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Self-Esteem and Health

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Abstract

Self-esteem is a central aspect of the self concept that develops during childhood and adolescence. Yet most people do not know that self-esteem also shapes people's health by influencing psychological, physical, and social well-being. The authors detail two dominant models that have emerged to explain these connections. First, the resource model proposes that self-esteem and health are linked because higher self-esteem is a psychological resource on which people can rely in times of adversity. Second, the self-and-social-bonds model of health posits that self-esteem predicts health outcomes because it regulates responses to the threat of rejection in a manner than can benefit, or undermine, health. The authors conclude by discussing the implications of these models for designing and implementing health interventions.

Keywords: self-esteem, health, well-being, resilience, belongingness, self, identity

Self-esteem has been the subject of intense empirical and theoretical study by psychological scientists for over fifty years, and in the latter decades of the 20th century this psychological phenomenon also succeeded in capturing the imagination of popular culture. The notion that one's feelings of worth as a person matter and have important consequences for emotion, cognition, behavior, and experiences resonated with the general public. People embraced insights from psychological science concerning the origins and nature of self-esteem, and individuals and governmental organizations alike sought methods for improving self-esteem and reaping the many benefits associated with positive self-regard, including career and academic success, and increased life satisfaction. As a result of this academic and public attention, if a student of psychology tells her friends or family that she is studying self-esteem, her disclosure will often be met with a nod of understanding or a personal anecdote concerning the listener's own experiences.

Yet despite the widespread popularity of self-esteem and the general acknowledgement of its importance, most students of psychology and the general public remain unaware that self-esteem also plays an important role in shaping people's health. Many people who hear of this connection may wonder, "How can *feelings* influence something tangible and *physical* like health?" This question arises from the lingering assumption that the mind and body are distinct entities, an assumption that arose during the dawn of modern Western medicine and continues to dominate Western conceptions of health. But this assumption is erroneous. In fact, the mind and the body are intimately connected, and this connection is abundantly evident in the pervasive links between self-esteem and the various dimensions of well-being that characterize human health.

What is self-esteem?

Before it is possible to understand how and why self-esteem predicts such a seemingly unrelated experience as health, it is essential to first understand how this psychological characteristic develops and how it relates to other aspects of *the self*: the collection of traits, qualities, schema, roles, beliefs, and attitudes that form the core of one's identity.

The self resides at the very center of one's psychological universe, allowing people to make sense of their past experiences, guide their present behavior, and predict their future experiences. Indeed, when the philosopher René Descartes famously opined, "I think, therefore I am," he was relying on his sense of self to prove his very existence.

As one might expect, a psychological system so important takes time to develop. The first sense of self that coheres during infancy is the sense of being an entity distinct from others, who persists over time and across places. Around the age of three, as children mature and interact with their social and physical worlds, they gradually develop beliefs about their specific traits and abilities ("I am athletic"), learn the social roles that they are expected to fulfil ("I am a girl"), and develop theories, or scripts, to explain and predict their actions ("If I ask Marjan to play with me, she will say yes"). As children approach puberty, they begin to evaluate their worth and value, and it is this global evaluative component of the self that psychologists call *self-esteem.*

Self-esteem develops in part through a reflected appraisal process, whereby children observe how other people treat them, and from that treatment, infer their worth. Being treated with responsive kindness, warmth, and positivity by social partners, especially family, communicates that the self is worthy and valuable. In contrast, being ignored, invalidated, overlooked, or abused by unresponsive or unavailable social partners, especially family, communicates that the self is not worthy of care or deserving of loving kindness. Over time and through repeated exposure, children internalize these social messages, and thus self-esteem is

born.

Of course, people are not passive *tabula rasa* onto which their social experiences write. Babies are born with a genetic heritage that shapes the ways in which they interact with the world, and these same forces influence the development of self-esteem. Of particular relevance to the discussion at hand, some people are temperamentally inclined to focus their attention and energy towards seeking rewarding experiences and to experience high levels of positive affect, whereas others are temperamentally inclined to focus their attention and energy towards avoiding punishing experiences, and to experience high levels of negative affect. In turn, these higher-order temperamental factors are also related to self-esteem. Reward-focused people who are relatively insensitive to stressors and recover quickly from negative moods will tend to develop higher self-esteem. In contrast, people who are temperamentally attuned to punishments like criticism, who react strongly to stress and take a long time to recover, and who experience frequent negative moods tend to develop lower self-esteem.

This association between temperament and self-esteem probably exists because temperament influences the ways in which people experience the world, which in turn informs self-evaluations. For example, if someone is very sensitive to rewards, she will be more likely to notice and internalize praise, and thus develop higher-self-esteem. Conversely, if someone is very sensitive to criticism, he will feel the sting of social rebuff more deeply, and thus will be more likely to develop lower self-esteem. Thus, temperament is a lens through which self-esteem-relevant experiences and messages must first pass before they are internalized, resulting in self-esteem that is highly subjective in nature. Two people with different temperaments can have the same experiences, and from those experiences infer different conclusions about their social worth, and thus develop different levels of self-esteem. As this example illustrates, self-

esteem develops from a true symbiotic interaction between nature and nurture.

