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Therapy for Low Self-Esteem: Structure of Treatment and Development of an Instrument for Evaluation (CILS-E) and Therapeutic Guide from the Model of Updating and Maintenance of Self-Esteem

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Abstract

The preliminary steps to start the clinical application of the self-esteem update and maintenance model are addressed, laying the foundations for the development of a new therapy to treat low self-esteem. Specifically, an explanation of low self-esteem is first provided from the theoretical components of the model, then providing both a structure of its treatment and a measurement instrument (CILS-E) that pursues a double diagnostic and therapeutic objective: To evaluate the critical incidents of low self-esteem suffered by the patient (self-registration) and extract relevant information to direct his treatment (self-report). Finally, a brief sample of clinical data collected with the aforementioned Instrument is detailed, as well as some results that provide favorable indications about the therapeutic possibilities offered by this approach.

Keywords: Low Self-Esteem; Therapy; Instrument; Treatment; Evaluation; Model

Abbreviations: RSCQ: Robson Self-Concept Questionnaire; SSES: State Self-Esteem Scale; CILS-E: Critical Incidents of Low Self-Esteem.

Introduction

The general purpose of this work is to initiate the clinical application of the recently proposed self-esteem maintenance and updating model [1], and its most immediate objective is develop, present and trial the use of a new instrument for evaluation and therapy for low self-esteem according to the principles of the model. For this reason, we will present here a summary of the model, the problem of low self-esteem from its theoretical perspective, the structure of its treatment and the characteristics of all, it should be noted that low self-esteem affects all age groups without distinction the instrument itself.

First of all, it should be noted that low self-esteem affects all age groups without distinction [2-9] and coexists with many mental disorders. Hence, to alleviate its psychological damage, therapies have been developed from various theoretical approaches. According to a current review [10], the following stand out: Traits and constructs, cognitive-behavioral, emotional rational behavioral, EMDR technique and metacognitive [11-20].

Theoretical Model

As we will see, its theoretical structure allows us to design a new therapy based on its formal components. According to the model [1], the continuous updating of self-esteem involves

the concurrence of two mental representations, called ego-Model and ego-Perceived, which are updated as certain situations called self-esteem instances are resolved. The model-Ego refers to the underlying criterion that intervenes in self-assessment, and the ego-Perceived corresponds to how the person ends up perceiving or conceiving himself -self-concept and/or self-image- depending on how he judges how he acted with respect to that criterion on every self-esteem instance. At the limit, the ego-Model represents how the person should behave at all times to meet his personal goals and for this reason feel proud of himself. As a mental scheme, it integrates and incorporates both an objective and an action plan [21,22]. The greater the coincidence between ego-Model and ego-Perceived, the higher self-esteem resulted, and the opposite.

Both types of self, as mental representations, are implicit to the subject [23], are multidimensional [24,25] and are related to and emerge from the concept of self [26-28]. On the other hand, it is known that both discrepancies with an ideal [29] and unfulfilled personal goals are related to low self-esteem [30].

By self-esteem instance reference is made to all those situations where a person can find himself and when, inevitably, his self-esteem will be at stake. They are usually those situations that involve errors, failure or social rejection [13,31]. The ego-Model plays a decisive role here: It prescribes and points out to the person what could be his best performance in each situation in order to meet his personal goals -something essential for self-esteem [30,32]. For example, if someone pursued social acceptance as a goal and was in a social situation, then the ego-Model would indicate how he should behave right there in order to achieve his mentioned purpose, giving him signals and indications of how to do it. It should be noted here that personal goals can involve both getting something -e.g., social acceptance-or avoiding something - e.g., criticism or ridicule.

It is well known that self-esteem is linked to performance [33] and personal competence [34] and that, in turn, produces a wide range of associated positive and negative consequences, depending on whether it is high or low [7,31,35,36].

For reasons of space, we will not extend the description of the theoretical model further -however, in [1] all the references that support its various components and operation can be consulted. On the other hand, in order to offer a general schematic view of the self-esteem updating and maintaining model, we include below the figures that appear in its aforementioned original publication, referring to its components (See Figure 1) and cognitive processes (See Figure 2), and to the assessment of the perceived self (See Figure 3).

