are indeed differences between groups, it provides almost no guidance for the therapist seeking to understand the construct or determine the most effective or efficient means of direct intervention.

Specifically, the unitary approach presents two major problems for the therapist who wants to use the information for intervention. First, if all self-concept elements contribute equally to self-esteem, then the therapist could increase positive self-esteem by improving any one or more of the elements, thereby raising the total self-esteem. Common observation indicates that this is not the case. Most people could attest that increasing their evaluation of themselves in one element or domain has not necessarily resulted in enhanced self-esteem; neither has a reduced evaluation in some domain necessarily led to diminished self-esteem. Second, under the unitary approach, the amount of change in self-esteem would be directly related to the amount of change in the self-concept elements; the therapist would have to make relatively large changes in a few elements or small changes in many elements to effect changes in self-worth. Most people could report, however, that there have been instances when relatively small changes in abilities or relationships seem to result in large changes in self-esteem. Conversely, most people can cite personal examples in which relatively large changes in abilities or relationships resulted in very little change in how they felt about themselves.

An alternate approach is to view self-concept as all the ideas we have about ourselves and to view self-esteem as the affective component of those ideas. In this differentiated way of thinking, not all parts of the self-concept need to feed into one's self-esteem, and those components of self-concept that do contribute to self-esteem do not have to contribute equally. Thus, the investigator can examine the various self-concept components, the relationship between the components, and the relationship of the components to self-esteem. Such an approach has been suggested by Burns (1979), Epstein (1983), Fitts (1981), Gergen (1971), Gordon and Gergen (1968), Harter (1983), Jordan and Merrifield (1981), L'Ecuyer (1981), Macoby (1980), Shavelson and Bolus (1982), and Wells and Marwell (1976).

Harter (1982, 1983, 1985c) proposed a differentiated model that may prove to be useful in occupational therapy. Like Rosenberg (1979), Harter suggested that people have a general sense of self that is not a simple summation of self-concept elements but, rather, is a result of the assessment of the elements of one's self-concept in relation to the importance of those elements. The important elements contribute much to self-esteem; the unimportant ones do not. This differentiated view of self-esteem allows one to examine not only the effects of intervention, but also the relationship of various self-concept elements to each other and to self-esteem. Harter, therefore, designed an instrument that taps a number of different domains and provides a rating of the importance of each of those domains as well as an estimation of the child's satisfaction with the self in general. The basic instrument, called the Self-Perception Profile for Children (Harter, 1979, 1985b), taps the domains of Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, and Behavioral Conduct. Each domain has six items, with an additional six items being devoted to the assessment of General Self-Worth. These domains tap categories that are similar to those Coopersmith (1967) listed as being essential contributors to self-esteem (power, significance, virtue, and competence). Harter (1979, 1985a, 1985c, 1987) has demonstrated that children over the age of 8 years can differentially assess their abilities in the various domains, assign different importance ratings to particular domains, and have general self-worth ratings that are different from the unweighted mean of the six domain scores.

Competence and Social Support as Components of Self-Esteem

If self-esteem is a general evaluation of self-worth on the basis of those parts of self-concept that we perceive to be important to us, then a second step in the understanding of self-esteem would be to determine what those component parts might be. The literature reveals two general divisions: (a) competencies that we recognize in ourselves and (b) perceived social acceptance by people who are important to us. James (1890) emphasized competence and adequacy by stating that our self-esteem is determined by the ratio of our "successes" to our "pretensions" (p. 310). He believed that people set standards for themselves and feel good about themselves if they meet or exceed those standards. If they fall short, they will have negative self-feelings.

Cooley (1902/1968) and Mead (1925/1968) viewed self-esteem primarily as a social construct. They claimed that through the process of internalization or reflection, people use others' actions to assess their own worth as human beings. Thus, a person's perception of how he or she is viewed by others largely determines his or her self-view.

James's (1890) formulation that self-esteem equals one's successes divided by one's pretensions has been supported by others. In a study in which I used information from 655 children in grades three through seven (Mayberry, 1985), success was opera-
tionalized by the competence/adequacy ratings in five domains (Academic, Social Acceptance, Athletics, Appearance, and Behavioral Conduct), and pretension was operationalized by the importance ratings related to each domain. One analysis in my 1985 study complied closely with James’s formulation through the division of the competence ratings by the importance ratings; a second analysis in the same study subtracted importance from competency, thus assuming that people commonly set an objective and then assess how close they come to attaining that objective. The results of both analyses were almost identical. The discrepancy scores (competence/adequacy scores minus importance ratings) were better predictors of self-esteem ratings than were competence scores alone (Harter, 1987; Mayberry, 1985).