Once self-esteem crystallizes around the age of 12, it remains remarkably stable across the lifespan. Perhaps due to its high degree of stability, people often rely on their self-esteem to regulate their interactions with their material and social worlds. The lens of self-esteem helps people to make sense of their past experiences, to determine a present course of action, and to predict future outcomes. In each of these domains, lower self-esteem individuals tend to adopt a more pessimistic and cautious outlook than higher self-esteem individuals, who can be quite optimistic and blithe in many circumstances. For example, a lower self-esteem person may attribute past failures to personal shortcomings, and thus avoid situations that call on the skills he believes he does not possess because he anticipates failure. In contrast, a higher self-esteem person is more likely to dismiss past failures as resulting from external factors, and thus pursue opportunities that offer rewards he feels equipped to effectively claim. These differing orientations are evident in school and workplace settings and in social contexts ranging from interactions with strangers to interactions with lovers, and they result in differing outcomes for people with lower and higher self-esteem. In many life domains, higher self-esteem individuals tend to experience more positive outcomes than their lower self-esteem counterparts, and this difference extends to the domain of health.

How is self-esteem related to health?

Following the World Health Organization, we consider health to be a multi-faceted construct comprising psychological, physical, and social well-being. Self-esteem predicts outcomes in each of these varied domains.

Psychological well-being. Self-esteem is negatively associated with a range of mental health concerns, including depression, anxiety, stress, disordered eating, negative body image,

and suicidal ideation. Although it is difficult to determine whether self-esteem is a cause or consequence of these mental health conditions, longitudinal studies that control for third variables and rule out reverse causation can help to tease apart these possibilities. For example, one such study observed that adolescents with low self-esteem and individuals whose self-esteem declined during adolescence were more likely to experience depression fully two decades later (Steiger, Allemand, Robins, & Fend, 2014). Another study that examined self-esteem and mental health outcomes at multiple points in time found that lower self-esteem predicts depression, which, in turn, predicts heightened rates of stressful life events (Orth, Robins, & Meier, 2009). The consensus among psychological scientists is that lower self-esteem is an independent risk factor for the development of numerous mental health conditions.

Physical well-being. Self-esteem is also related to a broad range of physical health conditions. For example, lower self-esteem university students report that they experience worse physical health, visit the doctor more often, and miss more days of school due to illness than their higher self-esteem counterparts (Stinson et al., 2008). Moreover, self-esteem is positively associated with people's ability to recover from physical illness and cope with chronic health conditions, including heart disease, HIV/AIDS, cystic fibrosis, and autoimmune disorders. For example, compared to higher self-esteem individuals, lower self-esteem individuals with asthma or rheumatoid arthritis experience more negative affect, less positive affect, greater stress and symptom severity, and more symptom interference and activity restrictions in daily life (Juth, Smyth, & Santuzzi, 2008). Lower self-esteem is also a risk factor for mortality among the elderly. These and other links between self-esteem and physical health offer a stark reminder of the extensive mind-body connections that characterize the human experience.

Social well-being. Self-esteem is also strongly tied to social well-being. Lower self-

esteem individuals report that they receive less social support, experience more interpersonal stress, and suffer from loneliness and social isolation to a greater extent than their higher self-esteem counterparts. Such perceptions may accurately reflect important developmental experiences of acceptance and rejection from family and peers. But with the changing social context of adulthood, appraisals of social well-being can diverge from objective reality. Lower self-esteem individuals often underestimate their social partners' actual regard, whereas higher self-esteem individuals' perceptions are often more accurate, or perhaps even overly optimistic. Such individual differences are thought to be motivated by concerns about rejection. Lower self-esteem people are extremely risk-averse and would rather err on the side of caution and overlook some acceptance cues than risk rejection by perceiving acceptance that is not actually present. In contrast, higher self-esteem people are blithe in the face of rejection, and will boldly perceive acceptance from even the most neutral social companions. These differing social orientations can have self-fulfilling consequences. Lower self-esteem individuals' social insecurities and resultant cool, inhibited social behavior can be off-putting to social partners, whereas higher self-esteem individuals' confident and warm social behavior is attractive to others. Thus, self-esteem and social well-being are linked throughout the lifespan by a recursive process whereby early social experiences help to forge self-esteem, which later guides social experiences that further reinforce self-esteem.

Why is self-esteem related to health?

Two dominant models have emerged to explain why self-esteem and health are so intricately woven together.

A resource model of self-esteem and health. Self-esteem and health may be linked because higher self-esteem is a psychological resource on which people can rely in times of

adversity. In this model, the same temperamental factors and developmental experiences that give rise to higher or lower self-esteem also give rise to characteristic psychological orientations that benefit, or undermine, health. Specifically, the affective, cognitive, and motivational styles that characterize higher self-esteem may allow such individuals to cope with and recover from stressors more effortlessly and quickly than their lower self-esteem counterparts. For example, higher self-esteem individuals effectively employ strategies to improve negative moods and prolong positive moods, whereas lower self-esteem individuals tend to allow negative moods to linger and will actively dampen positive moods (Wood, Heimpel, & Michaela, 2003). Higher self-esteem individuals are also motivationally inclined to overlook criticism, failure, and other negative outcomes in favor of rewarding goal pursuit, whereas lower self-esteem individuals are decidedly attentive and sensitive to negative stimuli.