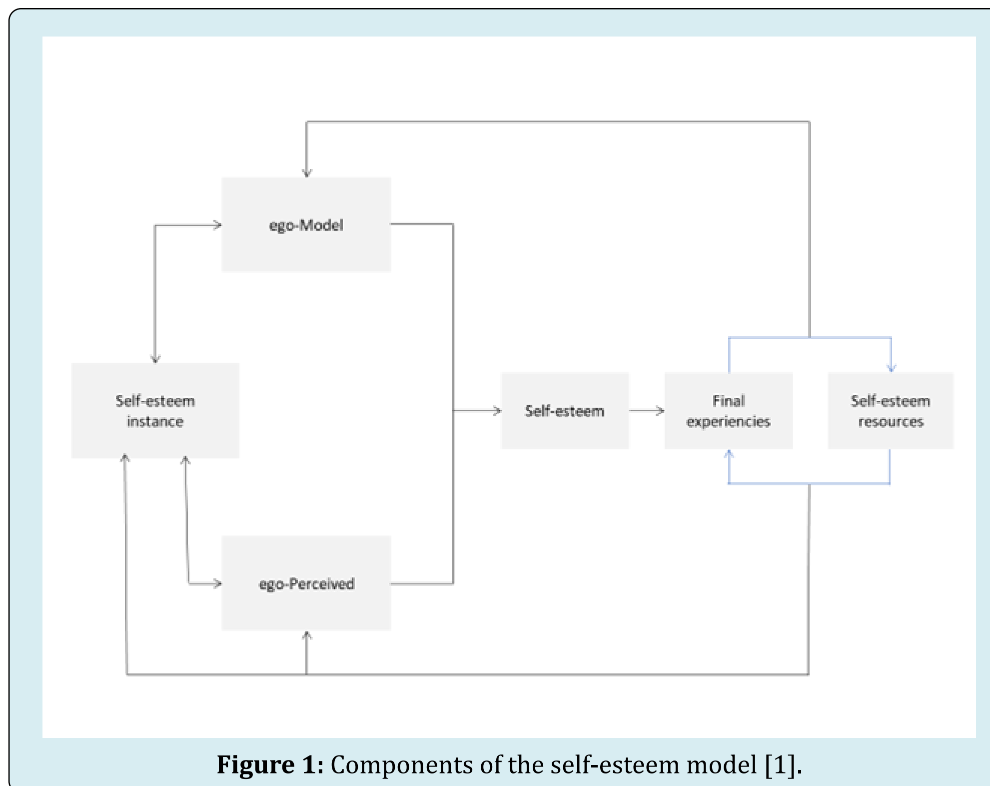

Figure 1: Components of the self-esteem model [1].

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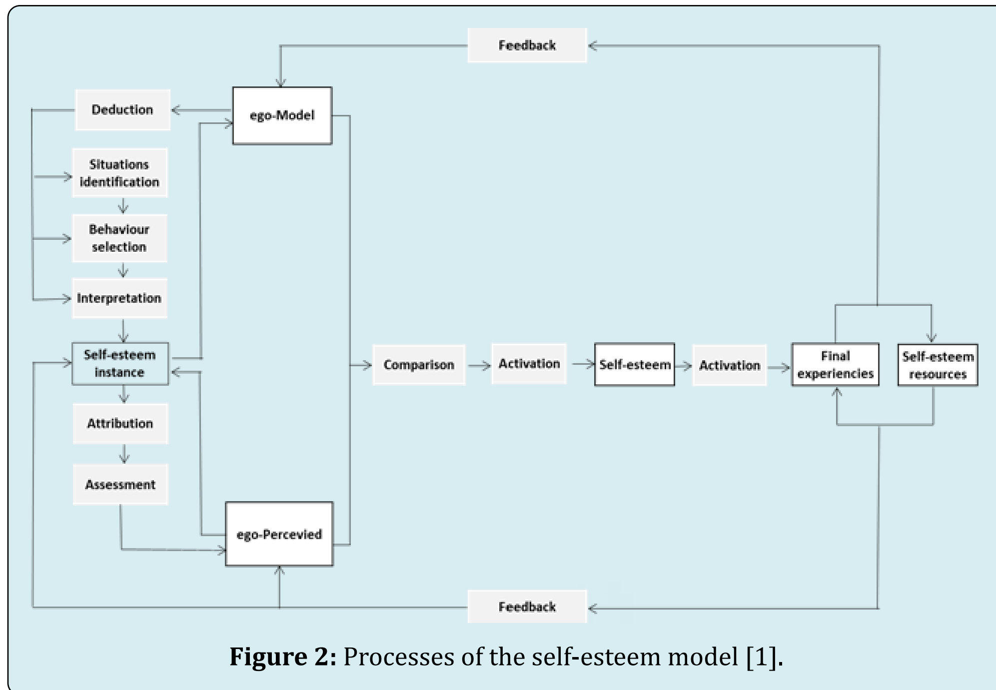

Figure 2: Processes of the self-esteem model [1].