The idea that both competency and social support contribute to general self-worth ratings has also been supported. Harter (1987) studied children in elementary school and middle school and found that competence (as operationalized by the difference discrepancy score) and social support were additive in their effects on general self-worth, but that there were no interaction effects. The children with the highest self-worth scores were those who had both high social support scores and low discrepancy scores. Conversely, the children with the lowest self-worth scores were those with low perceived social support and high discrepancy scores. Between these two extremes were the children who showed relatively low self-worth ratings if either their discrepancy scores were high or their perceived social support was low. Thus, both competence and social support appeared to contribute to self-esteem, with neither being able to fully compensate for deficiencies in the other.

The implication of the above findings for occupational therapy is that the therapist must examine both the evidence of a patient’s perceived competencies and the social support that the person feels he or she has. Only when both components are considered can the therapist make an adequate assessment.

Mechanisms for Assessing and Maintaining Self-Esteem

To understand self-esteem, one must understand mechanisms for its formation and modification. According to James’s (1890) ratio of successes to pretensions as a determinant of self-esteem, one can change self-esteem by either changing one’s successes (i.e., becoming better in a domain that is important) or changing one’s pretensions (i.e., lowering one’s expectations). Changing one’s successes may often involve long-term effort and may, in fact, be impossible; some things are beyond a person’s ability to change. An examination of the feasibility of changing one’s pretensions, therefore, is important.

Discounting (Bem, 1972; Goethals & Darly, 1977) is a mechanism by which expectations might be changed (the second aspect of James’s formula). When people discover that they are not good in some domain, they may choose to subsequently discount the importance of that domain and thereby balance the equation in order to maintain adequate self-esteem. A child who discovers that he or she is not good at sports, for example, may consequently decide that sports are not important and may therefore feel fine despite his or her lack of ability.

Evidence for discounting was first revealed when it was noted that children with high self-esteem tended to have importance ratings that were similar to their corresponding competence/adequacy ratings, whereas children with lower self-esteem tended to have importance ratings that were much higher than their corresponding competence/adequacy scores (Harter, 1985c). Such findings could be explained by discounting but could also be interpreted in other ways (e.g., by situational inference or simple coincidence). Vignettes were developed, therefore, to tap discounting more directly. In each vignette (one for each domain), a hypothetical child of the same sex discovers that she or he is not doing well even though the domain has been important. In a pilot edition of the instrument, the subject was asked to decide what the hypothetical child would do. One of the choices was a discounting alternative. This edition was administered to 60 sixth graders (Harter, 1985a), 20 of whom were identified as having high self-esteem ratings, 20 with medium levels, and 20 with low self-esteem ratings. In the domain in which they had their lowest competence/adequacy, 80% of children in the high self-esteem group chose discounting alternatives, compared with 55% of the middle self-esteem group and 30% of the low self-esteem group [$X^2 (2, n = 60) = 12.4, p < .005]$.

The instrument was revised so that the subject could rate the importance of the domain as the hypothetical child would, that is, hardly important at all (1), not very important (2), pretty important (3), or still very important (4). The vignettes were given to 113 sixth, seventh, and eighth graders (Mayberry, 1985). The findings initially seemed to indicate that the children with low self-esteem actually discounted more than the children with medium or high self-esteem ($m = 2.43$, $2.72$, and $2.81$, respectively, with the lowest score indicating the most discounting). All domains were averaged in that analysis.

With the assumption that people discount primarily in those domains in which they are experiencing trouble, another analysis was undertaken in which the sample was matched by both domain and lowest competence score. The results upheld the hypothesis. Although the matching resulted in a small sample

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(n = 30), the trend in the mean discounting scores was 2.5 for the children with high self-esteem, 2.8 for the middle self-esteem group, and 2.9 for the low self-esteem group (lower scores represent greater tendency to discount). Even when the next-to-lowest competence score was examined, the trend was similar (high m = 2.83, medium m = 3.08, low m = 3.17).

When regression lines were computed for each self-esteem group, the low self-esteem group tended to discount evenly across all competence levels (slope = .025 from highest to lowest competence), whereas the middle and high self-esteem groups discounted more in low competence domains (slopes = -.053 and -.127, respectively). The above convergent evidence was interpreted as supporting the notion that children can and do use discounting to maintain their self-esteem. Occupational therapists might use this information to help children with disabilities alter their ideas of what is important in their lives and thereby improve or maintain their self-esteem.

