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Summary
ring, met narcisme als prototype van de laatste. Bovendien bleek de gezonde zelfwaardering bescherming te bieden tegen de negatieve gevolgen van falen en andere schaamtevolle ervaringen en werd negatieve feedback als nuttig en leerzaam ervaren. Dit alles bleek in veel mindere mate van toepassing voor kinderen met een kwetsbare positieve zelfwaardering. Van de onderzochte zelfregulatiestrategieën die bijdragen aan het herstel van de zelfwaardering na een schaamtevolle ervaring bleek dat de strategie van de ‘positieve zelfbeweringen’ zowel voor kinderen met een gezonde zelfwaardering als voor kinderen met een kwetsbare positieve zelfwaardering het meest effectief. De defensieve zelfregulatiestrategie waaraan kinderen met een kwetsbare positieve zelfwaardering geneigd zijn de voorkeur te geven, bleek echter op geen enkele wijze bij te dragen aan het herstel van de zelfwaardering na een schaamtevolle ervaring. Een gezonde zelfwaardering heeft dus een stevige basis in de realiteit en staat niet chronisch in de stijgers zoals wel het geval is met de narcistische zelfwaardering, het prototype van de kwetsbare positieve zelfwaardering. Voor de klinische praktijk betekent dit, dat het stimuleren van een gezonde zelfwaardering door het vergroten van een meer realistisch bewustzijn van de eigen zelfgevoelens en -gedachten, inclusief de eigen competenties, een belangrijk doel moet zijn om de onderhoudsgevoelige kwetsbare positieve zelfwaardering een meer stevige basis in de realiteit te geven.

Summary
The purpose of the research described in this thesis is to contribute to the knowledge base about the self-image and self-esteem in children and to obtain a better insight into the ways children try to keep their self-esteem intact after it has been negatively affected. The research has its origins in clinical practice and in the observation that many children with emotional and/or behavioral problems express having a positive self-image and a positive self-esteem even if their way of functioning leaves much room for improvement. This fact is not only surprising, but also stands in sharp contrast with the literature, claiming that children with emotional and/or behavioral problems have a negative self-image and low self-esteem. How can we explain this contradiction? For a long time the psychoanalytic notion of defense mechanisms was accepted as the answer to this question but in more recent self-esteem literature this theme has again been examined and elaborated upon. Regulation of the self-esteem plays an important role in these theories, as well as the distinction between a healthy and a fragile positive self-esteem. The basic assumption is that people are motivated to maintain their self-esteem. Whether this is successful in situations where their self-esteem is being threatened or what kind of regulation
strategies are being used would depend on the nature and quality of that same self-esteem. In chapter 1 of the thesis the general assumption in the literature has been discussed, suggesting that a healthy positive self-esteem is characterized by stability, a relative absence of the need for external validation together with a strong foundation in reality. Moreover, a healthy positive self-esteem is seen as offering protection against deterioration of self-esteem after failure or shameful experiences. The empirical support for this argument originates from studies with adults. Research into the nature and quality of self-esteem in children is still very recent, as well as research into the ways in which children try to keep their self-esteem intact. The assumption that the findings from studies in adults would also apply to children has been tested in this thesis.

**Denial as a possible explanation for the positive self-esteem of children with psychiatric problems**

The notion that children with emotional and/or behavioral problems have a negative self-image and low self-esteem is not always supported in clinical practice. Indeed, many children who are hospitalized with psychiatric problems claim to have a positive self-image and positive self-esteem. The question is why this is the case, since most children with mental health problems have reason enough to express a negative self-image. From this perspective, their positive self-evaluation can be seen as ‘idealized’. In chapter 2, the hypothesis that denial in children with emotional and/or behavioral problems explains why they have an idealized self-evaluation has been tested.

The study revealed that children with emotional and/or behavioral problems who estimate themselves extremely high on the scale Global Sense of Self-Esteem of CBSK, in comparison to the norm-group of CBSK, showed less associations as measured by the Children’s Apperception Test (CAT), indicating that they exhibited more resistance than those who took a more realistic assessment with regard to their overall self-esteem. This outcome supports the hypothesis that self-evaluation of children with psychiatric problems is kept artificially high, or that they idealize their self-esteem through denial.