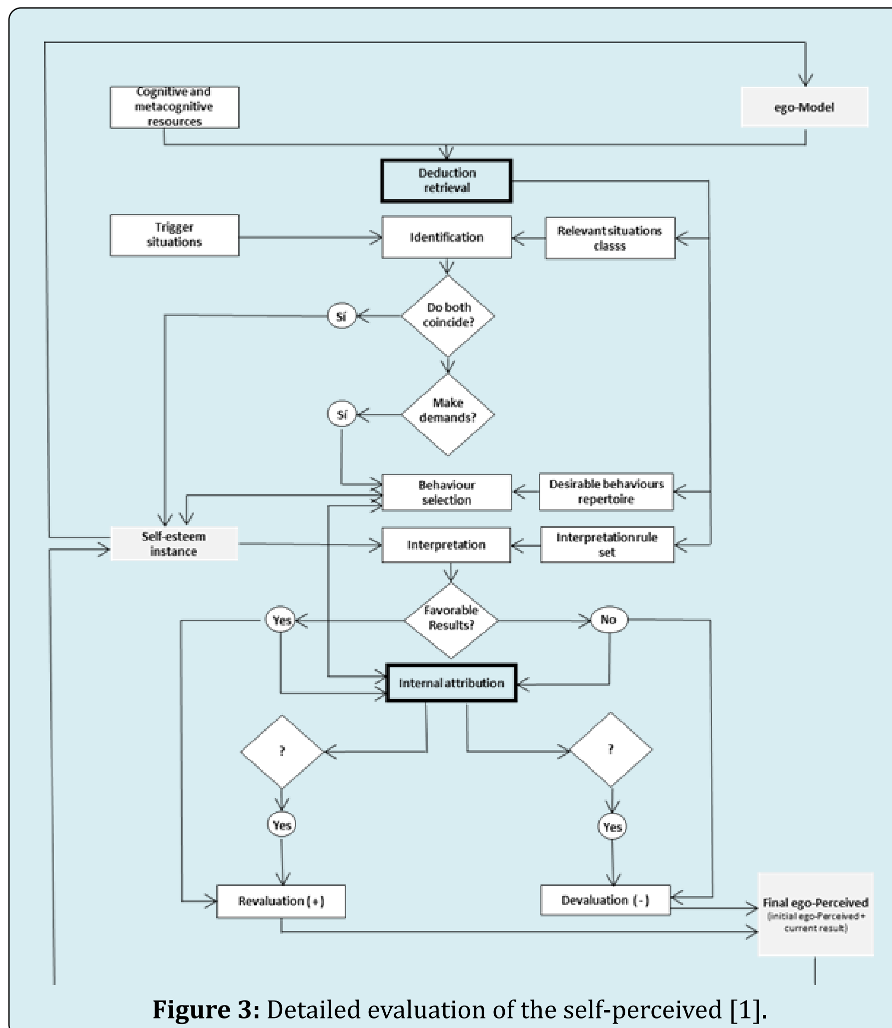

Figure 3: Detailed evaluation of the self-perceived [1].

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Low Self-Esteem

From the reference model [1] and from the systematic interaction between its component elements it is deduced that the difficulties faced by patients with low self-esteem can be located on one or more of the following axes:

- Identify-not identify both the self-esteem instances and the demands that they themselves raise.
- Realize-not becoming aware of the underlying activated ego-Model.
- Deducing/retrieving-not deducing/not retrieving the appropriate information from this mental representation -e.g., repertoire of possible behaviors, estimation of their effects, interpretation criteria of the result.
- Integrate-not integrate the personal goals and demands of the self-esteem instance through the ego-Model to select the best behavior to carry out in that situation.
- Implement-not implement (inhibit) the selected behavior due to barriers internal and/or external.
- Adjust-misadjust (bias) the various evaluations and self-evaluations involved: in the entire process Estimation of potential results for each alternative behavior, effectiveness of the performance itself, result of the self-esteem instance, causal attribution of this result, and how all this affects the ego-Perceived and the resulting self-esteem.

We will now deal with these issues in more detail:

Self-Esteem Instances: There is a wide range of situations that could become self-esteem instances: For example, a certain situation that is initially irrelevant can suddenly become a self-esteem instance because a person who is hypercritical of the patient breaks into it. The patient must first of all identify to which area of his personal objectives the emerging instance corresponds. There is also great diversity in this last respect: it could be about personal objectives of acceptance, competence or control -taking up here those most frequent individual concerns [37] -without forgetting their reflexive versions of self-acceptance, self-discipline or self-control-; it could also be personal objectives of performance, social competence or physical appearance -dimensions of self-esteem included in the scale of Heatherton [38]. Next, the patient must recognize the demands that each self-esteem instance raises in order to attend to them and thus resolve the situation in which he finds himself according to his objectives committed therein. In the matter at hand, a serious obstacle could arise: The patient's present or current circumstances do not allow him to satisfy his personal goals in any way -and he does not want/cannot renounce the latter either. Think, for example, of someone who was seeking social acceptance or professional competence and was suffering from mobbing in his job.

Ego-Model: The patient must infer and become aware of the peculiarity of the underlying ego-Model that had been activated -recognizing even certain values that could permeate his description and/or image -e.g., "being cordial", "being efficient", "seeming resolved"- and appreciate what type of self-criterion this mental representation reflects: perfectionist or illusory, realistic or pragmatic, inappropriate or strange... Determining this question is decisive and will condition the steps to follow in the treatment -e.g., rejecting an ego-Model based on an ideal criterion for being unattainable and/or modifying it in some way, accepting another ego-Model with a more practical sense and/or that better adjusts to reality as the most convenient self-criterion. Take note of the fact that if self-esteem depended on achieving impossible goals, embodied in an idealized ego-Model, then the person could be doomed to continuous frustration and could even indulge in counterproductive behaviors that would further aggravate his low self-esteem problem. -e.g., lying, exaggerating achievements, systematically criticizing others.

With the ego-Model a new impediment may arise: That the patient lacks those necessary cognitive resources -e.g., cognitive flexibility to substitute and/or modify mental representations. In eating disorders, an excessively rigid ego-Model usually emerges in relation to physical appearance -this dimension prevailing over any other possible domain of personal objectives. It could be said that here, among all the possible ego-Models that could be activated on certain self-esteem instances -assuming now here a list or structure of ego-Models, takes center stage and predominates over all the others, exclusively that ego-Model that is more harmful to the patient.

Articulation Self-Esteem Instances and Ego-Model: In any self-esteem instance the patient will have to link his personal goals with the situational demands in the representational content of the ego-Model that serves as his criterion. This will require both a prior clarification of his own objectives and sufficient mental capacity to deduce from the ego-Model what it would be best to do on each self-esteem instance in order to try to satisfy them. In short, this articulation would be about situationally particularizing a general personal objective, thus connecting permanent goals with current circumstances through the ego-Model. Here, obviously, an obstacle would arise, if not a difficulty, as long as the patient does not have and/or is not aware of his personal objectives, drifting through the different situations that arise. Another difficulty at this point would occur when the patient accuses a lack of cognitive resources and/or essential knowledge to make the necessary deductions and estimates, as postulated by the theoretical model -e.g., the ego-Model should also facilitate the criteria of interpretation of the outcome of each self-esteem instance.