**Social Comparison and Self-Esteem**

An important part of maintaining self-esteem is social comparison. The literature reveals that people use others both for determining how well they have done (Festinger, 1954) and for learning what they should do (Ruble, 1985). The ability to use other people as points of reference develops rather gradually, but once it becomes fully operational, which occurs usually between the second and fourth grades (Ruble, 1983; Ruble & Rholes, 1981), it can have a profound effect on one's view of self. Studies have shown that children rate how well they have done depending on the comparison groups used (Renick, 1985; Rogers, Smith, & Coleman, 1978; Rosenberg, 1979; Silon & Harter, 1985). For example, Renick (1985) found that when data were gathered in the regular classroom setting, children with learning disabilities tended to have low levels of self-esteem. When these children were asked to think in terms of their fellow students with learning disabilities (in the resource room), however, their self-worth ratings improved. Perhaps therapists should control the comparison groups that children use or at least be aware of them as an important component in the determination and maintenance of self-esteem.

**Social Desirability and Defensiveness**

The influences of social desirability and defensiveness on children's self-esteem ratings can also be considered in the maintenance of self-esteem. Social desirability involves the tendency to respond as one should, regardless of what one actually thinks or feels. To combat children's natural tendency to provide socially desirable responses when provided with yes or no alternatives in self-report instruments (Burns, 1979; Rosenberg, 1979; Wylie, 1979), Harter (1979, 1985b) developed the format for her Self-Perception Profile for Children and Social Support Scale for Children to give children permission to choose the half of a two-part item that was most like them and then to rate whether the chosen half was just "sort of true" for them or "really true" for them. For example, a general self-worth item says, "Some kids like the kind of person they are BUT other kids often wish they were someone else." The competence/adequacy scales, social support scales, and importance rating forms all followed the same format, allowing a score from 1 to 4 for each item.

Researchers have noted that the tendency to give socially desirable answers is strong, particularly in younger children (Burns, 1979; Crandall, Crandall, & Katkovsky, 1965). The children in studies cited previously in this paper were well aware of the socially desirable alternative on any item. In fact, a few children in these studies marked only those alternatives that were considered most socially desirable. So far, such children have been ones who had previously been identified as emotionally disturbed and who were not part of the regular classroom groups. They have helped to confirm, however, that children tend to know the socially desirable selections, but most children feel free to choose other alternatives.

Because self-esteem is something that is defended at almost any cost, one might expect defensive behavior in threatening situations. In a small pilot study of 18 children with disabilities (Mayberry, 1986), I noted during follow-up interviews that some of the children seemed unrealistic in their self-ratings in one or two domains. An instrument was designed to give the children permission to be realistic. Two drawings were prepared for each domain, one showing a same-sex child wishing that she or he was very good, and one showing the child knowing that she or he was not very good. The plates were shown to the child and explained. The child then completed a real-ideal evaluation in which a statement relating to each of the five domains of the Self-Perception Profile for Children was first marked according to how the child believed she or he really was. As a last step, the child filled out the original Self-Perception Profile for Children, with an initial instruction to mark each item as she or he really was, not how she or he wished to be. Although not statistically manipulated, the data seemed to support more outwardly realistic ratings by the children on the second administration of the profile. The results supported the idea that although children generally seem to give honest responses on a self-report instrument that allows a...
spread of ratings, some children, particularly those with problems, may be defensive in some of their ratings. Therapists and investigators should be aware of this tendency.

Future research should examine which domains, if any, might be particularly valuable for the therapist working with persons with disabilities. Additional insight concerning how self-esteem does or does not change over time might also be valuable. The comparative presence of discounting and defensive responses between children with and without physical disabilities might be valuable as well.

Summary and Conclusion

Self-esteem, or general self-worth, appears to be an important construct and one that occupational therapists use frequently in their practice. Self-esteem may be more than the sum of all aspects of a person's self-concept; it may be the way one feels about the self-concept domains that are important to him or her, including the domains of competence and social support. Self-esteem may be determined by a person's evaluation against his or her own standards and may be strongly influenced by comparisons to other people and by honest self-expression. Discounting is a mechanism that may be used to ensure that patients have an adequate level of self-esteem.

Occupational therapists should try to determine what domains are important for any given child (e.g., schoolwork, getting along with adults) and how well that child is doing in them. For important domains that are problematic and not susceptible to appreciable change, the therapist may assist the child in altering his or her view of their importance so that disappointments do not have as great an effect and energies can be directed toward positive experiences. The therapist can also help the child by ensuring that an adequate system of social support is available and that, when social comparison is necessary or unavoidable, comparison sources that allow the child to make favorable judgments are available.

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References