**Differences between healthy positive self-esteem and narcissistic self-esteem, the prototype of the fragile positive self-esteem in children**

Today, a distinction is made in self-esteem literature between a healthy positive self-esteem and a fragile positive self-esteem, with narcissism as prototype of the last. It is assumed that a healthy positive self-esteem is characterized by coherence and stability and a relative absence of the need for external validation. A fragile positive self-esteem,
on the other hand, is seen as unstable and highly dependent on external validation. In studies with adults these assumptions have found empirical support. The purpose of the two studies, described in chapter 3, was to determine whether the distinction between a healthy and a fragile positive self-esteem in children can be empirically supported as well.

Study 1 examined to what extent children with a healthy positive self-esteem (high scores on the scale Global Sense of Self-Esteem - CBSK) differ from children with a fragile positive self-esteem (high scores on the narcissism scale - CNS) with regard to the sense of coherence (measured by the Sense of Coherence questionnaire), self-acceptance and self-competence (measured by the Self-Assessment Manikin scale) and the need for external validation of the self-esteem (as measured by the Contingency scale for Children).

The results of this first study support the hypothesis about the distinction between a healthy positive self-esteem and narcissism, the prototype of the fragile positive self-esteem in children. A high score on Global Sense of Self-Esteem appeared to go along with a sense of coherence and self-acceptance, while the relationship between a high score on narcissism and a sense of coherence and self-acceptance was considerably less. Children with a healthy positive self-esteem and children with narcissistic self-esteem both estimated their own competence equally high. A high score on the Contingency Scale, which reflects the need for external validation of the self-esteem, appeared to be associated with high scores on narcissism. Consequently, a healthy positive self-esteem in children, in accordance with adults, appears to be characterized by a sense of coherence and self-acceptance, something which to a much lesser degree can be said for the fragile positive, in this case, the narcissistic self-esteem.

In study 2 the different meanings of external validation for the self-esteem of children with fragile positive and a healthy positive self-esteem were further examined by considering the extent in which children feel that temporary success or failure in different domains (social acceptance or rejection, success or failure at school and in competitive terms being better or inferior) lead to an increase or decrease of their the self-esteem.

The results of study 2 offer further support for the fragility of the narcissistic self-esteem, which appears to be dependent on temporary success or failure experiences. Children with narcissistic self-esteem (high scores on CNS) indicated that they felt better about themselves after a success, while a failure experience led to a decrease in self-esteem. Temporary success or failure experiences led to strong fluctuations in the self-esteem (‘I can feel good about me when I’m successful, but not if I have failed’). These children, consequently, appeared highly dependent on the external validation of their self-esteem. Self-esteem in children with high scores on the CBSK and low scores on CNS (healthy positive self-esteem) was found relatively independent of temporary successes, as these did not lead to
feeling better about themselves. More importantly, these children indicated that negative experiences did not immediately lead to a decrease in self-esteem. They continued to feel good about themselves, even when someone did not like them, if they were not doing so well at school, or if they were not doing as well as others. Where the healthy positive self-esteem appears to have a protective effect, the fragile positive, narcissistic self-esteem seems to lack this effect.

The role of a healthy positive self-esteem after failure and in dealing with negative feedback

To our knowledge still little empirical research has been done into possible protective effects of a healthy positive self-esteem in children. One of the few studies of children reveals that a fragile positive self-esteem with narcissism as a prototype increases the emotional stress after negative feedback, while a healthy positive self-esteem remains intact after negative feedback. These findings are consistent with research literature in adults showing that a healthy positive self-esteem after negative feedback, indeed, takes on the assumed buffer function. The results of the study reported in chapter 3 also suggest that a healthy positive self-esteem has a possible protective function for children in failure experiences, in concordance with the findings in studies of adults. This has led to a further investigation of the protective function of the healthy positive self-esteem and the possible absence of it in a fragile positive self-esteem in children in two separate studies reported in chapter 4.