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Implementation of the Selected Behavior: After the above, the patient must then start the selected behavior and evaluate its result. In its case, if this behavior could not have been implemented on the self-esteem instance, he should analyze what external and/or internal barriers have been that prevented it and, from there, try to obtain the necessary resources -e.g., search for information, training in social skills. If such resources were inaccessible, this would be a real problem. And here it is appropriate to make an observation: The selected behavior -within the behaviors at hand on the self-esteem instance, according to the ego-Model should not be confused with that behavior that should be carried out based on irrational beliefs of ideality or similar characteristic [39]. It is not a matter of carrying out an ideal action, but of selecting and carrying out the most convenient behavior among the available options, in all cases adhering to the estimation of its final result on self-esteem.

Estimates and Evaluations: Furthermore, the patient will also have to make precise assessments of various questions and alternative options in successive steps, which entails complex cognitive operations. First, he will need to estimate the situational impact of the different behaviors you might display on each self-esteem instance; then, he must assess how he has acted and resolved each situation and to what factors he attributes this result; and finally, he must also interpret how all this has affected his ego-Perceived (final) and his self-esteem. The damage in this matter would come from the fact that the patient did not have valid and reliable criteria for his calculations or that he executed them without precision, with attribution biases or, even, with a lack of consistency between them.

Treatment

Therapeutic Objectives: The therapy for low self-esteem designed from the reference model and that we suggest here should focus mainly on helping the patient to:

- Identify the self-esteem instances and their demands in connection with his personal goals.
- Realize, analyze and adjust the nature of the ego-Model.
- Select the most convenient behavior for each self-esteem instance, in order to facilitate the fulfillment of his personal objectives -it is always chosen from the perspective of an end-, and based on the previous estimation of its final consequences on self-esteem.
- Model and/or mold the selected behavior to improve it or, where appropriate, investigate and become aware of what internal or external barriers could have prevented or inhibited its staging.
- Adjust the attribution of the result obtained on the self-esteem instance, (e specify the evaluation of his final ego-Perceived as he would have resolved the situation.
- Finally, Estimate properly the positive or negative impact that all this has on his self-esteem.

As a whole, this therapy aims to optimize the patient's performance on those self-esteem instances that arise so that, in this way, they go up the slope of self-esteem, updating and maintaining higher values. The short-term tactic of beginning to become aware of self-esteem instances, even anticipating them, preparing an appropriate action plan to deal with them adequately is part of a medium-term strategy aimed at facilitating the patient's achievement of his personal goals and, with it, as we have been commenting, to improve his self-esteem. It constitutes a very analytical clinical approach in a double sense: It strives to always look for the most convenient alternative behavior for each situation, and even admits breaking down the same situation into three consecutive different self-esteem instances: Before, during and after the situation.

In our opinion, the novelty of this approach, now taking both the theoretical model and its clinical application together, lies in considering the ego-Model as a principle to deduce useful information from its representational content to solve in the most efficient way possible each situation in terms of self-esteem.

Action Mechanisms: Unlike the operation of other existing therapies for low self-esteem [10], here it is about achieving a therapeutic change through causing cognitive dissonance in the patient, leading him to compare:

- The behavior performed on past self-esteem instances -and its results.
- Other possible alternative behaviors that he could have implemented in the same situation with better possibilities of achieving his personal goals and, through them, raising his self-esteem.

This dissonance would also allow the patient to detect and realize those internal or external barriers that inhibited/prevented implementing the most appropriate behavior, also providing clues about other probable mental disorders coexisting with self-esteem and that were maintaining it over time. For example, a social phobic patient with low self-esteem will not be able to act according to his ego-Model because, among other things, he has been avoiding certain social situations.

Treatment Structure: It is suggested to give it following the sequence of components detailed below, making it more flexible according to the demands of each specific case:

- Initial evaluation of the patient's self-concept and self-esteem: For this, in principle, any of the existing scales can be used, such as the Self-Concept Questionnaire (RSCQ) [40] and/or the State Self-Esteem Scale (SSES) [38]. It would also be appropriate to assess the patient's symptomatic state of anxiety and/or depression - for

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example, with the Hamilton Anxiety Scale, HAM-A [41] or with the BDI of Beck et al [42].

- Psychoeducation: the model underlying the therapy will be explained to the patient, emphasizing how his present self-esteem can go down or up depending on how he behaves on self-esteem instances that arise spontaneously or on those that are prescribed as homework in therapy.
- Monitoring: self-registration of critical incidents of low self-esteem -Part-I of the Instrument (see Annex - I).
- Particular therapy of the model: according to what was mentioned above in the therapeutic objectives section -Part-II of the instrument (see Annex - I).
- General therapy using techniques from other clinical approaches [37,39,43-46] to adjust the self-model and implement the best behavior in each situation, such as: refocusing attention to identify self-esteem instances and better detect their demands, cognitive restructuring and/or modification of beliefs to adjust the viability of the ego-Model, estimation of costs and benefits to choose between different behaviors, reattribution to examine the factors that have intervened in the result of the self-esteem instance or training in social skills to improve his performance.
- Complementary clinical interventions: Where appropriate, specific treatment of other Axis I and/or Axis II disorders according to the DSM-IV multiaxial assessment that may have surfaced during the course of therapy for low self-esteem -e.g., therapy for social phobia when the selected behavior has been inhibited by shame or therapy for narcissistic personality when the ego-Model demands admiration.
- Follow-up of the initial evaluation of the patient's self-concept and self-esteem as well as his symptomatic state.

Instrument

In order to achieve the aforementioned therapeutic objectives in the Introduction, we will use the new Instrument that we present in this Section: It is the self-registration and analysis of Critical Incidents of Low Self-esteem (CILS-E). Its principal structure consists of two well-differentiated parts: A first one of an evaluative nature, and a second one, with a therapeutic purpose (see Annex - I).