In turn, these characteristic psychological orientations are thought to influence health. Thus, people with lower self-esteem exhibit a stronger stress-illness association than higher self-esteem individuals, such that they are more likely to experience psychological and somatic problems both on and following stressful days (DeLongis, Folkman, & Lazarus, 1988). Lower self-esteem individuals are also more susceptible to illness and mood disturbance when stress levels increase, even if overall stress is low. In light of these and other findings, many psychological scientists consider lower self-esteem to be a causal risk factor for poor health outcomes.

A self-and-social-bonds model of health. A second explanatory model posits that self-esteem predicts health outcomes because self-esteem regulates responses to the threat of rejection in a manner than can undermine lower self-esteem individuals' health (Stinson et al., 2008).

A growing body of evidence suggests that self-esteem plays an important role in a broader psychobiological regulatory system that services the fundamental human *need to belong*, which is a drive to connect with and maintain relationships with benevolent social partners, and conversely, avoid the social pain of rejection. In particular, people rely on their self-esteem to makes sense of their past social experiences, regulate their responses to in-the-moment social cues concerning acceptance and rejection, and to predict their future social experiences. As we have already discussed, lower self-esteem individuals readily perceive rejection from others and react strongly to avoid the rejection they often anticipate, whereas higher self-esteem individuals eagerly anticipate acceptance from others and pursue rewarding opportunities for social connection with little concern about rejection. In turn, these differing psychological orientations influence physiological responses to the threat of rejection.

For everyone, the threat of rejection activates a neuroendocrine system called the hypothalamic-pituitary-adrenal axis (HPA), which triggers a cascade of hormones that characterize the physiological stress response. However, because lower self-esteem individuals are more sensitive to rejection threats than higher self-esteem individuals, they are more likely to exhibit this stress response in their daily lives. For example, lower self-esteem individuals experience a heightened physiological stress response to the threat of rejection, as indicated by increased salivary cortisol levels immediately following rejection and during the early recovery phase (Ford & Collins, 2010). Unfortunately, chronic activation of the HPA is physiologically costly and can undermine health, which may explain why lower self-esteem individuals experience worse health outcomes than their higher self-esteem counterparts. Consistent with this account, on the day following an experience of interpersonal rejection, lower self-esteem individuals report heightened stress, poorer general health, increased physical symptoms of

illness, and worse sleep quality relative to both higher self-esteem individuals' experiences on similar days and their own experiences following days when they did not experience rejection (Ford & Collins, 2013). Thus, poor outcomes in the domain of social well-being may be an important mechanism to explain why individuals with lower self-esteem also experience poor outcomes in psychological and physical health domains.

Conclusions

It is tempting to conclude from the preceding discussion that improving self-esteem could result in a miracle panacea. Unfortunately, attempting to improve self-esteem is more easily said than done. The stability of important self-views like self-esteem is so essential to people's daily functioning that people will vociferously defend their existing self-views against the forces of change, even when such defense means maintaining negative evaluations about the self. As a result, attempts to directly improve self-esteem through positive self-statements or other forms of positive feedback often backfire for lower self-esteem individuals, resulting in undesirable decrements to well-being.

Thus, we suggest that rather than targeting self-esteem directly, health interventions should instead attempt to improve the quality of people's social bonds. Such interventions could directly improve health by improving people's social well-being. In turn, because social well-being has been causally implicated in both physical and psychological well-being, such interventions may have spillover benefits for other health domains. Moreover, social well-being interventions could result in persistent benefits if repeated positive social experiences are internalized over time, resulting in increased self-esteem. Psychological scientists have already identified a number of effective social well-being interventions, including belongingness interventions for stigmatized or marginalized groups. Close relationships researchers have also

identified simple interventions that specifically target the social doubts that are characteristic of lower self-esteem. Currently, psychological scientists are working to determine whether this and other promising social well-being interventions can serve as “psychological immunizations,” yielding long-term increments in self-esteem that also benefit well-being and health.

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Biographical Note

Danu Anthony Stinson is an Associate Professor in the Psychology Department at the University of Victoria, Canada. Most of her research to date has examined how and why self-esteem influences health and well-being. More recently, she has begun to investigate and seek ways to alleviate social-psychological barriers to health and well-being that affect negatively stereotyped groups, including higher body-weight people and women in high-status social positions.

Alexandra N. Fisher is completing her Master of Science degree in social psychology at the University of Victoria, Canada, under the supervision of Danu Anthony Stinson. She studies the social and interpersonal experiences of female breadwinners and other successful women. Specifically, her research examines the stereotypes and impressions that are often formed and applied to female breadwinners and how these impressions may influence close relationship initiation and maintenance processes.