Study 1 investigated in an experimental setup to what extent actual success or failure affects the self-esteem of children. It was a simple computer task that in the success condition could be completed within the specified time, but in the failure condition was ended prematurely. Self-esteem (state self-esteem) was measured both before and after the success or failure experience. It was expected that children with a healthy self-esteem would remain positive about themselves even after failure, while the self-esteem in children with a narcissistic self-esteem could not perform this protective function. Indeed, the results of study 1 seem to confirm the protective function of a healthy positive self-esteem. As expected, children scoring high on the CBSK thought equally positive about themselves after failure and after success. Children scoring low on the CBSK estimated their own competence also lower after failure than after success, but the difference between the effects of success and failure in this group
was less explicit than with children who scored low on the CBSK, indicating that failure had a less negative effect on their perceived competence than was the case in low-scoring children. Both boys and girls assessed their skills more positively after success than after failure, but the difference between the two conditions was larger with some boys than the difference with girls. This gender effect was dependent on the degree of narcissism. For boys scoring high in narcissism the difference between the success condition and failure condition was greater than for boys scoring lower on narcissism. It is not inconceivable that this observed effect could mainly be attributed to the tendency of narcissistic boys to overestimate their own competence after success. The preservation of positive feelings about oneself after failure seems to be reserved to children with a healthy positive self-esteem. Yet these children are not immune to the consequences of success or failure: they seemed less positive after failure about their own competence than after success. In other words, children with a healthy positive self-esteem appear indeed susceptible to positive or negative outcomes but their self-feeling remains intact whatever the outcome.

In study 2 the opinion of children was asked about the usefulness of negative feedback and how they deal with it. Adult study shows that constructive responses to negative feedback are dependent on the nature of the self-esteem (healthy or fragile). It was expected that children with predominantly healthy positive self-esteem, like adults, more often would ask for feedback and would want to learn from it, in contrast to children with a predominantly narcissistic self-esteem. Moreover, it was expected that children with healthy self-esteem would respond less emotionally to negative feedback and would be less inclined to avoid negative feedback than children with narcissistic self-esteem. The relationship between levels of self-esteem and reactions to negative feedback was measured in the Feedback procedure developed by us (meaning negative feedback, emotional responses to negative feedback, dealing with negative feedback).

The results of study 2 show convincingly that children with predominantly healthy positive self-esteem (high score on the Rosenberg Self-Esteem Scale) have a different opinion about negative feedback than children with fragile positive self-esteem, that is, with a greater tendency to narcissism (high score CNS). A high score on self-esteem showed a positive correlation with ‘sense of negative feedback’ and ‘learning from negative feedback’ and a negative correlation with ‘emotional response to negative feedback’ and ‘avoidance of negative feedback’. A high score on narcissism, on the contrary, proved to be positively related with ‘emotional response to negative feedback’ and ‘avoidance of negative feedback’. In other words, children with a healthy positive self-esteem find feedback useful and feel that they can learn from it. Negative feedback does not make them anxious or sad, and children with a healthy positive self-esteem are therefore not inclined to avoid negative
feedback. Children with a narcissistic self-esteem, in contrast, think negatively about the usefulness of negative feedback, and feel bad or anxious about themselves after getting negative feedback. This suggests that children with a healthy positive self-esteem see the importance of feedback, even if it is negative, as an opportunity to increase their own competencies. Children with narcissistic self-esteem on the other hand seem inclined to avoid negative feedback or to avoid being exposed to negative self-feelings.

The effectiveness of various self-regulation strategies after an attack on children’s self-esteem

Generally, it can be assumed that people are motivated to maintain their self-esteem. Self-conscious emotions (such as pride, embarrassment, guilt and shame) play an important role. From the self-conscious emotions shame is the most painful emotion, as a shameful event leads to negative judgment by the shamed person on himself (‘I’m a stupid person or clumsy, ugly or weak’). A shameful experience is so closely linked to self-esteem that it demands a solution, in this case ‘restoration of the self-image and self-esteem’. Self-regulation strategies play an important role in this. In chapter 5, the hypothesis that the nature of the self-esteem in children affects the choice of the self-regulation strategy after a shameful experience was tested as well as to what extent the preference for and the expected and actual effectiveness of the different self-regulation strategies differ between children with a healthy positive self-esteem and children with fragile positive self-esteem.