Part-I: Behavior performed, is a Self-registration Sheet with 7 items where the patient describes his observations: Here he details the situations that have caused him low self-esteem and how he really behaved there. Part-II: Alternative behaviors, is an Analysis Sheet of the previous self-registration, an examination carried out from the principles of the theoretical model; It consists of 17 items. This second part effectively constitutes a therapy script to be completed during the treatment session, where the patient, in discussion with the therapist, self-reports about other possible options for action in that same initial situation. In this Part, the patient must infer and carefully consider other alternative behaviors that could have been more convenient to perform on that instance to improve his self-esteem.

As can be seen in Annex - I, the CILS-E evaluates behavioral variables -e.g., behavior performed-, and cognitive variables -e.g., identifying self-esteem instance, estimating results and attributions-, as well as more complex structures -ego-Perceived, ego-Model - involving intrapsychic entities [47]. Some CILS-E items are open questions and others are answered either with a 11-points Likert scale (see details of its valuation tranches in the instructions of the Instrument in Annex-I) or by assigning a percentage.

The structure of the CILS-E fulfills a double evaluative and therapeutic function, in that:

- It collects information on the behavior carried out by the subject on past self-esteem instances and on other alternative behaviors that could have been carried out in the same situation.
- Serves as a guide and support for the course of treatment.
- Facilitates therapeutic change thanks to two factors:

Cognitive dissonance produced by its bipartite composition and the very use of the self-observation process -where the identification of the problem behavior instigates the aforementioned change [48]. As stated, there is a close relationship between evaluation and treatment with the theoretical model -e.g., asking the patient about the attribution of results-, in line with the traditional behavioral approach [49]. Apart from its clinical use, the design of the CILS-E allows it to be used for both theoretical and clinical research purposes: Exploration and testing of hypotheses and/or tests of therapeutic efficacy -the CILS-E also incorporates a third auxiliary part with two items for weekly monitoring critical incidents of low self-esteem that have occurred.

The CILS-E is a mixed technique since it combines characteristics of self-registration, self-report and subjective techniques. Specifically, its first part is a paper-and-pencil self-monitoring technique [50], which requires the patient to attend to and record his behavior according to a designated procedure, then writing down the behavior performed, the result obtained, the results obtained, and his subjective experience, in accordance with the type of information susceptible to self-observation [48] and that, on the other hand, is usually obtained with this type of instrument [51]. In its second part, as we have seen, the patient provides his self-report. For the rest, the data collected is generally subjective in nature, since it is only the patient who describes the situation and qualifies himself, his response being voluntary

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and, in this sense, potentially manipulable, in accordance with subjective techniques [12].

To conclude this section, it is appropriate to comment that although these evaluation techniques have proven their validity [52], they are not exempt from criticism due to their lack of relationship with manifest variables [53,54] and there are even proposals for its improvement [55]. Even so, they have been widely used either in isolation to evaluate hidden variables of various kinds [56-58], or together with other manifest variables [59].

Method

At present, our objective is limited only to testing the use of CILS-E, presenting below, as an example, some preliminary results to show the type of data that can be obtained with this Instrument. It should be noted that this is not, sense strict, a case study, nor a psychometric analysis of this measurement technique. A small group of patients who voluntarily agreed to participate in this study as long as their anonymity was respected were used as subjects. Therefore, the Instrument in question was used, and the data collection procedure was carried out in two successive moments: First self-registration and then self-report (in the same therapy session). Following the European Directive 2001/20 for patients, the corresponding Informed Consent was obtained, stating in this document the description of the clinical investigation, confidentiality and voluntary participation.

Given the exploratory nature of this study and that our intention has been none other than to offer some examples of the evaluation and treatment possibilities offered by the ICBA, for this reason a defined criterion for the participation of the subjects was not followed, resorting simply to those cases that we had most at hand. For the rest, we consider it opportune to include not one, but two self-records of Patient 2 to show that the evaluation that we propose is not monotonous and that the aforementioned Instrument can detect the versatility of incidents of low self-esteem that can happen to the same subject, also providing certain indications about the coexistence of other possible psychopathologies that suppose different barriers for her self-esteem. We estimate that the two records corresponding to the same subject do not affect or introduce any bias in our results because here, in reality, no data analysis is carried out, but only a description of them is presented.

Results

Patient 1

22-year-old female, university student. Initial evaluation: Self-concept (RSCQ)= 110 and self-esteem (SSES)= 40; with anxiety (HAM-A= 47) and depression (BDI= 26). Temporarily suspended treatment.

Self-Registration Sheet: Part I. The low self-esteem incident took place when working groups were formed in class. The patient was assigned by her teacher to a work group, its members did not allow her to participate, and she had a behavior of inhibition. She assigned this situation to the area of social acceptance, badly evaluating her performance (value= + 2) and negatively interpreting how the situation was resolved (value = - 7). She attributed the result to internal factors (percentage = 50%) and external factors (percentage = 50%), poorly evaluating both her final ego-Perceived (value= + 1-2) and her resulting self-esteem (value= + 2).