In two studies using the same study population, the hypothesis was tested that the nature of the self-esteem affects the choice of the self-regulation strategy after a shameful experience. In study 1 children after a shameful experience (doing something stupid in front of others) were presented with a defensive and self-compassion self-regulation strategy. The defensive regulation strategy referred to ‘denigration of others’, and self-glorification (‘I think of how awesome I actually am’). The defensive regulation strategy seeks to prevent or minimalize negative self-feelings. The self-compassion strategy referred to mildness about oneself after a shameful incident and the relativity of one’s own ‘stupidity’ as something human. Self-compassion is supposed to provide protection by ensuring personal shortcomings as something human by which self-disapproval after failure or feelings of shame can be prevented. The reaction to a shameful experience was measured using the Response to an Embarrassing Event (RBG) questionnaire, developed by us. The expected effectiveness of the elected self-regulation strategy was measured by the Response to an Embarrassing Event is Effective Strategy (RBGES) questionnaire with the same scales as in the RBG. As in studies reported in previous chapters, self-esteem was measured
again using the Rosenberg Self-Esteem Scale (RZW) and narcissism with the Childhood Narcissism Scale (CNS).

The results from study 1 reveal that children with a healthy positive self-esteem had a greater preference to respond to embarrassing situations with mildness about themselves and to consider their own failure as human (self-compassion). Children with narcissistic self-esteem, on the other hand, appeared to prefer defensive self-regulation strategies. Similar results were found with regard to the observed effectiveness of the selected self-regulation strategy. Children with a predominantly healthy positive self-esteem were more likely to assess self-compassion strategies as helpful in the recovery of the affected self-esteem. Children with narcissistic self-esteem, on the other hand, tended to regard defensive strategies as far more effective to repair the affected self-esteem.

In Study 2, we were particularly interested in whether the use of different self-regulation strategies actually affects the recovery of self-esteem after a shameful event. Unlike Study 1, we examined not only the effectiveness of self-compassion and defensive self-regulation strategy, but also added the self-regulation strategy ‘positive self-statements’ and compared these three strategies with a control condition in which children were asked to describe an activity they like to do.

The positive self-statements were to relate to real situations in which the children ‘were really pleased with themselves’, a strategy which may contribute to the child feeling better again about him- or herself after a negative experience. Before the experimental manipulation children were asked to write about a shameful memory. Then they were randomly assigned to the four conditions (that is: self-compassion, positive self-statements, defensive and a control condition ‘write about what you like to do’) and asked to write some comments about the conditions to which they were assigned. The effect of each of these conditions was examined on the ‘state’ self-esteem (‘how do you feel right now about yourself?’), and the two implicit forms of the ‘state’ self-esteem, being positive mood and the desire to undertake social activities after a negative experience. It was expected that expressing positive self-statements would have a generally applicable positive effect on the recovery of self-esteem. It was also expected that writing about the condition self-compassion the positive effect on the recovery of the self-esteem would only be visible in children with a healthy positive self-esteem. From the defensive strategy and the control condition no effect was expected with regard to the recovery of the self-esteem.

The results of study 2 show, as expected, that expressing positive self-statements is an effective strategy in the restoration of the ‘state’ self-esteem after a shameful situation. This proved the case with all children, regardless of their self-esteem. A defensive self-regulation strategy or just writing about what someone likes to do (the control condition)
proved ineffective. Contrary to our expectation self-compassion itself had no effect on the recovery of self-esteem, not even in children with a healthy positive self-esteem. Regarding the aspect of state self-esteem expressed as ‘improving mood’ the same effect became visible: positive self-statements had a positive impact on the recovery of the mood as opposed to a defensive strategy or just writing ‘about what you like to do’ (control condition). Self-compassion also led to better mood recovery than defensive strategy, but there was no difference with the control condition. The effectiveness of the strategy again did not depend on the nature of the self-esteem. With regard to the aspect of state self-esteem expressed as ‘undertaking social activities in order to undo the negative experience’ it appeared that both positive self-assertion and self-compassion proved a better strategy than the control condition, but did not differ with the defensive self-regulation strategy. Again, the effectiveness of the strategy used was found to be independent on the nature of the self-esteem. It seems that realistic positive self-statements have a generally applicable effect on the recovery of the self-esteem after a shameful experience. Noteworthy is the fact that the benefits that children with a fragile positive self-esteem expect from defensive strategies (study 1) do not occur in reality (study 2). The use of positive self-statements (and to a lesser extent, also self-compassion) appears to be more effective than defensive strategies. Children with a fragile positive self-esteem, therefore, should benefit more by choosing a different strategy than the strategy of their preference.