Analysis Sheet: Part II. The patient did identify the situation as a self-esteem instance in the area mentioned. Her ego-Model would have required to impose herself on the created situation, having been her personal goal to actively participate in the team. The demands of the self-esteem instance were not to be trampled on and, according to her ego-Model, she should have stood up for herself. The repertoire of alternative behaviors and their respective estimation of results were: Insisting on participating (value = + 6), talking to the teacher (value= - 5), hitting them (value= - 8) and displaying assertive behavior (value= + 7). This last option was the behavior selected during the analysis. The barriers that prevented her from behaving in this way were shame and fear of reprisals (internal barrier) and that her group mates did not see her well (external barrier). If she had behaved according to the selected behavior, she understands that then the self-esteem instance would have been resolved in a positive way (value= + 7), now mostly attributing its result to internal causes (percentage= 80%) and, to a lesser extent, to external causes (percentage= 20%). Her final ego-Perceived (value= 7) and also her self-esteem (value= + 8) would have been raised.

Patient 2

18-year-old female, vocational training student. Initial evaluation: Self-concept (RSCQ = 91) and self-esteem (SSES) = 48; with anxiety (HAM-A = 45) and depression (BDI = 32). Treatment completed with the following evaluation: RSCQ = 152, SSES = 92; and HAM-A = 20 and BDI = 11.

Self-Registration Sheet: Part I. The patient conceptualized the situation as one of social competence. It was an informal meeting with friends and also with some new guys she didn't know. Her behavior consisted of isolating herself and ending up leaving. She rated her own performance very poorly (Value = + 0-1) as well as the result of the situation (value = - 8), mainly attributing the result obtained to internal factors -she did not feel capable- (percentage = 90%) and in some measure also to external factors -the others did not address me (percentage = 10%). She rated low her final ego-Perceived (value = + 1-2) and the resulting self-esteem (value = + 4).

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Analysis Sheet: Part II. She began the self-esteem instance with a medium-low initial ego-Perceived (value = 4). Her ego-Model would have required opening up to others, showing interest in getting to know them... The situation would have required initiating conversations, participating and sharing with others. The alternative behaviors that would have predictably led to a negative result of the analyzed self-esteem instance were: Not talking and checking her mobile, not showing interest in anyone; and the alternative behaviors with a positive estimation of results were: being nice, bringing up topics of conversation, asking questions. The behavior selection fell right on being nice. If she had acted like this, then she believes that her resulting self-esteem would have been high (value = + 10).

Same previous patient, new self-esteem instance three weeks after the preceding critical incident. We summarize her Self-registration Sheet and Analysis Sheet.

Self-Registration Sheet: Part I. Situation: At night at home, the day before the driving theory test, in a context of personal competition. Performance: The patient repeatedly took different driving school tests, which went wrong one after another... Her performance was considered quite poor (value = + 1) and she negatively assessed the result of the self-esteem instance itself (value = - 8). She made an exclusively internal attribution of the result (percentage = 100%), and both her final ego-Perceived-I (value = + 1) and the resulting self-esteem (value = + 2-3) were very low.

Analysis Sheet: Part II: Indeed, she identified the situation as a self-esteem instance, related to personal competence -specifically, regarding her intelligence. Low initial ego-Perceived (value = + 3). Ego-Model: Appear self-confident, calm. Personal goals: Pass all possible tests. Demands of the situation: Concentrate on the task. Repertoire of behaviors deduced from the ego-Model in connection with personal goals: Being confident and concentrating on the task, being relaxed and calm, relaxing before continuing, quitting - all of them with a positive outcome estimation for the self-esteem instance. Selected behavior: Quit. The internal barriers that prevented her from carrying out the selected behavior were her own insecurity and the belief that she was not really ready. She believes that if she had implemented the selected behavior, the result of the self-esteem instance would have improved markedly (value = + 9), as well as her final perceived self (value = + 9 and the resulting self-esteem (value = + 9).

Patient 3

36-year-old woman, teacher. Initial evaluation: Self-concept (RSCQ= 94) and self-esteem (SSES)= 44; also, with anxiety (HAM-A= 31), and depression (BDI= 26). Ongoing treatment.

Self-Registration Sheet: Part-I. Situation: At home, playing chess with her partner, in a context of personal competition. Performance: She lost the game and felt horrible, getting angry with herself. See judged that her performance had been very poor (value= -6), and that the self-esteem instance had been poorly resolved (value= -6). Exclusively internal attribution (percentage= 100%). Very low final ego-Perceived-I (value= + 2) and resulting self-esteem (value= + 3).

Analysis Sheet: Part-II. She perceived the situation as a self-esteem instance, relative to the context cited above. Initial ego-Perceived: (Value= + 6-7), and personal goal: To win, to feel superior. Demands of the situation: chess strategies, having a good time. Ego-Model: Win or lose with sportsmanship. Alternative behaviors: dismiss such a competitive spirit, go without expectations, have a good time. This last option would be just the behavior she selected. Internal barrier: Prove to be at the level. Final ego-Perceived (value= + 7), and self-esteem: (Value= + 7). See a summary of some of these results in Table 1.

Behavior Performed (Part-I: Self-Registration Sheet)				Selected Alternative Behavior (Part-II: Analysis Sheet)			
Patient	Result Instance	Final Ego-Perceived	Resulting Self-Esteem	Result Instance	Initial Ego-Perceived	Final Ego-Perceived	Resulting Self-Esteem
1	-7	1-2	2	7	8	7	8
2	-8	1-2	4	+7-8	4	7	10
2	-8	1	2-3	9	3	9	9
3	-6	2	3	7	6	7	7

Table 1: Observed and estimated consequences, respectively, for the behavior performed on the self-esteem occasion and for the selected alternative behavior that could have been performed in that same situation.

Note: Occasion result: result of the self-esteem occasion. Final ego-Perceived: how the subject has seen himself when leaving the self-esteem occasion. Resulting self-esteem: how the subject has estimated himself when leaving the self-esteem occasion. Initial ego-Perceived: how the subject saw himself upon entering the self-esteem occasion (all values on a 11-points (range 10-0) Likert scale, with positive and negative values for the outcome of the occasion, and with values only positive for the rest of the variables).

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In this above Table, on the left, the consequences observed in the behavior performed are presented, and on the right the estimated consequences if the most convenient alternative behavior to raise self-esteem had been carried out. The variable “result instance” refers to the result of the self-esteem occasion itself for self-esteem purposes, with a negative sign indicating that such a result has lowered self-esteem and a positive sign, that it has raised it, while the registered value indicates, for its part, the magnitude of the consequences produced. The variables “final ego-Perceived” and “resulting self-esteem” refer, respectively, to how the subject has seen and estimated himself at the end of or leaving the self-esteem occasion; while the variable “initial ego-Perceived “ -only evaluated on the occasion of the alternative behavior- refers to how the subject had seen himself when starting or entering the self-esteem occasion, low values indicating negative effects and high values positive effects on these last three variables. The values corresponding to the ego-Model are not included because in this study they were always assumed to have a value= 10 on the scale.

Discussion

As the results show, in all the self-esteem instances analyzed, the behaviors selected according to the ego-Model would have resolved the situation better than the behaviors carried out de facto. Likewise, the estimates for the final ego-Perceived tend to improve the initial ego-Perceived in the analysis -except in one case because the physical aspect was intermingled with personal competence-, also surpassing these last estimates to those corresponding to the final ego-Perceived consigned previously in the self-registrations -with an average increase of 6 points. The self-esteem estimated in the analysis also rises accordingly with respect to that consigned in the self-registrations -now reaching an average increase of more than 5.5 points. All this, in our opinion, assumes that the present trial of the Instrument (CILS-E) has sufficiently passed its initial test.

In general, these preliminary results show that, at the time of the analysis, the behaviors selected based on the ego-Model, and that hypothetically could have been carried out as alternative behaviors during the same self-esteem instance described in the corresponding self-registrations, would increase the resulting self-esteem in that situation, which provides some support, albeit indirect and delayed, to the model of updating and maintaining self-esteem. It should be added to the above that in the case of the patient who finished the treatment, her final evaluation significantly improved the initial evaluation both in self-concept and self-esteem as well as in the symptomatic state.

Extrapolating the results obtained in the therapy sessions to the habitual functioning of the patients in their daily lives, the components of the model (Figure 1) would explain how their low self-esteem would be the result of the discrepancy that occurs between their ego-Model and their ego-Perceived thanks to how they usually face the self-esteem occasions. Such situations, as has been seen, are resolved poorly, so that their ego-Perceived (final) suffers, consequently distancing themselves from their ego-Model self (criterion), and thus resulting in damage to their self-esteem.

In addition to this, the processes of the model (Figure 2) would also explain the cognitive-behavioral dynamics of low self-esteem, since although these patients identify the different self-esteem occasions that are presented to them, nevertheless it seems that they are not capable of deliberately select and implement at that moment that behavior that could be more convenient for their self-esteem persisting, on the contrary, in a behavior that is really harmful to them, a consequence aggravated by the absence or insufficiency of those self-esteem resources -e.g., social skills, ability to concentrate- necessary to meet the demands that such situations place on them. Despite these difficulties and inconveniences observed, with the help of the particular therapy of the model proposed above, patients do become capable both of recognizing the demands that the occasion of self-esteem raises in connection with their personal objectives and of describing the ego-Model and even to select other alternative behaviors that could be of more benefit to their self-esteem.

Finally, focusing now on the evaluation of the ego-Perceived (see Figure 3), the model would also account for how these patients have been constantly misvaluing themselves by biasing both the interpretation of the results of the self-esteem occasion and the attribution of self-esteem causes, markedly internal, that is, patients end up blaming themselves for the failure. At this point, it has been found that patients also manage to correct such biases, although now with general therapy techniques such as, for example, with the classic reattribution technique [45].

All of this as a whole would be consistent with the main assumption of the model, namely, that self-esteem is updated and maintained as the patient resolves the situations where their self-esteem is at stake. This is reflected in the feedback loops proposed in the theoretical model (see Figures 1 and 2).

- From self-esteem towards the ego-Model and the ego-Perceived.
- Between both representations.
- From them towards the self-esteem occasions.

A frequent poor resolution of such situations would crystallize in the maintenance of low self-esteem and the opposite if from now on patients began to resolve them

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well thanks to the therapy for low self-esteem according to the present theoretical approach of its updating and maintenance. In short, it should be pointed out now that from the model we are dealing with, self-esteem would never be so much a trait or state as a result.

On the other hand, as we have explained, the Analysis Sheet provides proof of certain cognitive biases and personal maladjustments, as well as some indications about other probable disorders, valuable information that can be used to set the course of therapy and choose the most appropriate therapeutic techniques. -e.g., reattribution in case of a clearly biased attribution of results. Barriers that surfaced in the analysis could be used in a similar way. Focusing now on the self-reports analyzed here, the Analysis Sheet of the first patient and the first Analysis Sheet of the second patient point to the existence of two social phobias that, if such a diagnosis is confirmed, would require a focused complementary clinical intervention, in our opinion, in deconditioning -more marked in the case of the first patient- and/or even in training in social skills -especially in the case of the second. On the other hand, in the second Analysis Sheet of this second patient, concern, insecurity and lack of concentration are revealed, indicating a possible anxiety disorder that would require timely therapy. It should be mentioned that in this Analysis Sheet, the behavior selected by the patient supposes an escape behavior -perhaps inadvisable in other circumstances-, but the patient's persistence in it was being detrimental both to her final ego-Perceived and to her self-esteem. Finally, in the case of the third patient, the analysis reveals a certain rigidity in her when considering how to deal with the self-esteem instance, which reveals an urgent need to win at all costs, forcing herself to perform perfectly, without fault, which provides indications, perhaps, of an obsessive-compulsive personality disorder or traits.