The importance of the research findings for our understanding of a healthy and fragile positive self-esteem

The research reported in this thesis has, empirically demonstrated for the first time that a qualitative distinction can be made between a healthy positive and a fragile positive self-esteem in children. This qualitative distinction is especially visible in three aspects, namely, the sense of coherence, self-acceptance and the need for external validation to maintain a stable self-esteem. Children with a healthy positive self-esteem experience their lives in general as understandable, predictable and meaningful (sense of coherence). They are in affective regard satisfied with themselves, including their shortcomings (self-acceptance), and their self-esteem is not much dependent on external validation (for example by ‘needing to be better than others’). In children with fragile positive or narcissistic self-esteem the sense of coherence and self-acceptance appears much less present and the need for external validation is relatively large in order to feel good about themselves. These findings are consistent with the literature showing that a healthy positive self-esteem is characterized by stability, a relative absence of the need for external validation and a firm foundation in reality.
The second important finding is that a healthy positive self-esteem provides protection against the negative consequences of failure experiences. This is consistent with the limited amount of literature written about children claiming that negative feedback increases the emotional stress in children with narcissistic self-esteem, while a healthy positive self-esteem helps the self-esteem to remain intact after negative feedback. Likewise in our study the self-esteem of children with a healthy positive self-esteem remained intact after a failure experience. This applies to a much lesser extent to children with a fragile positive self-esteem. The demonstrated protective function of a healthy positive self-esteem for children is consistent with studies of adults with a healthy positive self-esteem also offering the same protection after failure against a decline in the self-esteem.

Another important finding in this regard is that children with healthy positive self-esteem perceive negative feedback as useful and believe that they can learn from it. Children with fragile positive self-esteem, on the other hand, tend to ignore negative feedback in order to avoid negative feelings and prevent being exposed to them. The latter finding is also consistent with research in adults, revealing that constructive responses to negative feedback depend on the nature of the self-esteem (healthy or fragile). The advantage of a healthy positive self-esteem is twofold: firstly, self-esteem offers protection against the decline in positive self-feelings after a negative experience; secondly, it also stimulates healthy self-esteem children to learn from negative feedback and failure experiences.

Self-regulation strategies were found to play an important role in maintaining a positive self-esteem, especially when it comes to handling shameful experiences. The results of our research confirm the preference of children with narcissistic self-esteem to respond to a shameful experience with defensive self-regulation strategies. Children with healthy self-esteem appeared to be more inclined to make use of self-compassion strategies (failures are seen as human) after a shameful experience. Children with narcissistic self-esteem believe that defensive self-regulation strategies are more effective than self-compassion strategies for the restoration of self-esteem. Children with healthy positive self-esteem, on the contrary, assess self-compassion strategies as being more effective in restoring the damaged self-esteem after a shameful experience. This difference in use and evaluation of self-regulation strategies between a healthy and a fragile positive self-esteem disappeared when children were asked to respond to a certain self-regulation strategy after a shameful experience. Positive self-statements were considered by both children with a healthy positive self-esteem and a fragile positive self-esteem to be the most effective for the restoration of their self-esteem. This finding is remarkable with regard to children with fragile positive self-esteem since they expected a positive impact from defensive strategies. These defensive strategies are in fact (after experimental manipulation), not effective. Positive
self-statements apparently are generally applicable regardless of the nature of the positive self-esteem (healthy or fragile). This idea fits with the ‘broaden-and-build theory’ which assumes that the activation of positive qualities after negative experiences contributes to the growth of positive emotions which enables self-feelings to become more balanced. In other words, positive emotions create a kind of barrier against an excessive drop in self-esteem after a shameful experience.