The completion of the Analysis Sheet, as we have seen, forms a substantial part of the particular therapy of the model and, in this regard, it should be noted that the particular clinical approach of the model also differs from the currently existing therapies for self-esteem that, we understand, are more biased by focusing their therapeutic objective mainly around the ego-Perceived in one way or another. As Duro A [10] has shown, these therapies focus well on certain positive qualities of the subject, as in trait-based therapy [6] either on adjusting the patient's cognitions about himself and increasing his abilities, as occurs in cognitive-behavioral therapy [7,16] either in making the subject aware that thoughts about himself are not necessarily reliable representations of himself, in the case of the mindfulness approach [60] either in deconditioning traumatic memories of the self, which is what is done with the EMDR technique [4] or, finally, by reducing self-critical ruminations [61] objective of metacognitive therapy. In no case do these therapies incorporate the concept of ego-Model as a principle to derive from this mental representation those behaviors that are estimated to be more adequate and appropriate on different self-esteem occasions. Nor do they articulate the perceived self or the patient's personal goals with self-esteem occasions, as is done here.

Regarding the therapeutic efficacy of the present approach, and the fact that the patient becomes clearly aware of the meaning contained in the results of the analysis and of the potential benefits that its presumed projection would bring him on future instances of self-esteem that may arise, can serve as a powerful argument to motivate him to change. During the analysis, the patient realizes that the way in which he has been behaving on a day-to-day basis is maintaining his low self-esteem, that is, the patient now realizes that he is acting in a way that is detrimental to his mental health and that, for this reason, he should discuss with himself to start behaving in a way that is more convenient for his self-esteem. In short, information and arguments appear in the analysis that exhort the patient to always carry out the best behavior for his self-esteem in each situation, dissuading him at the same time from carrying out the worst behavior -in the fullest sense of the concept of deliberation of the Aristotelian rhetoric.

At present, it is not possible to make a direct comparison of our results with other similar studies because, as our research is based on a recent theoretical model, there is still no precedent -given the close relationship that exists, as is understandable, between the theoretical components of the basic model and the clinical variables that are adopted as measures. However, to better define our results in this field of study, differentiating them from the results obtained from other clinical and theoretical approaches, we will now describe the measures used in a small sample of works carried out on low self-esteem that we extract from the references cited by Duro A [10].

Hall PL, et al. [6], based on a trait approach, use for their therapy ten positive qualities that the patient thinks they possess, and use self-esteem, anxiety, depression, psychotic symptomatology, social functioning and satisfaction of the patient as variables in their study. For their part, and from a cognitive approach, Pack S, et al. [14] measure the health, generalized anxiety and self-esteem of patients through self-reports, while Waite et al. [16], on the other hand, measure self-concept, depression, anxiety and clinical results. Kolubinski DC, et al. [20], from a metacognitive approach, evaluates self-esteem, self-criticism, self-critical rumination, metacognition, and negative affect. As can be seen, in any case these are measures of a more static nature -they are measures of mental, functional or symptomatic status-, which have very different qualities from our measurements

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made with the CILS-E Instrument, of a much more dynamic nature, where the patient's interaction with each critical situation and the different consequences that it brings are recorded.

In conclusion, and in accordance with our objective, we estimate that the present study makes the following contributions:

- Initiates the clinical application to treat low self-esteem of the self-esteem updating and maintaining model [1].
- Proposes a treatment for low self-esteem designed from the components of the theoretical model, setting specific therapeutic objectives, explaining its specific mechanism of action and developing its own treatment structure.
- It provides, at the same time, a measurement Instrument (CILS-E) for the proper collection of data, whose format is in accordance with the theoretical model.
- Offers some preliminary results that provide some support for the principles of the model; and, lastly.
- It makes it possible, from now on, from the new focus of study on self-esteem represented by the model that concerns us, starting from the theoretical model and using the CILS-E measurement Instrument tested here, subsequent investigations both of a theoretical nature -for the contrast of hypotheses-, as well as methodological -psychometric analysis of the CILS-E-, or clinical -estimation of the therapeutic efficacy of the proposed treatment.

Clearly, this article suffers from various limitations that must be taken into account to qualify the scope of its results. In principle, of a methodological nature, due to the very use of a self-registration and self-report instrument, whose pros and cons we have previously examined. Secondly, the results, although promising and giving confidence to the proposed clinical approach, are still clearly insufficient, being limited to data obtained after the self-esteem instance, already during the course of therapy. That is, they still do not reflect the application by the patient of the principles of this new therapy in real time and situations.

Due to the aforementioned limitations and the possibilities that now jointly offer the theoretical model and the evaluation instrument, future research should carry out the appropriate psychometric evaluation of the CILS-E -reliability, convergent and discriminant validity- with sufficiently large samples of subjects and using control groups. In addition, from a clinical perspective, studies with systematic measures of self-concept and self-esteem before-during-after treatment should be addressed to verify the efficacy of the therapy proposed here. This would imply moving from a mere a posteriori analysis of low self-esteem critical incidents, to an a priori planning of how the patient should implement the selected behavior based on the ego-Model during the next self-esteem instances that he experiences.

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