Recommendations for further research and implications for clinical practice

In the last chapter of the thesis the limitations of the studies, recommendations for further research and implications for clinical practice have been discussed. Although this series of studies began with an observation of children in a clinical setting, the general application of the results from the subsequent studies to the clinical setting is somewhat limited. The replicability of the results from these studies into clinical groups requires therefore additional research. One of the major limitations of the reported studies is the predominantly cross-sectional character and the mere use of self-report lists of children, some with more limited validity than initially expected.

Further research could be directed both towards the clinical practice as well to the further deepening of certain concepts that are central to these studies. For example, the operationalization of the clinical notion of denial (study 1) could be used as an outcome measure in clinical treatment of children, who at the beginning of treatment show an idealized self-evaluation. Furthermore, the distinction between a healthy positive and a fragile positive self-esteem (study 2) for the purpose of scientific research or diagnosis can be further examined by not only using self-report measures but also information from teachers about the social, emotional and academic functioning of children and by exploring the implicit aspects of healthy positive and fragile positive self-esteem. The study to investigate the protective function of the healthy positive self-esteem (study 3) invites to study the reaction of children when they actually get feedback on a task instead of being only prompted by a questionnaire on how they think to handle feedback. As far as the various self-regulation strategies (study 4) are concerned, it would be interesting to examine in a follow-up study whether a shift is seen through the child’s development in the use of the self-regulation strategies.

The research also has implications for clinical practice. For diagnostic practice this would mean that all scores on self-esteem questionnaires (among others CBSK, CNS) need to be examined to see whether they are in line with what can be expected given the nature of the problems that led to the referral and the clinical impression.
Generally, the treatment of children with a fragile positive self-esteem aims to increase the skills to deal with the threats to the self-esteem. The shortage of these skills is often accompanied by a lack of awareness of the needs of others. The major challenge in the treatment is motivating the youngster to be willing (dare) to look at himself, to get more insight into his thinking and feeling and to focus and participate on change, without explicitly activating feelings of inferiority, which are a permanent source of threat to self-esteem. For children with weaker forms of fragile positive self-esteem this may include the Competitive Memory Training (COMET), a self-image and self-esteem-training for children and young people, and mindfulness. For children with a fragile positive self-esteem, who fully comply with the prototype of the fragile positive self-esteem, narcissism, Schema Therapy, an integral form of psychotherapy based on cognitive behavioral therapy, attachment- and emotion-focused traditions, is a useful type of treatment.

Conclusion

In this thesis the investigation of the self-esteem of children has been reported, following the clinical observation that many children with psychiatric problems report having a positive self-image. It was examined whether denial and self-idealization is a possible explanation. This proved to be the case. Subsequently, the question was asked whether a positive self-image and a positive self-esteem in some children may have a special meaning and whether a qualitative distinction can be made between two types of positive self-esteem, healthy and fragile, with narcissism as a prototype of the latter. This distinction proved valid, also in children. We have shown that these two forms of self-esteem, healthy positive versus fragile positive, can be differentiated in terms of sense of coherence, self-acceptance and the extent to which the need exists for external validation to maintain the self-esteem. A healthy positive self-esteem is characterized by a sense of coherence, self-acceptance and a relative absence of external validation. Moreover, it appeared that a healthy positive self-esteem protects against the negative consequences of failure and shameful experiences and that negative feedback was experienced as useful and instructive. All this proved to be to a much lesser extent applicable to children with fragile positive self-esteem. Subsequently, we examined the self-regulation strategies which contribute to the restoration of self-esteem after a shameful experience. The most effective strategy to restore the self-esteem, both for children with a healthy positive and a fragile positive self-esteem, turned out to be positive self-statements, followed by self-compassion. The defensive self-regulation strategy, to which children with fragile positive self-esteem tend to give preference, did not prove in any way to contribute to the restoration of self-esteem after a shameful experience. A healthy positive self-esteem has a solid foundation in
reality and is not chronically in need of maintenance as is the case with the narcissistic self-esteem, the prototype of the fragile positive self-esteem. For clinical practice this means that promoting a healthy positive self-esteem, by developing a more realistic awareness of children’s own self-feelings and thoughts, including their own competencies, should be an important objective towards the fragile positive self-esteem in order to give it a more solid foundation in reality.